

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

I am \_\_\_\_\_, of \_\_\_\_\_ . This is my Directive to Physicians and Family or Surrogates.

**Treatment decisions while I am able to make my wishes known**

I recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored.

**Treatment preferences if I become unable to make my wishes known**

***If I have a "terminal condition."*** If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care (indicate your preference by initialing in front of one of the following paragraphs):

\_\_\_\_\_ Withhold life sustaining treatment—I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

\_\_\_\_\_ Do not withhold life-sustaining treatment—I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

***If I have an "irreversible condition."*** If, in the judgment of my physician, I am suffering with an irreversible condition (other than a "terminal condition," which is provided for above) so that I cannot care for myself or make decisions for myself and am expected to die (but not necessarily within six months) without life-sustaining treatment provided in accordance with prevailing standards of care (indicate your preference by initialing in front of one of the following paragraphs):

\_\_\_\_\_ Withhold life sustaining treatment—I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

\_\_\_\_\_ Do not withhold life-sustaining treatment—I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

**Additional Requests.** For example, in those circumstances where I have indicated that certain treatments are to be withheld: (i) procedures to be discontinued or withheld include cardiac resuscitation, mechanical respiration, tube feeding, and antibiotics; however, (ii) I do want the administration of saline solutions, so that I will not die from dehydration, and I do want medication to alleviate pain (including any pain resulting from withholding or withdrawing treatment) even though it may shorten my life. I do not want to be maintained in or approaching what is known as a vegetative state. I prefer to live out my last days at home rather than in a hospital, if it does not jeopardize the chance of my recovery to a meaningful and sentient life and does not impose an undue burden on my family.

Whether I have either a terminal condition or merely an irreversible condition: (a) for so long as there is a reasonable possibility of my recovery to a meaningful and sentient life, even if only for a matter of weeks or even days, I request that I be kept alive using available life-sustaining treatment; on the other hand, (b) whenever there is not a reasonable possibility of my recovery to a meaningful and sentient life, I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible.

**Effect of electing hospice care**

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

Additional matters

Immediately prior to the execution of this Directive, I executed a Medical Power of Attorney, dated \_\_\_\_\_, naming the following person(s), in the order listed, as my agent(s):

(1) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(3) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I do not have a Medical Power of Attorney, or if I have revoked my Medical Power of Attorney executed on \_\_\_\_\_, I designate the person(s) named immediately above to make treatment decisions with my physician compatible with my personal values.

If the above persons are unavailable or if I have not designated an agent, and I am unable to make my wishes known, I understand that an agent will be chosen for me following standards specified in the laws of Texas. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. This Directive will remain in effect until I revoke it. No other person may do so.

I have been provided with an information statement (a copy is attached) containing instructions for completing this Directive as well as certain definitions of the terms used in this Directive. I have read and understand the information contained in that information statement.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Declarant

**Witnesses**

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witnesses may not be persons designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. The witnesses may not be entitled to any part of the estate and may not have a claim against the estate of the patient. The witnesses may not be the attending physician or an employee of the attending physician. If the witnesses are employees of a health care facility in which the patient is being cared for, the witnesses may not be involved in providing direct patient care to the patient. The witnesses may not be officers, directors, partners, or business office employees of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

\_\_\_\_\_  
Witness #1 Signature

\_\_\_\_\_  
Witness #2 Signature

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

## **INFORMATION CONCERNING THE DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES**

Instructions for completing the directive to physicians and family or surrogates. The Directive to Physicians and Family or Surrogates, also known as an Advance Directive (“Directive”) , is an important legal document. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill. You are encouraged to discuss your values and wishes with your family or chosen agent, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning.

Initial the treatment choices that best reflect your personal preferences. Provide a copy of your Directive to your physician, usual hospital, and family or agent. Consider a periodic review of your Directive. By periodic review, you can best assure that your Directive reflects your preferences. In addition to the Advance Directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

### **Definitions**

**“Artificial nutrition and hydration”** means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

**“Irreversible condition”** means a condition, injury, or illness:

- (1) that may be treated, but is never cured or eliminated;
- (2) that leaves a person unable to care for or make decisions for the person’s own self; and
- (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

*Explanation:* Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer’s dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

***“Life-sustaining treatment”*** means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient’s pain.

***“Terminal condition”*** means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

*Explanation:* Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

Signed on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, to confirm that I received this information statement prior to execution of my Directive to Physicians and Family or Surrogates and that I have read and understand the information contained herein.

\_\_\_\_\_, Declarant