

Why Use the Patient Self-Protection Document?

The Patient Self-Protection Document (PSPD) is a life-affirming version of the Durable Power of Attorney for Health Care (DPAHC). The purpose of a DPAHC is to name someone you trust, usually a family member or close friend, to make health care decisions for you in the event you are unable to do so yourself. It is extremely important to confirm that your selected agent agrees with your perspective on end of life issues.

With the passage of the Patient Self-Determination Act (Danforth/Moynihan) in the Budget Reconciliation Act of 1990, the legal landscape was changed. As of December 1, 1991, every adult patient entering any health care facility receiving Federal funds will be questioned about whether they have signed an advance directive (either a living will or durable power of attorney for health care). As a DPAHC, the Patient Self-Protection Document is clear and effective for addressing this requirement.

In the current medical and legal climate that actively promotes euthanasia and assisted suicide for the disabled and terminally ill, we endorse this specific form, realizing that there is no substitute for a competent physician, faithful to the Hippocratic ethic and tradition, as the prime protector of the rights of the terminally ill and the incompetent disabled.

The document has two critical pages that must be signed and dated in the presence of witnesses: one page of "Instructions for My Health Care" and one page for designating an agent(s) as durable power of attorney for health care. You may add your specific personal instructions if you wish. **However, our endorsement is for the document as presented.** Original copies of your document should be provided to your agent(s), and might also be given to your physician, or health care institution, at your discretion.

Review the document periodically. You may revoke it in writing or orally in the presence of two witnesses who will attest to the revocation in writing, or by destroying it. You must let all holders of the copies know of your revocation or any alterations.

If you need assistance, please contact: Illinois Right to Life Committee, 65 E. Wacker Place, Suite 800, Chicago, IL 60601, (312) 422-9300.

Illinois Right to Life Committee is indebted to the following individuals who developed the original version of this Patient Self-Protection Document, which has only needed minimal revisions over these many years: Nancy Czerwiec, Marie Dietz, Julie Grimstad, Theresa Hanley, Mary Perona, Bonnie Quirke, Msgr. William Smith, S.T.D., Joseph Stanton, M.D., and Shirley Wood

*For redistribution, this document may be reproduced **only** without alteration.*

Patient Self-Protection Document

(INSTRUCTIONS FOR MY HEALTH CARE)

Since it is not possible to foresee the specific circumstances under which someone else may have to make health decisions for me, and since it is not possible to foresee what specific decisions I might make if certain circumstances did occur, I have thought seriously about and confirmed the beliefs and principles on which I base decisions I make for myself. In the following paragraphs I have set down these principles and beliefs as instructions for those who must make decisions for me should I become legally incompetent.

I direct my agent(s) and all those in charge of my medical care to follow these instructions in making health care decisions for me if I am incompetent to make them myself and, where the instructions are not explicit, to honor the spirit of these reflections:

- Because human bodily life is inherently good and not merely instrumental to other goods, nothing should be done which will directly cause my death, nor should anything be omitted when such an omission would be the direct and primary cause of my death. Euthanasia, whether by omission or commission, is not permitted. I instruct my agent(s) and my physician to assist me in fulfilling the days of my life until natural death.
- I wish to receive medical care and treatment appropriate to my condition, which offer a reasonable hope of benefit without excessive pain, expense or other excessive burden to me, and which do not pose a severe threat to my life. I direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the "quality" of my life.
- I wish food and fluids provided to me either orally, intravenously, by tube, or by other means to the full extent necessary to both preserve my life and to prevent death by dehydration and/or starvation, unless death is truly imminent from an underlying fatal disease, or unless I am unable to assimilate foods or fluids.
- If I am diagnosed as terminally ill, pain relief and basic nursing care, specifically including food and fluids as noted above, should be provided, as well as ordinary nursing and medical care appropriate to my condition. Although pain relief may be necessary, it should never be intended to cause death by suppression of breathing or terminal sedation.

These instructions are always a part of my Self-Protection Document and are binding not only on my appointed agent but on any health care personnel or institution which makes a decision regarding my care and/or treatment.

Name (Print) _____

Patient Signature _____

Date _____

Patient Self-Protection Document

(DURABLE POWER OF ATTORNEY FOR HEALTH CARE)

I, _____, do hereby designate and appoint

(name) _____,

(address) _____,

(city, zip, state) _____,

(home phone) _____, (work phone) _____

as my attorney-in-fact/agent to make my health care decisions for me in the event that I become incompetent and only for the duration of such incompetency.

Health care decisions are highly personal. Because specific, written advance directives ("living wills") have serious limitations and are open to serious misinterpretations which may interfere with decisions in accord with my wishes and/or which are appropriate in a specific situation, I have discussed carefully my preferences for medical treatment with the above named agent. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

I direct my agent to choose on my behalf the appropriate course of treatment or non-treatment which is consistent with the attached instructions. I charge my agent and all those attending me neither to approve nor commit any action or omission which by itself or by intent will cause my death.

This document is intended to confer legal immunity on my agent unless my agent is not acting in accordance with the limitations, provisions, and directions expressed in this document. This document does not confer legal immunity on any physician or health care institution.

If the person named as my agent is not available or is unable to act as my agent, I appoint the following persons to serve in the order listed:

1. Alternative Agent: _____,

(address) _____, (phone) _____

2. Alternative Agent: _____,

(address) _____, (phone) _____

By signing here I understand the purpose and effect of this document:

(patient signature) _____,

(address) _____, (phone) _____

This document, dated _____, supersedes any advance health care directive previously signed by me.

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that he/she appears to be of sound mind and under no duress, fraud or undue influence. I am not the person appointed agent by this document, nor am I the patient's health care provider, nor an employee of the patient's health care provider.

First Witness: _____, signature _____,
(address) _____, (date) _____

Second Witness: _____, signature _____,
(address) _____, (date) _____

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION:

I further declare that I am not related to the patient by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of his/her estate under a will now existing or by operation of law.

First Witness Signature _____

Second Witness Signature _____

Only this document bearing my original signature is to be considered legally valid. A photocopy of this signed document can be used for informational purposes only. Original signature documents should be provided to the agents listed herein, and might also be given to your physician, your health care facility, and possibly others. Be sure to keep a distribution list so you can notify all holders of copies if you revoke your document. **State laws vary. Outside Illinois, see an attorney before signing.** If you have any questions regarding this Patient Self-Protection Document, please contact IRLC at illinoisrighttolife@ameritech.net or call (312) 422-9300.

Original signed copies of this document have been provided to:

**Declaration of My Intent Regarding
Organ/Tissue Donation Upon Death**

Recognizing the persuasion that may be exercised on my agent, or other relatives, if I am deemed to be a candidate for organ/tissue donation, I, _____, want to declare here my intent regarding organ/tissue donation upon my death. *(Initial your selection.)*

____ I refuse to make an anatomical gift of any organ or tissue under any circumstances.

____ I refuse to make an anatomical gift of any vascularized organ (vital organ). I do not want any vascularized organ (vital organ) taken for transplantation or for any other purpose. My agent, appointed by this DPAHC, may make all other decisions regarding anatomical gifts after my agent is certain that I am dead. *(This option is recommended if you do not consider brain death to be a reliable determination of death. More information on this issue is available from Illinois Right to Life Committee.)*

____ I authorize an anatomical gift of any organ or tissue, but at the discretion of my agent, as appointed by this DPAHC.

____ I authorize an anatomical gift of only the following organs or tissue: _____

but at the discretion of my agent, as appointed by this DPAHC.

____ I authorize an anatomical gift of any organ or tissue based on my irrevocable intent. *(This option is consistent with registration in the Organ/Tissue Donor Registry – offered to you each time you renew your driver's license.)*

Signature _____ Date _____

Witness _____ Date _____

Witness _____ Date _____