

Advance Medical Directives



Floyd Memorial Hospital
and Health Services

This book belongs to:

Name: _____

Address: _____

Phone: _____

ADVANCE MEDICAL DIRECTIVES

Many people today are making decisions about the medical care they will be given if they become seriously ill and unable to communicate.

These people are making their wishes known before they become seriously ill. While they are able to make such decisions they are stating their health care wishes in writing, through legal documents called advance medical directives.

Floyd Memorial Hospital and Health Services wants you to be informed about advance medical directives and your rights regarding health care preferences under Indiana law. This brochure is designed to answer your questions about living wills, the appointment of a health care representative or surrogate and other advance directives. The information will be very helpful in getting you started on your decision-making process.

IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as physician) about your medical problems. Your physician makes a diagnosis and informs you about available medical treatments. You then decide which treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

Advance Directive is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

WHAT IS OUR STATE LAW REGARDING ADVANCE DIRECTIVES?

In 1990, the Indiana General Assembly passed the Living Wills and Life-Prolonging Procedures Act, which allows anyone over the age of 18 and of sound mind to execute an advance directive in the state of Indiana. These are legal documents if executed properly. The Patient Self Determi-

nation Act of 1990 requires all hospitals participating in Medicare or Medicaid to discuss with all adult inpatients whether or not they have advance directives, to document their answers, and if requested, to provide information on state laws and hospital policies regarding advance directives.

WHAT IS FLOYD MEMORIAL'S POLICY CONCERNING THE IMPLEMENTATION OF THE PATIENT'S RIGHTS?

If the hospital or physician is unable or unwilling to comply with the desires of the patient indicated in the advance directive, the hospital or physician must provide the patient with a convenient and suitable alternative.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

Floyd Memorial has an ethics committee that can assist in decision-making about the end of life. Physicians, nurses, social workers, lawyers, clergy, patient representatives and sometimes professional bioethicists discuss issues, advise on hospital policy and review cases.

Although they will counsel a patient's family and make a recommendation, the final decision is up to the patient, the family and the physician.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- Talking directly to your physician and family
- Organ and tissue donation
- * Health care representative
- * Living Will Declaration or Life-Prolonging Procedures Declaration
- ** Psychiatric advance directive
- * Out of Hospital Do Not Resuscitate Declaration and Order
- ** Power of Attorney
- Code Status (Please discuss with your physician regarding resuscitation)

* Form in back of brochure

** Please discuss with your personal attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choice in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a “do not resuscitate” (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16. A person that wants to donate organs may include their choice in their will, living will, on a card or other document. A common method used to show that you are an organ donor is making the choice on your driver’s license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A Health Care Representative is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, you health

care representative may decide if food, water or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana Courts have made it clear that decisions made for you by your health care representative should be honored.

Note: This form can be found in the back of this booklet.

LIVING WILL

A living will is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you do or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directives.

Living Will Declaration: This document is used to tell your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make that decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be cancelled orally, in writing or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

NOTE: Both of these forms are in the back of this brochure.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code §16-36-1.7 provides the requirements for this type of advance directive.

NOTE: Please discuss further with your personal attorney.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a do not resuscitate order in your medical chart. If you are home when an emergency occurs, there is no medical chart or physician's order. For situations outside of a hospital or health facility, the Out of Hospital Do Not Resuscitate Declaration and Order is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5. The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital or health facility. This declaration may override other advance directives. The declaration may be cancelled by you at any time by a signed and dated writing, by destroying or canceling this document or by communicating to health care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

NOTE: This form is found in the back of this brochure.

POWER OF ATTORNEY

A power of attorney (also referred to as a durable power of attorney) is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is attorney in fact. Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a

power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

NOTE: Please discuss further with your personal attorney.

CODE STATUS

Code Status addresses resuscitation. For example, if the heart or breathing stop, does the patient want aggressive treatment to try and restore life? **The Living Will does not determine code status.** Your primary or attending physician is the only one who can change your code status from attempts to restore life to DNR (Do Not Resuscitate). Your code status will always be to resuscitate unless you or a legal representative has indicated otherwise. THIS APPLIES TO EACH ADMISSION.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician to tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizens groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

* Please see back of brochure for the following advance directive forms: Living Will, Life-Prolonging Procedures Declaration, Appointment of a Healthcare Representative/Surrogate, Out-of-Hospital Do Not Resuscitate Declaration.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney and other health care providers know that you have an advance directive. Be sure to tell them where it is

NOTE: Please discuss further with your physician and family.

located. You should ask your physician and other health care providers to make advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located and who to contact for your attorney in fact or health care representative, if you have named one.

FINAL THOUGHTS ABOUT ADVANCE DIRECTIVES

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.
- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.
- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.
- This information was prepared by the Indiana State Department of Health and Floyd Memorial Hospital and Health Services as an overview. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

If you have further questions regarding advance medical directives, you may call the Floyd Memorial Hospital and Health Services Social Services Department at 948-6730 or call the Hospital Chaplain at 949-5711.

REMEMBER: There is no substitute for communication with family members of your medical care requests. Please communicate your wishes prior to initiating advance medical directives.

LIVING WILL DECLARATION

Declaration made this _____ day _____ of _____, 20____. I _____ being at least eighteen(18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:(1)I have an incurable injury, disease or illness;(2) my death will occur within a short period of time; and (3) the use of life -prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this Declaration):

___I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

___I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

___I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under I.C.16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this Declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signature

Date

City

County

State

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant’s signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant’s estate or directly financially responsible for the declarant’s medical care. I am competent and at least eighteen (18) years old.

Witness

Date

Witness

Date

APPOINTMENT OF A HEALTH CARE REPRESENTATIVE OR SURROGATE

I, _____ voluntarily appoint, _____ whose telephone number and address are:

() _____

_____, respectively, as my health care representative who is authorized to act for me in all matters of health care in accordance with I.C.16-8-12 and I.C.30-5 et. seg., except otherwise specified below.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care.

If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if my death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with me, after consultation with my family and others, to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions (if any):

This appointment becomes effective and remains effective if I am incapable of consenting to my health care. I do authorize my health care representative hereby appointed to delegate decision making power to another.

Dated this _____ day of, _____ 20 _____

Signature

Printed

Address

I declare that I am an adult and at least eighteen (18) years of age and that at the request of the above named individual making the appointment, I witnessed the signing of this document by the Appointer on the date noted above.

Signature of Witness Printed Name

Witness Address/Telephone Number

Signature of Witness Printed Name

Witness Address/Telephone Number

INDIANA LIFE-PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____.
(day) (month, year)

I, _____.
(name)

being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence _____

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years old.

Witness _____ Date _____

Witness _____ Date _____



**STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER**

State Form 49559 (12-99)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness

Printed name

Date

Signature of witness

Printed name

Date

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Date

Printed name of attending physician

Medical license number

NOTES

REMEMBER: There is no substitute for communication with family members of your medical care requests. Please communicate your wishes prior to initiating advance medical directives.