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## Ad Hoc Committee of Americans for the Protection of the Sick, Disabled and Elderly

Illinois Right to Life Committee

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**AD HOC COMMITTEE OF AMERICANS FOR  
THE PROTECTION OF THE SICK, DISABLED AND ELDERLY  
TO THOSE WHO VALUE OUR OPINION:**

Over the past 10 years we, the undersigned, have been steadfast in opposing euthanasia whether masquerading as "death with dignity" or the so-called "right to die." Because of its internal flaws and because it is the vehicle by which the "right to die" folk hope to advance their real agenda, we have been adamant in opposing the living will. It is gratifying to see that judgment sustained by an ever widening circle of informed opinion.

The durable power of attorney (DPA) for health care, while less flawed than the living will, has until now been viewed cautiously by us but not endorsed.

With the passage of the Patient Self-Determination Act (Danforth/ Moynihan) in the Budget Reconciliation Act of 1990, the landscape has been legally changed. As of November 30, 1991 every patient entering any health care facility receiving federal funds will be questioned about whether they have signed a living will or DPA. To meet this problem, we have drawn up what we believe is a life protective document, "The Patient Self-Protection Document".

Fully cognizant that in an ideal world such a document would be unnecessary, 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 three pages: One page of "Instructions For My Health Care" and a two page form for designating an agent(s). Both the instruction page and the form must be signed and dated. You may add specific personal instructions if you wish. However, our endorsement is for the document as presented. Copies of the document should go to your agent, your physician, any health care institution you enter and your family.

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. *Be sure to let all holders of the copies know of your revocation or any alterations.*

If you need assistance, please contact: *Illinois Right to Life Committee*, 11244 South Western Ave., Chicago, IL 60643, (312) 239-6457; *Center for Pro-Life Studies*, P. O. Box 166, North Troy, VT 05859, (802) 988-4041; *Center for the Rights of the Terminally Ill, Inc.*, 2319 18th Ave. South, Fargo, ND 58103, (701) 237-5667.

**SIGNATORIES\***

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*\*Institutional designation for identification purposes only.*

## 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 the beliefs and principles on which I base decisions I make for myself. In the following few paragraphs I have set down these principles and beliefs as instructions for those who must make decisions for me should I become 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 for myself:

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 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 life God has numbered for me.

I wish to receive medical care and treatment appropriate to my condition, which offers a reasonable hope of benefit without excessive pain, expense or other excessive burden to me and which does not pose a severe threat to my life.

I wish food and fluids provided to me unless death is inevitable and imminent so that the effort to sustain my life is futile, or unless I am unable to assimilate food or fluids. While certain treatments may be futile in combating or curing a disease, treatment or care which sustains life is not futile.

If I am diagnosed as terminally ill, pain relief and basic nursing care, specifically including food and fluids as above noted, should be provided, as well as ordinary nursing and medical care appropriate to my condition.

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)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### PATIENT SELF-PROTECTION DOCUMENT

#### (DURABLE POWER OF ATTORNEY FOR HEALTH CARE)

I, \_\_\_\_\_, do hereby designate and appoint

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

as my attorney-in-fact/agent to make 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 carefully discussed my preferences for medical treatment with the above named agent.

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 does not confer legal immunity on any agent, 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 person(s) to serve in the order listed below:

i. Alternative Agent:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

ii. Alternative Agent:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Current Address

\_\_\_\_\_  
Telephone

## PATIENT SELF-PROTECTION DOCUMENT

### WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that he/she signed or acknowledged this durable power of attorney for health care in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence. I am not the person appointed as 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: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Second Witness:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

(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.

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_