Directive to Physicians and Family Members

The Texas Health and Safety Code authorizes the use of a written Directive to Physicians and Family Members in accordance with the guidelines set out below.

Printed and distributed courtesy of the Texas Medical Association Board of Councilors
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Guidelines for Signers

General Information

If you are at least 18 years old, of sound mind, and acting on your own free will, you may sign a DIRECTIVE TO PHYSICIANS ("DIRECTIVE") concerning your own care in the presence of two qualified witnesses. The DIRECTIVE allows you to instruct your physician not to use artificial methods to extend the natural process of dying. Before signing the DIRECTIVE, you may ask advice from anyone you wish, including your attorney.

If you sign the DIRECTIVE, you must tell your physician. Ask that it be made part of your medical record. If you have signed a written DIRECTIVE of which your doctor is unaware, inform your doctor of its existence. If you become physically or mentally unable to do so, another person may inform your physician.

Witnesses

The DIRECTIVE must be witnessed by two competent adults.

At least one witness cannot be a person who:

a. is related to you by blood or marriage;
b. has a claim on your estate;
c. has been designated by you to make a health care treatment decision on your behalf;
d. your attending physician;
e. is employed by your attending physician;
f. is an employee of a health care facility in which you reside, if the employee is involved in providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Effect of Directive

The DIRECTIVE becomes effective - meaning that life-sustaining treatment can be withdrawn - only when you become a "qualified patient." A qualified patient means a patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician.

No one may force you to sign the DIRECTIVE. No one may deny you insurance or health care services because you have chosen not to sign it. If you do sign the DIRECTIVE, it will not affect your insurance or any other rights you may have to accept or reject medical treatment. If your attending physician chooses not to follow the DIRECTIVE, he/she must make a reasonable effort to transfer responsibility for your care to another physician.

You may designate another person to make treatment decisions for you if you become incompetent, or are otherwise mentally or physically incapable of communication. However, you do not have to do so in order for the DIRECTIVE to be a legal document. If you do, that designated person may also execute an out-of-hospital do-not-resuscitate order

Enforceability of a Directive Executed in Another Jurisdiction

A directive or similar instrument validly executed in another jurisdiction shall be given the same effect as a DIRECTIVE validly executed under the law of this state. This does not authorize the administration, withholding, or withdrawal of health care otherwise prohibited by the law of this state.

Revocation

The DIRECTIVE is valid until it is revoked. You may revoke the DIRECTIVE at any time, even in the final stages of a terminal illness. If you revoke the DIRECTIVE, be sure your physician is told of your decision. The physician or the physician designee shall record in the patient's medical record the time and date when the physician received notice of the written revocation and shall enter the word "VOID" on each page of the copy of the DIRECTIVE in the patient's medical record. If you change your mind after executing a DIRECTIVE, your expressed desire to receive life-sustaining treatment will at all times supersede the effect of a DIRECTIVE.

Minors

If a qualified patient is under 18 years of age, any of the following persons may execute a DIRECTIVE on behalf of the patient: (1) the patient's spouse, if the spouse is an adult; (2) the patient's parents; or (3) the patient's legal guardian. However, the desire of a competent qualified patient who is under 18 years of age shall always supersede a DIRECTIVE executed on his/her behalf. A form which may be executed on behalf of a minor is provided.

Directive to Physicians and Family Members

Instructions for completing this document:

This is an important legal document known as a "Directive to Physicians." 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 spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in competing 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 spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this Directive to Physicians, 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.

Information is provided courtesy of the Texas Medical Association for general information and is not intended to serve as legal advice. Any legal advice needed for a particular situation should be obtained from an attorney.

Permission is granted to reproduce this document.

Directive to Physicians

For Persons 18 years of Age and Over

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:

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:

____ 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

____ 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, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

____ 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

____ 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: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment).

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.

If I do not have a Medical Power of Attorney and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values.

Name _____

Address _____

Name _____

Address _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document).

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson 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.

I understand that under Texas law this Directive has no effect if I have been diagnosed as pregnant. This DIRECTIVE will remain in effect until I revoke it. No other person may do so. I understand that I may revoke this DIRECTIVE at any time.

I understand the full import of this DIRECTIVE and I am emotionally and mentally competent to make this DIRECTIVE.

Signed _____

City, County and State of Residence _____

Date _____

Two competent witnesses must sign below, acknowledging your signature. The witness designated as "Witness 1" may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. The witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. The witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of the health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of the health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____

Witness 2 _____

TEXAS LAW DOES NOT REQUIRE THIS DIRECTIVE TO BE NOTARIZED.

Directive to Physicians

For Persons Under 18 Years of Age

DIRECTIVE made this _____day_____(month year).

On behalf of _____ a qualified patient under the DIRECTIVE TO PHYSICIANS who is under 18 years of age I/we _____ being of sound mind, willfully and voluntarily make known my/our desire that his/her life not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time the patient whose name appears above has an incurable or irreversible condition caused by injury disease or illness certified to be a terminal condition by two physicians and if the application of life-sustaining procedures would serve only to artificially prolong the moment of his/her death and if his/her attending physician determines that his/her death is imminent or will result within a relatively short time without application of life-sustaining procedures I/we direct that such procedures be withheld or withdrawn and that he/she be permitted to die naturally.

2. On behalf of the said patient it is my/our intention that this DIRECTIVE shall be honored by his/her physicians as the final expression of my/our legal right to refuse medical or surgical treatment on behalf of the said patient and to accept the consequences from such refusal.

3. If the patient has been diagnosed as pregnant and that diagnosis is known to her physician this DIRECTIVE shall have no force or effect during the course of her pregnancy.

4. This DIRECTIVE shall be in effect until it is revoked. I/we understand that my/our authority to execute this DIRECTIVE on behalf of the above-named patient expires on his/her 18th birthday.

5. I/we understand the full import of this DIRECTIVE and I/we am/are emotionally and mentally competent to make this DIRECTIVE.

6. I/we understand that the desire of the above-named patient, if mentally competent, to receive life-sustaining treatment shall at all times supersede the effect of this DIRECTIVE.

Signed _____

City, County, and State of Residence _____

Indicate relationship to patient _____Adult Spouse _____Parents _____Legal Guardian

Two competent witnesses must sign below, acknowledging the signature of the person executing the DIRECTIVE on the minor patient's behalf. The witness designated as "Witness 1" may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. The witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. The witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of the health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of the health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1_____

Witness 2_____

TEXAS LAW DOES NOT REQUIRE THIS DIRECTIVE TO BE NOTARIZED.