The Motor Neuron Disease Association of South Africa and Genoa Underwriting Managers: Webinar on Zoom

Presenter: Dr Truida Grové

Title: "The Legal Enforcement of Living Wills in South Africa and Its Relevance in Medical Practice"

21 June 2024

Possible generic examples of living wills and related documents

1. Carstens and Pearmain: "Living Will"[1]

" 'EXAMPLE ONLY'*[2]

LIVING WILL

1. I, (name)……..
   of (address)……..

make this Living Will after careful consideration and while in sound mind, to state my wishes in case I become unable to communicate, and cannot take part in decisions about my medical care.

2. I do not wish to be kept alive by medical treatment, if I have a physical illness with no likelihood of recovery, and/or if my mental functions become permanently impaired, and/or if I become permanently unconscious with no chance of regaining consciousness.
3. I request that medical treatment be kept to the minimum needed to keep me comfortable and free from pain, even if this should hasten the moment of death. I expressly direct that I be given whatever quantity of drugs required to keep me free from pain or distress even if the moment of death is hastened thereby. I expressly do not consent to be kept alive artificially, including (but not confined to) performing a gastrostomy, inserting a nasogastric tube or employing any form of mechanical ventilation, and/or to provide any form of tube feeding.
4. I have informed this doctor/clinic of this Living Will.

---

[1] Carstens PA & Peramain D *Foundational Principles of SA Medical Law* (2007) Annexure V Source: American Medical Association Medicolegal Forms with Legal Analysis (1991).

[2] Disclaimer: "The authors and publishers of this book wish to emphasise the fact that the foregoing annexures (as contained on the CD-Rom), specifically the examples of various forms and precedents are solely offered as practical generic examples/illustrations of the practical application of medical law. These examples are in no way to be regarded as all encompassing forms/precedents and are published for general information and are not intended as legal advice. As every situation depends on its own facts and circumstances, the purpose of the annexures is to provide practical guidance only. The examples of forms/precedents provided are therefore illustrative only. They lack specific content and substance and should under no circumstances be used as they stand. The authors and publishers therefore accept no responsibility for any consequences or damages of whatever nature flowing/arising from/brought about by the use of and/or reliance on the forms/precedents contained in the foregoing annexures by anyone."

(name)…….

(address)…….

(contact telephone for doctor/clinic)…..…….

5. I give consent to any person to apply for a court order to ensure that this Living Will is followed if any medical, health authority or institution, and or family member or partner refuses to follow my instructions.

6.* I wish to be kept alive for as long as it is reasonable to enable the following person(s) to be with me before I die, even if this means temporarily going against the wishes stated earlier in this Living Will.

(name)…….

of (address) ……...

(telephone numbers)……

7. I appoint this person

(name)…….

of (address)……

(telephone numbers)…….

to take part in decisions about my medical care on my behalf, and to represent my views about them, if I am unable to do so. I wish to be consulted about or involved in those decisions. Further, I wish those caring for me to respect the views expressed on my behalf unless they are in conflict with my wishes in this Living Will.

8. This document remains effective until I make it clear, while in sound mind, that my wishes have changed.

9. This declaration is signed and dated by me and confirmed by the two witnesses below.

Signed	Date
Witnesses:	
Signature:	Signature:
Name:	Name:
Address:	Address:

* May be omitted. If necessary delete, date and sign in full.

* NOTE DISCLAIMER AT THE END OF THE INDEX"

2. Carstens and Pearmain: Health Care Proxy[3]

"EXAMPLE ONLY"*

[3] Carstens PA & Pearmain D *Foundational Principles of SA Medical Law* (2007) Annexure Q Source: American Medical Association Medicolegal Forms with Legal Analysis (1991).

HEALTH CARE PROXY

I appoint as my proxy decision-maker(s):

……

Name and Address

and (optional)

…… ……

Name and Address

I direct my proxy to make health-care decisions based on his/her assessment of my personal wishes. If my personal desires are unknown, my proxy is to make health-care decisions based on his/her best guess as to my wishes. My proxy shall have the authority to make all health-care decisions for me, including decisions about lifesustaining 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 health-care decisions. My proxy is then to have the same authority to make health-care decisions as I would if I had the capacity to make them, EXCEPT (List the limitation, if any, you wish to place on your proxy's authority):

I wish my written preference to be applied as 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 favoured 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 if there is disagreement between their wishes…… shall have final authority.

Signed:

……

Signature Printed Name

……..

Address Date

Witness:

……

Signature Printed Name

……

Address Date

Witness:

……

Signature Printed Name

……..

Address 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 interventions 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 fulfil his/her wishes.

Signed:

……..

Signature Printed Name

……..

Address Date

* NOTE DISCLAIMER AT THE END OF THE INDEX

3. National Health Amendment Bill, 2019: "Guideline for a Living Will"[4]

"**SCHEDULE 3**

GUIDELINE FOR A LIVING WILL

(*Section 7B*)

I, ……..(full name),

in making this Living Will, wish to confirm that I

- am 18 years or older;
- am of sound mind;
- act of my own free will, free from duress induced by others; and
- have carefully considered my own values, beliefs and preferences, as well as misfortunes of body and/or mind that may befall me.

Hence, should I, as a result of illness, injury or any other trauma, at a future date,

- develop a terminal and incurable medical condition; or
- become permanently vegetative; or
- become completely and irreversibly unconscious,

and, as a consequence, no longer possess the requisite rationality or competence to

[4] National Health Amendment Bill, 2019 Schedule 3 to clause 7(B). This specific draft can also be downloaded from DignitySA's website "Download your living will" <https://dignitysouthafrica.org/advancedirective> (accessed 08-05-2023).

have or communicate my health care decisions, I grant authority to and authorise any medical professional and/or medical facility and/or other carer to execute this Living Will, thereby allowing me to die a natural death by refraining from keeping me alive by artificial means, or by potentially life-sustaining medical intervention, treatment or procedure, such as:

- artificial nutrition;
- artificial hydration;
- dialysis;
- any medication or drug, including antibiotics, administered through any method, including an IV tube; or
- life support of any kind.

[*The maker of a Living Will is free to insert a clause instructing an attending or treating medical doctor/health care professional, or any other person, not to discontinue a specific form of life-sustaining treatment, for example, artificial hydration.*]

In addition, I authorise any attending medical professional and/or medical facility and/or other carer to administer to me comfort or palliative care, specifically adequate medication to alleviate my pain and suffering, even though it might hasten my natural death as a secondary consequence.

Moreover, I give permission for any of my organs or tissue to be donated for legitimate medical or scientific purposes. [This clause may be excluded.]

MAKER of this Living Will

Name (print in full) . . . . . .

Signed at (name of place) . . . . . .

Identity or passport number . . . . . .

Signature . . . . . Date . . . . . .

WITNESS 1 to the signing of this Living Will

I declare that I have witnessed the signing of this Living Will by (i) the maker of the Living Will and (ii) witness 2.

Name (print in full) . . . . . .

ID or passport number . . . . . .

Relationship to the maker . . . . . .

Telephone number . . . . . .

Email address . . . . . .

Full residential address . . . . . .

Signa**ture . . . . . Date . . . . . .**

WITNESS 2 to the signing of this Living Will

I declare that I have witnessed the signing of this Living Will by (i) the maker of the Living Will and (ii) witness 1.

Name (print in full) . . . . . .

ID or passport number . . . . . .

Relationship to the maker . . . . . .

Contact telephone number . . . . . .

Email address . . . . . .

Full residential address . . . . . .

Signature . . . . . Date . . . . . ."

4. National Health Amendment Bill, 2019: "Guideline for durable power of attorney for health care"[5]

"**SCHEDULE 2**

GUIDELINE FOR A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(*Section 7A*)

I,……..(full name),

in granting this Durable Power of Attorney for Health Care, wish to confirm that I

- am 18 years or older;
- am of sound mind;
- act of my own free will, free from duress induced by others; and
- have carefully considered my own values, beliefs and preferences, as well as misfortunes of body and/or mind that may befall me.

Hence, should I, as a result of illness, injury or any other trauma, at a future date, develop any condition as a consequence of which I lack the requisite competence to have or communicate any rational preferences regarding my future health care,

I wish to appoint…….(full name) as my agent (proxy) health care decision-maker, mandating him/her to act as my substitute for any and all of my health care and medical decisions, and instructing any person or institution to act on the directives of this duly appointed health care agent.

[5] National Health Amendment Bill, 2019 Schedule 2 to clause 7(A). This specific draft can also be downloaded from DignitySA's website "Download your living will" <https://dignitysouthafrica.org/advancedirective> (accessed 08-05-2023).

Should my first choice as health care agent be unable to assume this responsibility, I wish to appoint…..……..…(full name) as my alternative agent (proxy) health care decision-maker, mandating him/her to act as my substitute for any and all of my health care and medical decisions, and instructing any person or institution to act on the directives of this duly appointed health care agent.

I understand that this Durable Power of Attorney for Health Care mandates my health care agent to make health care and medical decisions on my behalf for the duration of my biological life, thus enduring while I am no longer competent to revoke it. Should I, however, regain the requisite competence, I understand that I would have the authority to revoke this health care mandate.

In making health care and medical decisions on my behalf, my health care agent should give due recognition to my known values, beliefs, principles and personal preferences. Should it be impossible or difficult to know the practical implications of these considerations in particular circumstances, my health care agent should act in my objectively determined best interest.

In particular, I authorise my health care agent (proxy) decision-maker to make any and all of my health care and medical decisions on my behalf, that is, any and all decisions I would have made while still competent.

In this mandate to my health care agent decision-maker, I specifically include decisionmaking directives that would be routinely included in a Living Will, that is, directives relating to refraining from life-sustaining medication, treatment or procedures that would otherwise prolong life, thus impeding a natural death. [This clause may be excluded.]

In addition, I mandate my health care agent to make decisions on my behalf regarding the donation of my organs or tissue for any legitimate medical or scientific purpose. [This clause may be excluded.]

[*The grantor/maker of a Durable Power of Attorney for Health Care is free to issue specific instructions or directives to his/her health care agent about any medical intervention that the grantor/maker chooses to include in or exclude from the mandate*.]

GRANTOR/MAKER of health care mandate/proxy

Name (print in full) . . . . . .

Signed at (name of place) . . . . . .

Identity or passport number . . . . . .

Signature . . . . . Date . . . . . .

WITNESS 1 to the signing of this Durable Power of Attorney for Health Care

I declare that I have witnessed the signing of this Durable Power of Attorney for Health Care by (i) its grantor/maker and (ii) witness 2.

Name (print in full) ……

ID or passport number …….

Relationship to the maker ……..

Contact telephone number …….

Email address …….

Full residential address ……..

Signature . . . . . Date . . . . . .

WITNESS 2 to the signing of this Durable Power of Attorney for Health Care

I declare that I have witnessed the signing of this Durable Power of Attorney for Health Care by (i) its grantor/maker and (ii) witness 1.

Name (print in full) ……

ID or passport number …….

Relationship to the maker ……..

Contact telephone number …….

Email address …….

Full residential address ……..

Signature …….. Date ……..”

5. South African Medical Association: “Living Will”[6]

LIVING WILL

TO MY FAMILY AND MY PHYSICIAN:

I,

NAME AND SURNAME_____ (ID NUMBER),

the undersigned, presently residing at

ADDRESS_____,

after careful consideration, make the following declaration, which I call my Living Will:

[6] South African Medical Association “Guidelines with regard to living wills” (2012) <https://www.sa medical.org/images/attachments/guidelines-with-regard-to-living-wills-2012.pdf> (accessed 08/05/2023).

1. This Living Will in no way revokes nor does it change any Will or Testamentary disposition as made by me at a previous occasion.

2. In this Living Will, unless an intention to the contrary appears clearly and concisely the following words carry the meaning as stated: -

- "Doctors" refer to one or more medical practitioners who may be requested to provide me with a prognosis from time to time, depending on my condition and clinical status at any given moment during my treatment and/or hospitalization

- "Secondary support system" refer to any artificial and/or mechanical life support system and/or medication/drugs to the same effect.

If the time comes when I can no longer take part in decisions for my own future, let this declaration stand as my directive.

If there is no reasonable prospect of my recovery from physical illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I do not give my consent to be kept alive by means of a Secondary support system, including by way of a pacemaker.

I also do not give my consent to any form of tube-feeding when I am dying; and I request that I receive whatever quantity of drugs and intravenous fluids as may be required to keep me free from pain or distress even if the moment of death is hastened.

This declaration is signed and dated by me in the presence of the under mentioned two witnesses present at the same time who at my request and in my presence and in the presence of each other have hereunto subscribed their names as witnesses.

Dated at _____ on this the _____ day of _____.

Witnesses (Not to be members of one's family or beneficiaries in the estate)

Signature _____ Signature _____
Name _____ Name _____

Address _____ Address _____

6. South African Living Will Society: "Living Will"

Living Will

"If the time comes when I can no longer take part in decisions for my own future let this declaration stand as the testament to my wishes. If there is no reasonable prospect of my recovery from physical illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I request that I be allowed to die and not be kept alive by artificial means and that I receive whatever quantity of drugs may be required to keep me free from pain or distress even if the moment of death is hastened."[7]

7. The presenter's generic example of a combined living will and advance directive document:

LIVING WILL

I the undersigned

Title:

Full names:

Identity Number or Passport Number:

Age:

Domicilium:

and

Residence:

hereby confirm that I am of sound mind and make this my living will. I have carefully considered all the below clauses and hereby instruct that my wishes and instructions contained herein be followed, once I am mentally incompetent or unable to communicate and cannot partake in my health care decisions.

Appointment of health care proxy

1. I hereby appoint:

Full names:

[7] The South African Living Will Society is no longer in existence. This version appeared in the South African Law Commission's Report "Euthanasia and the Artificial Preservation of Life" "Project 86" (1997) 156 and in Strauss SA *Doctor, patient and the law* (1991) 34.

Identity Number or Passport Number:
Address:
Telephone numbers:
Alternative telephone numbers:
to act as my health care proxy, to take part in decisions about my medical care on my behalf, and to represent my views, beliefs and desires about the medical care that I would want, if I am unable to do so. My proxy shall have the authority to make all health care decisions for me:
life-sustaining treatment,
(*list your specific treatments*)

The proxy shall not have the authority to make the following treatment decisions for me:
life-sustaining treatment,
(*list your specific treatments*)

(*Add a second alternative proxy if so desired. Then state which proxy has the overriding/final say*)

The proxy's authority becomes effective upon the treating doctor's determination, ideally confirmed by another doctor, that I lack the mental capacity to make or to communicate my own health care decisions.

Should any disagreement arise between the wishes I have indicated in this living will document and the decisions made by my above-mentioned proxy, I request that my proxy has the authority to override my written statements/ wishes contained elsewhere in this living will.[8]

Refusal of medical treatment

2. I do not wish to be kept alive by artificial medical treatment, including (but not confined to) performing a gastrostomy, inserting a nasogastric tube or employing any form of mechanical ventilation, and/or to provide any form of tube feeding if I have a physical illness with no likelihood of recovery, and/or if my mental functions become permanently impaired, and/or if I become permanently unconscious with no chance of regaining consciousness.
3. (Insert Do-Not-Resuscitate Order if required)

[8] See National Health Amendment Bill 2019 (Private Member's Bill) and when a patient's instructions as contained in a living will can be overridden.

Request for medical treatment

4. I request that medical treatment be kept to the minimum needed to keep me comfortable and free from pain, even if this should hasten the moment of death. I expressly direct that I be given whatever quantity of drugs required to keep me free from pain or distress even if the moment of death is hastened thereby. (The doctrine of double effect).

5. I wish to be kept alive for as long as it is reasonable to enable the following person(s) to be with me before I die, even if this means temporarily going against the wishes stated earlier in this Living Will.

Third party knowledge

6. I have informed my family doctor/clinic of this Living Will:

Name:

Address:

Contact telephone numbers:

Consent

7. I consent to the living will forming part of my medical record.

8. I waive the right to patient-doctor confidentiality of my medical record as far as it pertains to communicating the contents of my living will to my health care team, my family members and other parties who may have an interest in my illness/condition and the treatment thereof.

Doctor's release

9. Any medical practitioner and health care worker who adheres to the instructions contained herein, shall not be held liable for acting on my instructions, if done with reasonable skill and care.

Consent to legal proceedings

10. I give consent to any person to apply for a court order to ensure that this Living Will is followed if any medical, health authority or institution, and or family member or partner refuses to follow my instructions.

Organ donation

11. I feel very strongly that my organs may be donated. Even though I did not consent to life support, I do consent to my body temporarily being put on life support in order to retain the health of my organs to ensure optimal organ harvesting.

Values and beliefs

12. I hold the following values and beliefs that are relevant to my future health care: I am of the …….faith and thus request / refuse medical treatment involving blood transfusions or any of the following specified medical products:

Duration of directive

13. This document remains effective until I make it clear, while in sound mind, that my wishes have changed.

Signature and witnessing

14. This declaration is signed and dated by me and confirmed by the two adult witnesses below, in each other's presence.

15. I confirm that the undersigned witnesses are not beneficiaries in my Last Will and Testament and they will not benefit financially from my demise.

Patient's Signature: Full names: Date:

Witness 1:
Signature:
Name:
Address:
Telephone numbers:

Witness 2
Signature:
Name:
Address:
Telephone numbers: