Advance Directive for Voluntary Stopping of Eating and Drinking (VSED Directive)

My name is _____. My date of birth is _____.

As an adult with decision-making capacity, I have the right to direct my treatment and care, even if those choices lead to an earlier death. This includes the right to refuse medical treatment and the right to refuse oral food and drink. I have thought carefully about the circumstances in which I would want to stop prolonging my life with eating and drinking.

This directive instructs my health care agent or other legal decision-maker ("decision-maker") and all caregivers how to act on my behalf to ensure that my wishes for stopping eating and drinking are carried out.

1. Voluntary stopping of eating and drinking (VSED)

When I meet the conditions I have selected in section 2 (below) and can no longer feed myself:

- Do not help me with eating and drinking (by spoon-feeding, for example).
- Do not verbally or physically encourage or persuade me to eat or drink.
- Do not put food or liquids in my mouth.

2. Conditions for starting VSED

I want to start VSED when I have a serious and irreversible illness or chronic condition that will not significantly improve (even if it is not terminal), and when I meet (*initial one*)

__ **at least one** of the conditions I select below.

__ **all** of the conditions I select below

(*initial all that apply*):

__ I cannot communicate with others beyond a few words, eye movements, etc.

__ I do not recognize close family and friends.

__ I am indifferent to being fed, no longer want to eat or drink, and show no signs of enjoying eating and drinking.

__ I do not open my mouth to receive food and drink, or I turn my head away when offered food or drink.

__ I usually refuse food or drink

__ I frequently inhale or choke on food or drink.

__ The following additional conditions or situations (*specify*):

_____

(***Examples:*** *I have incontinence; I can no longer get in and out of bed on my own; I stay in bed and just want to sleep.*)

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3. If my decision-maker thinks my quality of life is still good when it is time to start VSED

If my decision-maker thinks my quality of life is still good enough and I seem comfortable or happy, my decision-maker (*initial one*):

__ **must follow this directive and start VSED.** I have given a lot of thought to this decision and insist that my wishes be followed.

__ may choose **not** to follow this directive. **I understand this means some or all of my choices may not be honored.**

4. Palliative care – relief from pain and discomfort

If food and drink are being withheld, I want palliative care to manage any pain or discomfort from my illness and from not eating and drinking (relief from dehydration, for instance).

I want palliative sedation if necessary to manage pain and discomfort (*initial one*):

__ **even if** it makes me unconscious.

__ **but not** to the point of unconsciousness.

5. If I express the desire to eat or drink

If eating and drinking has stopped, but I repeatedly show by words or gestures that I want to eat or drink, I want my caregivers to reassess my palliative care and (*initial one*):

__ continue to withhold all help with eating and drinking.

__ give me only enough food and drink to avoid discomfort, even if it's not nutritionally adequate (also known as 'minimal comfort feeding'). **I understand this approach will likely prolong my dying process.**

6. Medical facilities and providers that will not honor this directive

Before I receive care from a medical facility or provider (including my physician or residential hospice, or long-term care facility), I want the facility or provider to confirm it will follow the instructions in this directive. If the medical facility or provider will not follow the instructions in this directive due to moral, ethical, or other reasons, my decision-maker should make all reasonable efforts to make sure I get care from a facility or provider that will.

(*Initial if selected*)

__ **After** I am admitted or receiving care, if a facility or provider will not honor the instructions in this directive, my decision-maker should make all reasonable efforts to make sure I get care from another facility or provider that will. I understand this means I may be transferred to another medical facility or living situation that might cost more or be less convenient.

If a medical facility or provider will **not** follow this directive due to legal or institutional barriers, I want to be given only enough food and drink to avoid discomfort even if not nutritionally adequate (also known as 'minimal comfort feeding').

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7. Dispute resolution

My decision-maker will resolve any disagreement about the instructions in this directive and/or whether the conditions I have chosen have been met.

If no decision-maker is available, then I want my medical providers to make these decisions if that is legally allowed.

If any part of this directive is determined to be legally invalid, all other parts should be honored.

8. Health care decision-maker

__ I have named a health care decision-maker in the following legal document (*initial one and attach a copy, if possible*):

__ Power of Attorney for Health Care

__ Health Care Proxy

__ Other document (*name*): _____

__ I have **not** yet named a health care decision-maker.

9. Other advance planning

I intend this directive to supplement any existing documents about my end-of-life care. This directive does not revoke any existing documents except with respect to receiving food and liquid by mouth, in which case this directive shall govern.

I have the following other documents about advance planning or end-of-life wishes:

Name: _____

Name: _____

Name: _____

Name: _____

10. Liability Waiver

I voluntarily assume any and all risk associated with my choice to use VSED as an end-of-life option. I release all persons, including my health care decision-makers, medical providers, caregivers (including but not limited to my physicians, nurses, care facilities, doulas, or personal care providers, etc.), and family members and other loved ones from any and all liability that could result from any and all actions they may take in good faith reliance on my wishes as described in this directive. This includes my express release of civil liability and my strongly held wish that they **not** be subject to any criminal or disciplinary sanctions.

Further, I direct my estate to hold harmless and indemnify my health care decision-makers, medical providers, caregivers, family members, and other loved ones for acts done according to this advance directive in good faith.

Finally, I wish to make it clear that I am making this directive of my own free will and am doing so intentionally to ensure that my medical care is consistent with my stated

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wishes. As a result, I regard any action taken to undermine my wishes as described in this directive as medical battery and authorize my surrogate and/or my estate to pursue such a claim on my behalf.

11. Capacity

I am making this VSED Directive because if I cannot make decisions for myself, I want my decision-makers, medical and long-term care providers, caregivers, family, and other loved ones to honor every part of this directive.

I am of sound mind. I am voluntarily signing this VSED Directive and understand what it means. I make this advance directive of my own free will, and I have the mental and emotional capacity to do so.

I understand that honoring this directive might cause me to die sooner than if I received help with eating and drinking.

[Sign only in the presence of a notary or qualified witnesses]

_____ ▶ _____

Date My Signature

_____

Print name

➢ Notarization and Witnessing

While it is best to have this document both notarized and witnessed, in most places this document is legally binding with either one or the other.

Notarization

State of _____

County of _____

Signed or attested before me on (*date*): _____

by (*name*):_____.

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

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Statement of Witnesses

I, the witness, declare that the person who signed or acknowledged this VSED Directive:

- Is personally known to me
- Signed or acknowledged this VSED Directive in my presence
- Appears to be of sound mind and under no duress, fraud, or undue influence

I also declare that I am over 18 years of age (19 in Alabama) and that I am:

- **Not** the person's health care agent, decision-maker, or alternate decision-maker
- **Not** the person's health care provider, including an owner or operator of their long-term care, residential, or community care facility
- **Not** an employee of the person's health care provider
- **Not** financially responsible for the person's health care
- **Not** an employee of a life or health insurance provider for the person
- **Not** related to the person by blood, marriage, or adoption
- **Not** a beneficiary of any legal instrument, account, or benefit plan of the person
- **Not** a creditor of the person or entitled to any part of their estate under a will or codicil, by operation of law

(*Some states may have different rules about who may be a witness. Unless you know your state's rules, please follow the above.*)

Witness 1

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

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