

*The Church Foundation*  
*Chartered in 1926*



SOURCE MATERIAL FROM EPISCOPAL CHURCH FOUNDATION

## Medical Directive

*The Medical Directive comes into effect only if you become incompetent.  
Complete the form in the context of a discussion with a physician.*

*Following is a general form of medical directive reprinted with the permission of the American Medical Association.\* Please note that many states have enacted legislation on advanced care directives. Please consult your attorney, healthcare provider, or state attorney general regarding requirements for healthcare directives in your state.*

## INTRODUCTION

As part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during serious illness they are often unconscious or otherwise unable to communicate their wishes—at the very time when many critical decisions need to be made.

The Medical Directive allows you to record your wishes regarding various types of medical treatments in several representative situations so that your desires can be respected. It also lets you appoint a proxy, someone to make medical decisions in your place if you should become unable to make them on your own.

The Medical Directive comes into effect only if you become incompetent (unable to make decisions and too sick to make your wishes known). You can change it at any time until then. While you are fully competent, you should discuss your care directly with your physician.

I am undecided; I do not want this treatment should be indicated. If you choose a trial of treatment, you should understand that this indicates you want the treatment withdrawn if your physician and proxy believe that it has become futile.

The Personal Statement section allows you to explain your choices and say anything you wish to those who may make decisions for you concerning the limits of your life and the goals of intervention. For example, in situation B, if you wish to define "uncertain chance" with numerical probability, you may do so here.

Next you may express your preferences concerning organ donation. Do you wish to donate your body or some or all of your organs after your death? If so, for what purpose(s) and to which physician or institution? If not, this should also be indicated in the appropriate box.

In the final section you may designate one or more proxies who would be asked to make choices under circumstances in which your wishes are unclear.

# Medical Directive

## COMPLETING THE FORM

You should, if possible, complete the form in the context of a discussion with your physician. Ideally, this should occur in the presence of your proxy. This lets your physician and your proxy know how you think about these decisions, and it provides you and your physician with the opportunity to give or clarify relevant personal or medical information. You may also wish to discuss the issues with your family, friends, or religious mentor.

The Medical Directive contains six illness situations that include incompetence. For each one, you consider possible interventions and goals of medical care. Situation A is permanent coma; B is near death; C is with weeks to live in and out of consciousness; D is extreme dementia; E is a situation you describe; and F is temporary inability to make decisions.

For each scenario you identify your general goals for care and specific intervention choices. The interventions are divided into six groups: 1) cardiopulmonary resuscitation or major surgery; 2) mechanical breathing or dialysis; 3) blood transfusions or blood products; 4) artificial nutrition and hydration; 5) simple diagnostic tests or antibiotics; and 6) pain medications, even if they dull consciousness and indirectly shorten life. Most of these treatments are described briefly. If you have further questions, consult your physician.

Your wishes for treatment options: I want this treatment; I want this treatment tried but stopped if there is no clear improvement;

You can indicate whether-or-not the decisions of the proxy should override your wishes if there are differences. Additionally, should you name more than one proxy, you can state who is to have the final say if there is disagreement. Your proxy must understand that this role usually involves making judgments that you would have made for yourself had you been able and making them by the criteria you have outlined. Proxy decisions should ideally be made in discussion with your family, friends and physician.

## WHAT TO DO WITH THE FORM:

Once you have completed the form, you and two adult witnesses (other than your proxy) who have no interest in your estate need to sign and date it. Many states have legislation covering documents of this sort. To determine the laws in your state, you should call the state attorney general's office or consult a lawyer. If your state has a statutory document, you may wish to use the Medical Directive and append it to this form.

You should give a copy of the completed document to your physician. His or her signature is desirable but not mandatory. The directive should be placed in your medical records and flagged so that anyone who might be involved in your care can be aware of its presence. Your proxy, a family member, and/or a friend should also have a copy. In addition, you may want to carry a wallet card noting that you have such a document and where it can be found.

# Medical Directive

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*This Medical Directive shall stand as a guide to my wishes regarding medical treatments in the event that illness should make me unable to communicate them directly. I make this directive, being 18 years or more of age, of sound mind, and appreciating the consequences of my decisions.*

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Name (Sign & Print)

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Street Address, PO Box, and/or Apartment #

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City State Zip Code

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Signature Date

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## Witness:

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Name (Sign & Print)

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Street Address, PO Box, and/or Apartment #

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City State Zip Code

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Signature Date

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Notes:

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# Medical Directive

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## Situation A

If I am in a coma or persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:

*(Please select one of the following options)*

- |   |  |
|---|--|
| <input type="checkbox"/> Prolong life; treat everything                           | <input type="checkbox"/> Attempt to cure, but reevaluate often |
| <input type="checkbox"/> Limit to less invasive and less burdensome interventions | <input type="checkbox"/> Provide comfort care only             |
| <input type="checkbox"/> Other (please specify): _____                            |  |

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. <b>Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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# Medical Directive

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## Situation B

If I am near death and in a coma and, in the opinion of my physician and two consultants, have a small but uncertain chance of regaining higher mental functions, a somewhat greater chance of surviving with permanent mental and physical disability, and a much greater chance of not recovering at all, then my goals and specific wishes, if medically reasonable, for this and any additional illness would be:

(Please select one of the following options)

- |   |  |
|---|--|
| <input type="checkbox"/> Prolong life; treat everything                           | <input type="checkbox"/> Attempt to cure, but reevaluate often |
| <input type="checkbox"/> Limit to less invasive and less burdensome interventions | <input type="checkbox"/> Provide comfort care only             |
| <input type="checkbox"/> Other (please specify): _____                            |  |

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
<b>1. Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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# Medical Directive

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## Situation C

If I have a terminal illness with weeks to live, and my mind is not working well enough to make decisions for myself, but I am sometimes awake and seem to have feelings, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:

(Please select one of the following options)

- |   |  |
|---|--|
| <input type="checkbox"/> Prolong life; treat everything                           | <input type="checkbox"/> Attempt to cure, but reevaluate often |
| <input type="checkbox"/> Limit to less invasive and less burdensome interventions | <input type="checkbox"/> Provide comfort care only             |
| <input type="checkbox"/> Other (please specify): _____                            |  |

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
<b>1. Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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# Medical Directive

The Church Foundation  
Chartered in 1926

## Situation D

If I have brain damage or some brain disease that in the opinion of my physician and two consultants cannot be reversed and that makes me unable to think or have feelings, but I have no terminal illness, then my goals and specific wishes—if medically reasonable—for this and any additional illness would be:

(Please select one of the following options)

- |   |  |
|---|--|
| <input type="checkbox"/> Prolong life; treat everything                           | <input type="checkbox"/> Attempt to cure, but reevaluate often |
| <input type="checkbox"/> Limit to less invasive and less burdensome interventions | <input type="checkbox"/> Provide comfort care only             |
| <input type="checkbox"/> Other (please specify): _____                            |  |

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. <b>Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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# Medical Directive

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## Situation E

If I... (describe a situation that is important to you and/or your doctor believes you should consider in view of your current medical situation): \_\_\_\_\_

(Please select one of the following options)

- Prolong life; treat everything
  Attempt to cure, but reevaluate often  
 Limit to less invasive and less burdensome interventions
  Provide comfort care only  
 Other (please specify): \_\_\_\_\_

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. <b>Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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# Medical Directive

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## Situation F

If in my current state of health (describe briefly): \_\_\_\_\_

I develop have an illness that, in the opinion of my physician and two consultants, is life threatening but reversible, and I am temporarily unable to make decisions, then my goals and specific wishes—if medically reasonable—would be:

*(Please select one of the following options)*

- Prolong life; treat everything
  Attempt to cure, but reevaluate often  
 Limit to less invasive and less burdensome interventions
  Provide comfort care only  
 Other (please specify): \_\_\_\_\_

	WANT	WANT (Stop if no improvement)	UNDECIDED	DON'T WANT
1. <b>Cardiopulmonary Resuscitation</b> (chest Compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>Major surgery</b> (for example, removing the gall bladder or part of the colon).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>Mechanical breathing</b> (respiration by machine, through tube in the throat).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. <b>Dialysis</b> (cleaning the blood by machine or by fluid passed through the belly).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Blood transfusions or blood products.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>Artificial nutrition and hydration</b> (given through a tube in a vein or in the stomach).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>Simple diagnostic tests</b> (for example, blood tests or x-rays).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>Antibiotics</b> (drugs used to fight infection).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>Pain medications, even if they dull consciousness and indirectly shorten my life.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes:

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\_\_\_\_\_

\_\_\_\_\_

## Organ Donation

- I do not wish to make any anatomical gift from my
- I hereby make this anatomical gift, to take effect after my death:

### I GIVE:

- My body
- Any needed organs or parts
- The following parts: \_\_\_\_\_

### TO:

- The following person/institution: \_\_\_\_\_
- The physician in attendance at my death
- The hospital in which I die

### FOR:

- Any purpose authorized by law
- Therapy of another person
- Medical education
- Transplantation
- Research

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Notes:

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## **My Personal Statement**

Please mention anything that would be important for your physician and your proxy to know. In particular, try to answer the following questions: 1) What medical conditions, if any, would make living so unpleasant that you would want life-sustaining treatment withheld? (Intractable pain? Irreversible mental damage? Inability to share love? Dependence on others? Another condition you would regard as intolerable?) 2) Under what medical circumstances would you want to stop interventions that might already have been started? 3) Why do you choose what you choose?

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When I am dying, I would like—if my proxy and my healthcare team think it is reasonable— to be cared for:

At a Home/Hospice                       In a Nursing Home                       In a Hospital

Other \_\_\_\_\_  
\_\_\_\_\_

If there is any difference between my preferences detailed in the illness situations and those understood from my goals or from my personal statement, I wish my \_\_\_\_\_ to be given greater weight. (Choose one)

Treatment Section                       Goals                       Personal Statement

# Medical Directive (Healthcare Proxy)

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I appoint as my proxy and decision-maker(s): (Name & Address) \_\_\_\_\_

\_\_\_\_\_ & (optional) (Name & Address) \_\_\_\_\_

I direct my proxy to make healthcare decisions based on his/her assessment of my personal wishes. If my personal desires are unknown, my proxy is to make healthcare decisions based on his/her best guess as to my wishes. My proxy shall have the authority to make all healthcare decisions for me, including decisions about life-sustaining treatment, if I am unable to make them myself. My proxy's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate healthcare decisions. My proxy is then to have the same authority to make healthcare decisions as I would if I had the capacity to make them, EXCEPT (list the limitations, if any, you wish to place on your proxy's authority).

I wish my written preference to be applied exactly as possible/with flexibility according to my proxy's judgment. (Delete as appropriate)

Should there be any disagreement between the wishes I have indicated in this document and the decisions favored by my above-named proxy, I wish my proxy to have authority over my written statements/I wish my written statements to bind my proxy. (Delete as appropriate)

If I have appointed more than one proxy and there is disagreement between their wishes, \_\_\_\_\_ shall have final authority.

## Signed:

\_\_\_\_\_  
Name (Sign & Print)

\_\_\_\_\_  
Street Address, PO Box, and/or Apartment #

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature Date

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Medical Directive (Healthcare Proxy)

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## Witness:

\_\_\_\_\_  
Name (Sign & Print)

\_\_\_\_\_  
Street Address, PO Box, and/or Apartment #

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature Date

## Witness:

\_\_\_\_\_  
Name (Sign & Print)

\_\_\_\_\_  
Street Address, PO Box, and/or Apartment #

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature Date

## Physician (Optional):

I am \_\_\_\_\_'s physician. I have seen this advance care document and have had an opportunity to discuss his/her preferences regarding medical intervention at the end of life.

If \_\_\_\_\_ becomes incompetent, I understand that it is my duty to interpret and implement the preferences contained in this document in order to fulfill his/her wishes.

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Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_