LIFE-AFFIRMING MEDICAL PROXY (LAMP)
A Medical Power of Attorney Document

The Life-Affirming Medical Proxy (LAMP) was developed by HALO in response to calls from people seeking HALO's help to obtain a medical power of attorney (a.k.a. a durable power of attorney for health care) in emergency situations. The LAMP document can be readily downloaded in such situations. The American Bar Association advises, "Even if your state requires a specific form, doctors have a legal obligation to respect your clearly communicated treatment wishes in any manner or form expressed, as long as the wishes are medically appropriate." Sabatino, Charles. "Myths and Facts About Health Care Advance Directives." *BIFOCAL*, vol. 37, no. 1, 2015, pp. 6–9. Accordingly, regardless of where you reside, a signed and properly witnessed LAMP document should be accepted as a valid expression of your wishes.

The following states do not have specific requirements for advance directives: Arizona, Arkansas, Colorado, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Nebraska, New Jersey, New Mexico, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Virginia, Washington and Wyoming.

You may prefer to have a state-specific medical power of attorney if you reside in any of the following states which have unique legal requirements for medical advance directives: Alabama, Alaska, California, Connecticut, Delaware, Florida, Hawaii, Indiana, Kentucky, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Texas, Vermont, West Virginia, or Wisconsin.

For residents of these states, HALO recommends the state-specific Protective Medical Decisions Document (PMDD) distributed by the Patients Rights Council. The PMDD is not available online. To order, call 740-282-3810 or toll free 1-800-958-5678. (Wisconsin residents may prefer to use the PPAHC mentioned below.) HALO strongly advises everyone who is 18 years old or older or an emancipated minor to **complete a valid life-affirming medical power of attorney before you need it.**

Note: The LAMP has been adapted from the Wisconsin Protective Power of Attorney for Health Care (PPAHC), which is prepared by and available from Pro-Life Wisconsin. (For Wisconsin residents only, the Wisconsin-specific PPAHC is available for FREE download in PDF format at ***www.ProLifeWI.org****.)*

THESE MATERIALS ARE NOT LEGAL ADVICE. IT IS NOT REQUIRED, BUT YOU MAY WISH TO SEEK THE ASSISTANCE OR ADVICE OF AN ATTORNEY.

Questions and Answers About the LAMP Document

What is the Life-Affirming Medical Proxy (LAMP)?
The LAMP is a document that enables you to appoint someone you trust – a proxy – to make health care decisions for you, in accord with life-affirming principles (see p. ii) and your express wishes, in the event you become permanently or temporarily incapable of speaking for yourself.

Is the LAMP preferable to a Living Will?
Absolutely yes. By executing a LAMP, you ensure that the person with authority to make medical decisions for you is a carefully chosen family member or friend, familiar with your principles and wishes and capable of firmly protecting your best interests. Furthermore, your proxy will make decisions based on your current medical situation.

A Living Will, on the other hand, is an advance directive in which a person gives health care providers authority to withhold, withdraw or provide medical treatment and even ordinary care, such as tube-feeding, in future, unforeseeable circumstances. This is dangerous. Medical decisions should always be based on current information. (See "Principles for Medical Decision-Making," page ii.)

Should I name more than one proxy?
It is not required, but it is advisable to name an alternate proxy in case your primary proxy is unavailable or becomes incapacitated. *(continued on page ii)*

Should I periodically renew and/or review my LAMP?
Your LAMP is permanent, unless revoked by you. You should discuss your medical preferences and moral values with your proxy when you sign your LAMP and periodically review it with your proxy.

To whom should I give originally signed copies of my LAMP document?
You should give completed, witnessed, and originally signed documents to each of your proxies and keep one for yourself in a readily accessible place along with a record of each person to whom you have given a copy (such as your doctor, hospital, etc.). If you ever change or revoke your document, this record will be helpful.

How do I revoke a previously signed advance directive?
By completing your LAMP, you revoke any prior advance directive. It is wise to retrieve and destroy all copies of previously executed directives.

Life-Affirming Principles for Medical Decision-Making

1. No matter what life-sustaining procedure/medical treatment is in question, when in doubt, **err on the side of life**. A medical intervention can be tried with the option of stopping it if it proves ineffective or excessively burdensome *for the patient*.

2. It is the physician's obligation to truthfully and fully, in layperson's terms, discuss with the patient/proxy/family/guardian the benefits, risks, cost, etc. of available medical means that may improve the patient's condition/prolong life. The focus should be on what the person making medical decisions needs to know in order to give *truly informed consent*.

3. The patient or the patient's legal representative makes the decision whether a treatment is too burdensome. (Note: The patient's life must never be ended because it is considered a burden to the patient or others.) If a patient wishes to fight for every moment of life, this is a legitimate interest to be respected.

4. It is impossible to make morally sound, sensible, informed health care decisions based on guesswork about some future illness or injury and possible treatment options. Health care decisions must be based on *current* information.

5. Two extremes are to be avoided:

- Insistence on physiologically useless or excessively burdensome treatment even when a patient may legitimately wish to forgo it.
- Withdrawal or withholding of treatment with the intention to hasten/cause death.

6. The object and motive for administering **pain medication** must be to relieve pain. Death must not be sought or intended. (See HALO's fact sheet "Drugs Commonly Used in Hospice and Palliative Care.")

7. Nutrition and hydration, whether a person is fed with a spoon or through a tube, is basic care, not medical treatment. Insertion or surgical implantation of a feeding tube takes medical expertise, but it is an ordinary life-preserving procedure for a person who has a working digestive system but is unable to eat by mouth.

- Acceptable - During the natural dying process, when a person's organs are shutting down so that the body is no longer able to assimilate food and water or when their administration causes serious complications, stopping tube-feeding or spoon-feeding is both medically and morally appropriate. In these circumstances, the cause of death is the person's disease or injury, not deliberate dehydration and starvation.
- Unacceptable - When a person is not dying—or not dying quickly enough to suit someone—food and fluids are often withheld with the intent to cause death because the person is viewed as having an unacceptably low quality of life and/or as imposing burdens on others. The direct cause of death is then dehydration and starvation.

LIFE-AFFIRMING MEDICAL PROXY DOCUMENT

Document made this _____ day of_____
(day) (month) (year)

CREATION OF MEDICAL POWER OF ATTORNEY

By this document, I intend to create a medical power of attorney in which I appoint a medical proxy (attorney-in-fact) for the purpose of making medical decisions for me in the event I am unable to make medical decisions for myself due to incapacity and only for the duration of such incapacity.

DESIGNATION OF MEDICAL PROXY (or PROXIES)
(Print the information in this section.)

I,

Name: _____

Address: _____

Date of birth: _____

do hereby designate

Name: _____

Address: _____

Telephone: _____

to be my medical proxy (attorney-in-fact).

If he/she is ever unable or unwilling to be my medical proxy, I hereby designate

Name: _____

Address: _____

Telephone: _____

to be my alternate medical proxy (attorney-in-fact).

GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to the directions and limitations in this document, I hereby grant my proxy full authority to make health care decisions for me if I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. I expect to be fully informed about and allowed to participate in any health care decisions for me to the extent that I am able.

Nothing in this document shall authorize anyone to approve or commit any action or omission which will cause my death. While certain forms of care and treatment may be futile in curing a disease or injury, care or treatment which sustains life is not futile. I reject both euthanasia and assisted suicide, which are contrary to my belief that human bodily life is inherently good and not merely instrumental to other goods.

DIRECTIONS, SPECIAL PROVISIONS, AND LIMITATIONS

I have discussed my beliefs, principles, and health care preferences with my proxy. I trust my proxy to make health care decisions for me based on my desires as stated in this document or which I have otherwise expressed to my proxy.

1. I have discussed the meaning of the words used in this document with my proxy and my proxy's interpretation of them is controlling. "Benefit" refers to my physical health, comfort, and longevity and shall not be determined by quality of life judgments. **I direct that nothing in this document be interpreted to request or authorize providing, withholding, or withdrawing treatment or care when such an act or omission will cause my death**.

2. My proxy has the authority to request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records, and to consent to the disclosure of this information.

3. I direct that nutrition and hydration, administered either orally or by artificial means, be provided to me unless death is inevitable and imminent from a cause independent of nutrition and hydration so that the effort to sustain my life is futile or unless I am unable to assimilate food and fluids.

4. I direct my proxy to request, require, and consent to care, treatment, and procedures which are appropriate to my condition/offer hope of benefit.

5. I direct my proxy to withhold or withdraw consent to treatment, and procedures which are not appropriate to my condition/do not offer hope of benefit.

6. I authorize my proxy to determine whether a Do Not Resuscitate (DNR) order is appropriate for me.

7. I authorize my proxy to admit me to or discharge me from a nursing home or community-based residential facility under the conditions I have expressed to my proxy.

8. If I am pregnant, I direct that every effort be made to save the life of my child.

9. My agent shall not be held personally liable for any medical goods or services purchased or contracted for in compliance with my wishes regarding medical care and treatment, except as required by law.

10. I direct my proxy to firmly protect my rights and best interests, taking legal action if necessary.

11. It is my express wish that no one petition the court to remove or replace my proxy unless it can be clearly shown that my proxy has failed or refused to act in accord with these directions, special provisions, and limitations.

These instructions are always a part of my Life-Affirming Medical Proxy document and are binding on my proxy and health care providers.

This document is intended to be valid in any jurisdiction in which it is presented. Any invalid provision of this document shall not affect any other provision of this document or the appointment of my proxy.

IMMUNITIES

My proxy may not be held criminally or civilly liable for making decisions in accord with this document. No health care facility or provider may be held criminally or civilly liable for following the directions of my proxy acting in accord with this document.

REVOCATION OF PREVIOUSLY SIGNED MEDICAL DIRECTIVES

By signing this medical power of attorney, I revoke any prior medical directives I have made. This medical power of attorney shall remain in force until revoked by me in the presence of two witnesses. Additionally, if I, or anyone else on my behalf, execute a medical directive at a later date and I have not revoked this power of attorney, I direct that this power of attorney take precedence.

GUARDIAN OR CONSERVATOR

If it becomes necessary to appoint a guardian or conservator of the person for me, I nominate, in the same order of preference, my proxy and alternate proxy.

SIGNATURE OF PRINCIPAL

I, being of sound mind, intend this document to create a medical power of attorney. I am executing this document voluntarily.

Signature _____ Date _____

WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this medical power of attorney is voluntary. I am at least 18 years of age. I am not the person appointed as the principal's proxy in this document. I am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's medical care. I am not a health care provider who is serving the principal at this time; an employee of the health care provider, other than a chaplain or social worker; or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the principal is a patient. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate. I signed this statement in the conscious presence of the principal and saw the principal sign this document.

Witness No. 1:

(print) Name _____

(print) Address _____

Signature _____ Date _____

Witness No. 2:

(print) Name _____

(print) Address _____

Signature _____ Date _____

STATEMENT OF MEDICAL PROXY AND ALTERNATE MEDICAL PROXY

I understand that the principal (signer of this medical proxy document),

_____ , has designated me to be his or her medical proxy or alternate medical proxy if he or she is ever found to lack the capacity to make medical decisions for himself or herself. I further understand that my authority to make such decisions is only operative for the duration of the principal's incapacity. The principal has discussed his or her desires regarding medical decisions with me.

Proxy's signature _____

Address _____

Alternate proxy's signature _____

Address _____

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