LIVING WILL SAMPLE

This living will is but a *sample*, generously provided to us by congregational member Shelley Steuer, J.D. as an example of how to articulate one's wishes. In our workshop, we will be working with the Massachusetts Advanced Care Directive through the organization Prepare for Your Care. While you can always add such detailed information in the open space on p. 12 of the Prepare for Your Care Advanced Care Directive, for any number of reasons you might want to create a separate document with clear parameters such as these regarding certain interventions wanted or not wanted under certain conditions of health.

NOTE: This sample living will comes from the perspective of someone who is very clear that in the case she/er receives a terminal diagnosis (likely to cause death within 12 months) she/he does not want any medical interventions that have the purpose of prolonging life. She also gives clear markers of what kind of life would be unacceptable to her/him should she be living with a disease or illness from which no recovery is expected. And she/he also includes explicit thinking about dementia, and about debilitating disease such as Parkinson's or ALS. She/he is very clear that in all these cases she/he would want to be cared for with aggressive pain management.

Reading and sitting with this sample as a template might be interesting as a way to see where your thoughts and feelings have any resonance, and where they clearly may not. It is not presented here as a "recommendation" for you to adopt personally. Rather, it is more like a "thought piece" to stimulate your own thinking and feeling.

-- Nancy Flam

LIVING WILL

I, _____ of _____, Massachusetts ("the Principal") hereby create this Living Will to express my convictions, beliefs and wishes regarding my medical care in the event I become terminally or seriously ill and I am unable to make or communicate my own medical decisions due to a physical or mental disability. This document is intended to serve as guidance to my Health Care Agent and Alternate Agent (referred to in this document as my "Agent") under my Health Care Proxy.

1. <u>Statement of My Convictions, Beliefs and Wishes</u>

(a) If I am either:

(i) terminally ill in the opinion of my Agent after consulting with my treating physician(s);

(ii) in an irreversible coma, a persistent vegetative state or brain dead in the opinion of my treating physician(s); or

(iii) suffering from a serious disease or illness from which there is no expectation of recovery and that has caused me to have a profoundly diminished, and hence unacceptable, quality of life with no reasonable expectation of regaining an acceptable quality of life (as determined by my Agent),

I would want my Agent to order the cessation or withdrawal of all medical interventions intended to prolong my life, including artificially administered nutrition or hydration.

For the purposes of paragraph (i), above, the term "terminally ill" means a condition that, to a reasonable degree of medical certainty, will result in my death within twelve months.

For the purposes of paragraph (iii), above, my Agent should consider the following factors (together with conversations I have had with my Agent about these factors) in determining whether I have a profoundly diminished, and hence unacceptable, quality of life:

A. Inability to recognize family or close friends;
B. Inability to make or communicate responsible decisions about my personal matters;
C. Use of a ventilator that is required to keep me alive;
D. Having a feeding tube inserted into my stomach and/or being unable to be fed by a spoon;
E. Experiencing pain most of the time;
F. Experiencing extreme discomfort most of the time;

Initial if you want your agent to follow the instructions in paragraphs (b) or (c), below:

_____ (b) If I am ill with a disease characterized by dementia – Alzheimer's or any other form of dementia – I do not wish to be kept alive by feeding once I cannot hold a spoon or fork and feed myself. To be clear: I do not wish to be fed if I cannot feed myself due to dementia. I realize that this will result in starvation over a period of days or weeks, and that this will be difficult for the family members and professional people who care for me. I ask for aggressive comfort measures instead, including pain medications, sedatives if I am agitated, and as comfortable an environment as can be provided.

_____ (c) If I am ill with a physically debilitating disease – Parkinson's or ALS or any other form of weakness, wasting or inability to care for myself – I ask that my family honor any request I make during that time. This includes honoring my request to not eat and to not take medications that prolong life but do not hold the promise of improvement or cure. Again, I ask for aggressive comfort measures, but not for medical or nutritional measures that will prolong my life.

2. **Pain-free Death**. I do not want my death to be painful. I would want doctors to provide to me medication of any type or form liberally that can be administered by any medically acceptable means, even if the medication may have adverse cardiac or respiratory consequences, create an addiction, cause drowsiness, hallucinations or confusion or otherwise hasten my death.

3. **Organ, Tissue and Parts Donation**.
It is my wish to donate whatever organs can be useful

4. **Resolution of Disputes.** If there is a disagreement or dispute among my family members or other loved ones as to my intentions in matters governed by this Living Will, my Agent shall make the final and binding decisions regarding my care.

5. **Lawsuits.** My Agent is authorized to initiate, defend or otherwise participate in any legal proceedings (including actions for injunctive relief and/or damages) that may be necessary to carry out my wishes as expressed by me in this Living Will.

6. **HIPAA Release Authority**. I intend for my Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

_____ _____

Date , Principal

We affirm that this was signed or acknowledged in my presence, and that the person signing this document (the principal) appears to be of sound mind and under no duress. I am at least 18 years of age. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal. I am not entitled to any portion of the principal's estate upon his or her death, whether under any will or by operation of law.

Witness: _____ Witness: _____

Print name: _____ Print name: _____

Address: 64 Gothic Street, Northampton, MA Address: 64 Gothic Street, Northampton, MA

Date: _____ Date: _____