End of Life Issues
& Advance Directives

Included is a sample
ADVANCE DIRECTIVE FOR HEALTH CARE
...and Links to all 50 State’s Advance Directive Forms
About the Author...

Brett W. Decker, CLU

Following a successful 25+ year financial planning and sales career at various levels within the financial services and insurance industries, Brett W. Decker, CLU, has also established a highly successful track record as an Insurance CE subject matter expert and a CE provider resource over his most recent 16+ years. Brett has forged a new path by providing CE courses, resources, and services to CE providers and students all around the USA. He is a highly regarded "contract" instructor for Insurance CE Classes and Webinars and has conducted planning and insurance related live events for over 15 years with high marks from well over 10,000+ satisfied students in dozens of subject areas. In that same period, he also created and authored more than 80 specialized insurance CE courses, as well as updated and revised dozens more for CE providers nationally.

With 30+ years of experience in insurance sales, training, and client building activities in the insurance and financial services industries, he is also a recognized broad based subject matter specialist.

Brett's broad-based background, practical experience, "hands on" work in the insurance business, and exposure to the foremost marketing, sales and training consultants nationally uniquely equips him for the 'partner' role that he sees for himself in the education and support of others. His work with experts in the fields of communication, training and business development has given him much to draw on for his CE clients’ and students’ benefit. His interviews, conversations, and relationships with countless insurance people nationally add to his insight in CE course creation for the financial planning and insurance industries.
## Contents

1 End of Life Issues .................................................................................................................. 2  
   Thinking About the End of Life ......................................................................................... 2  
   Preparing For the End of Life ......................................................................................... 2  
   Talking about End-of-Life Wishes ................................................................................ 3  
   Defining the End of Life ................................................................................................. 4  
   Preferences for the End of Life ..................................................................................... 4  
   What Is End-of-Life Care? ............................................................................................... 4  
   Hospice Care .................................................................................................................. 5  
   Palliative Care ................................................................................................................ 5  
   Questions To Ask As the End of Life Approaches ......................................................... 5  

Planning for the Future ......................................................................................................... 5  
   Consider These Situations ............................................................................................... 5  
   Plan for the Future .......................................................................................................... 6  
   What Exactly Is an “Important Paper”? .......................................................................... 6  
   Personal Records ............................................................................................................ 6  
   Steps for Getting Affairs in Order .................................................................................. 7  
   Legal Documents ........................................................................................................... 8  
   Resources ....................................................................................................................... 8  
   Getting Your Affairs in Order ......................................................................................... 9  
   Who should you choose to be your health care proxy? ................................................. 9  
   How do you help someone with Alzheimer’s or dementia get their affairs in order? .... 9  

Advance Care Planning ........................................................................................................ 10  
   What Is Advance Care Planning? .................................................................................... 10  
   Medical Research and Advance Care Planning ............................................................ 10  
   Decisions That Could Come Up Near Death .................................................................. 11  
   CPR ................................................................................................................................. 11  
   Ventilator Use ................................................................................................................ 11  
   Artificial Nutrition or Artificial Hydration ...................................................................... 11  
   Comfort Care .................................................................................................................. 12  
   More About Hospice Care and Palliative Care ............................................................. 12  
   Getting Started ............................................................................................................. 12  

Do You or a Family Member have Alzheimer’s Disease? .................................................. 13  

Making Your Wishes Known ............................................................................................... 13  
   Living Will ...................................................................................................................... 13  
   Durable Power of Attorney for Health Care ................................................................. 14  
   Other Advance Care Planning Documents .................................................................. 14  
   What About Pacemakers and ICDs? ............................................................................. 15  

Selecting Your Healthcare Proxy ....................................................................................... 15  
Making It Official ............................................................................................................... 15
What are my options for treatment preferences for a terminal condition or state of permanent unconsciousness? ............................................................... 37
Can my health care agent make decisions regarding my treatment in a terminal condition or state of permanent unconsciousness? ............................................................... 37
Am I required to express my treatment preferences for a terminal condition or state of permanent unconsciousness in my ADHC? ............................................................... 38
Is my health care provider required to honor my ADHC? ............................................................... 38
What effect does my marriage or divorce have on my ADHC? ............................................................... 38
What is the difference between an ADHC and a durable power of attorney for health care? ............................................................... 38
What is the difference between an ADHC and a living will? ............................................................... 38
What is a guardian? .................................................................................. 39

4 Powers of Attorney and Advance Directives .................................................. 40
Financial Power of Attorney ........................................................................ 40
What is a financial power of attorney? ............................................................ 40
What are the typical powers granted under a Durable Power of Attorney? ....... 41
What Rules should my agent follow when acting on my behalf? ......................... 41
What if there is more than one attorney-in-fact? ............................................. 41
When does the power of attorney take effect? ............................................... 42
Does the power of attorney take away a principal’s rights? ................................ 42
Can the principal change his or her mind? ...................................................... 42
Can an attorney-in-fact be held liable for his or her actions? ......................... 42
Can an attorney-in-fact be compensated for his or her work? ......................... 42
Can the attorney-in-fact be fired? ................................................................. 42
What kind of records should the attorney-in-fact keep? ................................ 42

In General .................................................................................................. 43
Is the Advance Directive for Healthcare the same as a Durable Power of Attorney for Healthcare or my Living Will? .................................................. 43
What type of medical procedures and treatments are you talking about? ........ 44
Why do I need to complete an Advance Directive for Healthcare? .................. 44
What is a “Do Not Resuscitate” (DNR) order? ............................................. 44
When does a physician write a DNR order? .................................................. 44
How will medical personal know that a DNR order is in place? ...................... 45
Does a DNR order stop medical personal from treating a patient completely? .... 45
Can a DNR order be revoked? ................................................................... 45
What is a “code”? .................................................................................... 45
What is a “no code”? ................................................................................. 45
Is there a form of the Advance Directive for Healthcare? .............................. 45

5 What to Know and Do ............................................................................. 47
Things You Should Do ............................................................................... 47
Things You Should Know .......................................................................... 47

6 Advance Directive for Health Care .......................................................... 51
Purpose: .................................................................................................... 51
Instructions ........................................................................................................................................ 52
Definitions .......................................................................................................................................... 52
Certification of a terminal condition or state of permanent unconsciousness ........................................ 52
The difference between this advance directive form and the Living Will and Durable Power of Attorney for Health Care ........................................................................................................... 54
No limitation on the use of other advance directives forms ................................................................... 54
Three Parts of the Advance Directive for Health Care ........................................................................... 54
  Requirements for the person making an advance directive for health care ........................................... 55
  Executing the advance directive for health care ..................................................................................... 55
  Restrictions on the health care agent .................................................................................................. 55
Duty of the health care agent to act ..................................................................................................... 55
Authorized responsibilities/duties of the health care agent related to the necessary care of the declarant ...................................................................................................................................... 56
Prohibited actions by the health care agent .......................................................................................... 56
When the attending physician, health care provider and/or health care facility refuse to honor the advance directive for health care ............................................................................. 56
Revoking this advance directive for health care .................................................................................... 56
What to do with the completed form ................................................................................................... 57
7 Advance Directive for Health Care – “Forms” .................................................................................... 58
Advance Directive Form – “Sample” ..................................................................................................... 59
8 What to Do Now .................................................................................................................................. 65
Suggestions ............................................................................................................................................. 65
  Important Points to Remember About Advance Directives .......................................................... 66
R Resources ............................................................................................................................................ 67
End of Life Issues & Advance Directives

Objectives and Overview

Thinking about the end of a life is never easy, whether it is your own or the life of someone close to you. But, planning ahead and having a better understanding of what is happening in the last days and hours might mean a comfortable death and could make a very difficult time just a little easier. This course will help.

Thanks to the National Institute on Aging at NIH, the information in this course is based on scientific research and developed with experts in end-of-life issues. It's full of information to help us better understand advance care planning. There are also suggestions for beginning a conversation about end-of-life care and providing comfort care friends, clients, and others with someone near the end of life.

To underscore the realities of life and responsibility for consequences of our actions, we spotlight famous end of life cases and personalities.

In addition, if you're like most people, you and your clients aren't eager to spend time thinking about what would happen if you or they became unable to direct their own medical care because of illness, an accident, or advanced age. This course will help to tackle this more often and more confidently.

However, if you and your clients do not do at least a little bit of planning - writing down your and their wishes about the kinds of treatment you and they do or don't want to receive and naming someone you and they trust to oversee your and their care - these important matters could wind up in the hands of estranged family members, doctors, or sometimes even judges, who may know very little about what you and they would prefer.

So, we take a real close look at the Who, What, Where, Why, and How as it related to Advanced Directives. We even provide you with access to a sample and a link instruction for every state so you can make sure you have one for yourself and spouse, if any, and certainly for your clients.
Lesson 1 Objectives

Upon completion of this section, you will:

- Gain increased awareness of end of life issues.
- Know how to prepare for the end of life.
- Be prepared to think about, talk about, and define end of life wishes.
- Be prepared to begin planning for the future.
- Know how to get end of life affairs in order.
- Be able to better assist others in advanced care planning.
- Be able to better assist others in making their wishes known.

1 End of Life Issues

Thinking About the End of Life

Thinking about the end of a life is never easy, whether it is your own or the life of someone close to you. But, planning ahead and having a better understanding of what is happening in the last days and hours might mean a comfortable death and could make a very difficult time just a little easier. Here is some information to help.

Derived largely from the National Institute on Aging at NIH, the following information in this chapter is based on scientific research and developed with experts in end-of-life issues. It’s full of information to help you understand advance care planning. There are also suggestions for beginning a conversation about end-of-life care and providing comfort care friends, clients, and others with someone near the end of life.

Preparing for the End of Life

Few of us are comfortable talking about death, whether our own or a loved one’s. It is a scary, even taboo, subject for many. The end of a life, no matter how long and well lived, can bring with it a sense of loss and sadness. It can also be a reminder of our own mortality, so we may avoid even thinking about death.
This is normal -- but death is normal, too. All of us will face it at some point.

Because of advances in medicine, each of us, as well as our families and friends, may face many decisions about the dying process. As hard as it might be to face the idea of your own death, you might take time to consider how your individual values relate to your wishes for end-of-life care.

By deciding what end-of-life care best suits your needs when you are healthy, you can help those close to you to make the right choices when the time comes. This not only respects your values, but also may give your loved one’s comfort.

There are several ways to make sure others know the kind of care you want when dying.

**Talking about End-of-Life Wishes**

The simplest, but not always the easiest, way is to talk about end-of-life care before an illness. Discussing your thoughts, values, and desires about end-of-life care before you become sick will help people who are close to you to know what care you want. You could discuss how you feel about using life-prolonging measures (for example, CPR or a ventilator) or where you would like to be cared for (for example, home or nursing home). Doctors should be told about these wishes as well.

For some people, it makes sense to bring this up at a small family gathering. Some may find that telling their family they have made a will (or updated an existing one) provides an opportunity to bring up this subject with other family members. As hard as it might be to talk about your end-of-life wishes, knowing your preferences ahead of time can make decision-making easier for your family. You may also have some comfort knowing that your family can choose what you want.

On the other hand, if your parents (or another close relative or friend) are aging and you are unsure about what they want, you might introduce the subject. You can try to explain that having this conversation will help you care for them and do what they want. You might start by talking about what you think their values are, instead of talking about specific treatments. Try saying something like, “When Uncle Isaiah had a stroke, I thought you seemed upset that his kids wanted to put him on a respirator.” Or, “I’ve always wondered why Grandpa didn’t die at home. Do you know?”

Encourage your parents to share the type of care they would choose to have at the end of life, rather than what they don’t want. There is no right or wrong plan, only what they would like. If they are reluctant to have this conversation, don’t force it, but try to bring it up again at a later time.
Defining the End of Life

The end of life and how people die has changed a great deal in the past century. Thanks in large part to advances in public health, medicine, and health care, most Americans no longer die suddenly from injury or infection. Instead, we live longer and, more often than not, die after a period of chronic illness.

As a result, it is hard to know when the dying process begins. Some people pass quickly, while others recover from severe illness several times before death. Even people who are the same age and sex, with the same disease and state of health, are unlikely to reach the end of life at the same time.

We often rely on health care providers to tell us when the end of life is near. But even the most experienced health care provider may find it hard to predict when someone will die. An expert may say the end is within weeks or months, but the dying person slips away much sooner or survives for a year or more.

Preferences for the End of Life

Because the end of life is hard to predict, it is best to plan ahead. You might want to start by asking yourself or a loved one, “What is the best way to plan for the end of life?”

The answer will differ from person to person. Some people want to spend their final days at home, surrounded by family and friends. Others may prefer to be alone, or to be in a hospital receiving treatments for an illness until the very end.

The answer may also change over time -- the person who wanted everything possible done to prolong life may decide to change focus to comfort. Someone else who originally declined treatment may agree to an experimental therapy that may benefit future patients with the same condition.

No matter how a person chooses to approach the end of their life, there are some common hopes -- nearly everyone says they do not want to die in pain or to lose their dignity. Planning for end-of-life care, also known as advance care planning, can help ensure such hopes are fulfilled. We will learn more about advance care planning in the upcoming section “Planning for Care”.

What Is End-of-Life Care?

End-of-life care is the broad term used to describe the special support and attention given during the period leading up to death, when the goals of care focus on comfort and quality of life.
Hospice Care

One of the ways end-of-life care is provided is through hospice. Hospice, as defined by the Center for Medicare and Medicaid Services, is a program of care and support for a dying person whose doctor and a hospice medical director certify has less than six months to live.

The focus of hospice is on comfort, not cure. Currently, patients must be willing to give up curative treatments to receive Medicare coverage for hospice care. (Medicare continues to pay for any covered health problems that are unrelated to the dying person’s terminal illness.)

Palliative Care

Unlike hospice care, you do not have to be dying or give up curative treatments to receive palliative care. The term “palliative care” is sometimes mistakenly used to mean end-of-life care, but palliative care is a treatment available to anyone of any age who is suffering from the discomforts, symptoms, and stress of a serious illness.

Palliative care is used effectively to provide relief from many chronic conditions and their treatments, too. Older persons who are living with one or more chronic illnesses may benefit from palliative care long before they need end-of-life or hospice care. Unlike hospice care, palliative care may be used for as long as necessary.

Questions To Ask As the End of Life Approaches

Regardless of a person’s choices for treatment and care at the end of life, it is important to maintain the quality of a dying person’s life. To better understand the care options available for someone who is approaching death, you may wish to ask the dying person’s health care provider the following questions.

- Since the illness is worsening, what will happen next?
- Why are you suggesting this test or treatment?
- Will the treatment bring physical comfort?
- Will the treatment speed up or slow down the dying process?
- What can we expect to happen in the coming days or weeks?
- If I or my loved one take this treatment or participate in this clinical trial, will it benefit others in the future?

Planning for the Future

Consider These Situations

Ben has been married for 47 years. He always managed the family’s money. But since his stroke, Ben is not able to walk or talk. His wife, Shirley, feels overwhelmed. Of course, she’s
worried about Ben’s health. But, on top of that, she has no idea what bills should be paid or when they are due.

Across town, 80-year-old Louise lives alone. One night, she fell in the kitchen and broke her hip. She spent a week in the hospital and 2 months in a rehabilitation nursing home. Even though her son lives across the country, he was able to pay her bills and handle her Medicare questions right away. That’s because, several years ago, Louise and her son made a plan about what he should do in case Louise had a medical emergency.

**Plan for the Future**

No one ever plans to be sick or disabled. Yet, it’s this kind of planning that can make all the difference in an emergency.

Long before she fell, Louise put all her important papers in one place and told her son where to find them. She gave him the name of her lawyer, as well as a list of people he could contact at her bank, doctor’s office, insurance company, and investment firm. She made sure he had copies of her Medicare and other health insurance cards. She added her son’s name to her checking account and safe deposit box at the bank. Louise made sure Medicare and her doctor had written permission to talk with her son about her health and insurance claims.

On the other hand, Ben always took care of family money matters, and he never talked about the details with Shirley. No one but Ben knew that his life insurance policy was in a box in the closet or that the car title and deed to the house were filed in his desk drawer. Ben never expected that his wife would have to take over. His lack of planning has made a tough job even tougher for Shirley.

**What Exactly Is an “Important Paper”?**

The answer to this question may be different for every family. Remember, this is a starting place. You may have other information to add. For example, if you have a pet, you will want to include the name and address of your veterinarian. Include complete information about:

**Personal Records**

- Full legal name
- Social Security number
- Legal residence
- Date and place of birth
- Names and addresses of spouse and children
- Location of birth and death certificates and certificates of marriage, divorce, citizenship, and adoption
- Employers and dates of employment
• Education and military records
• Names and phone numbers of religious contacts
• Memberships in groups and awards received
• Names and phone numbers of close friends, relatives, doctors, lawyers, and financial advisors
• Medications taken regularly (be sure to update this regularly)
• Location of living will and other legal documents
• Financial Records
• Sources of income and assets (pension from your employer, IRAs, 401(k)s, interest, etc.)
• Social Security and Medicare/Medicaid information
• Insurance information (life, health, long-term care, home, car) with policy numbers and agents’ names and phone numbers
• Names of your banks and account numbers (checking, savings, credit union)
• Investment income (stocks, bonds, property) and stockbrokers’ names and phone numbers
• Copy of most recent income tax return
• Location of most up-to-date will with an original signature
• Liabilities, including property tax—what is owed, to whom, and when payments are due
• Mortgages and debts—how and when they are paid
• Location of original deed of trust for home
• Car title and registration
• Credit and debit card names and numbers
• Location of safe deposit box and key

Steps for Getting Affairs in Order

Put your important papers and copies of legal documents in one place. You can set up a file, put everything in a desk or dresser drawer, or list the information and location of papers in a notebook. If your papers are in a bank safe deposit box, keep copies in a file at home. Check each year to see if there’s anything new to add.

Tell a trusted family member or friend where you put all your important papers. You don’t need to tell this friend or family member about your personal affairs, but someone should know where you keep your papers in case of an emergency. If you don’t have a relative or friend you trust, ask a lawyer to help.

Give permission in advance for your doctor or lawyer to talk with your caregiver as needed. There may be questions about your care, a bill, or a health insurance claim. Without your consent, your caregiver may not be able to get needed information. You can give your okay in advance to Medicare, a credit card company, your bank, or your doctor. You may need to sign and return a form.
Legal Documents

There are many different types of legal documents that can help you plan how your affairs will be handled in the future. Many of these documents have names that sound alike, so make sure you are getting the documents you want. Also, State laws vary, so find out about the rules, requirements, and forms used in your State.

Wills and trusts let you name the person you want your money and property to go to after you die.

Advance directives let you make arrangements for your care if you become sick. There are two ways to do this:

A living will gives you a say in your health care if you become too sick to make your wishes known. In a living will, you can state what kind of care you do or don’t want. This can make it easier for family members to make tough healthcare decisions for you.

A durable power of attorney for health care lets you name the person you want to make medical decisions for you if you can’t make them yourself. Make sure the person you name is willing to make those decisions for you.

For legal matters, there are two ways to give someone you trust the power to act in your place:

- A general power of attorney lets you give someone else the authority to act on your behalf, but this power will end if you are unable to make your own decisions.

- A durable power of attorney allows you to name someone to act on your behalf for any legal task, but it stays in place if you become unable to make your own decisions.

Resources

You may want to talk with a lawyer about setting up a general power of attorney, durable power of attorney, joint account, trust, or advance directive. Be sure to ask about the lawyer’s fees before you make an appointment.

You should be able to find a directory of local lawyers at your library, or you can contact your local bar association for lawyers in your area. Your local bar association can also help you find what free legal aid options your State has to offer. An informed family member may be able to help you manage some of these issues.
Getting Your Affairs in Order

Who should you choose to be your health care proxy?

If you decide to choose a proxy, think about people you know who share your views and values about life and medical decisions. Your proxy might be a family member, a friend, your lawyer, or someone with whom you worship.

If your aging parents can no longer make their own health care decisions, how do you decide what type of care is right for them?

It can be overwhelming to be asked to make health care decisions for someone who is no longer able to make his or her own decisions. Get a better understanding of how to make health care decisions for a loved one, including approaches you can take, issues you might face, and questions you can ask to help you prepare.

How do you help someone with Alzheimer’s or dementia get their affairs in order?

A complication of diseases such as Alzheimer’s is that the person may lack or gradually lose the ability to think clearly. This change affects his or her ability to participate meaningfully in decision making and makes early planning even more important. Find legal and financial planning tips for people with Alzheimer’s disease, including information on advance directives, resources, and additional advance planning advice.

Interested in organ donation and transplantation? Find resources I am considering becoming an organ donor. Is the process different for older adults?

There are many resources for older organ donors and recipients available from the U.S. government. Find information for potential donors and transplant recipients over age 50, including how to register to be a donor.

I want to make sure my affairs are in order before I die, but I’m not sure where to begin.

The National Institute on Aging has a resource about End of Life: Helping With Comfort and Care.

This guide can help you and your loved ones discuss key issues at the end of life, including finding hospice care, what happens at the time of death, managing grief, and preparing advance directives along with resources for more information.

For more information about getting your affairs in order, please see the Resource section at the end of your course.
Advance Care Planning

What Is Advance Care Planning?

Advance care planning is not just about old age. At any age, a medical crisis could leave someone too ill to make his or her own healthcare decisions. Even if you are not sick now, making healthcare plans for the future is an important step toward making sure you get the medical care you would want, even when doctors and family members are making the decisions for you.

More than one out of four older Americans face questions about medical treatment near the end of life but are not capable of making those decisions. This tip sheet will discuss some questions you can think about now and describe ways to share your wishes with others. Write them down or at least talk about them with someone who would make the decisions for you. Knowing how you would decide might take some of the burden off family and friends.

Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know about your preferences, often by putting them into an advance directive.

An advance directive is a legal document that goes into effect only if you are incapacitated and unable to speak for yourself. This could be the result of disease or severe injury—no matter how old you are. It helps others know what type of medical care you want. It also allows you to express your values and desires related to end-of-life care. You might think of an advance directive as a living document—one that you can adjust as your situation changes because of new information or a change in your health.

Medical Research and Advance Care Planning

Medical research plays an important role in the health of Americans of all ages. Because of advances in medicine and in public health, Americans are living longer and staying healthier as they grow older. The National Institute on Aging (NIA) supports much of the research around the country that looks at how people age and how to improve their health in their later years. NIA is part of the National Institutes of Health (NIH), the nation’s medical research agency.

Some NIA-supported research focuses on advance care planning, including examining why people might complete advance directives and the effect of these directives on end-of-life care. In one study, for example, scientists funded by NIA found that advance directives can make a difference and that people who document their preferences in this way are more likely to get the care they prefer at the end of life than people who do not.
Decisions That Could Come Up Near Death

Sometimes when doctors believe a cure is no longer possible and you are dying, decisions must be made about the use of emergency treatments to keep you alive. Doctors can use several artificial or mechanical ways to try to do this. Decisions that might come up at this time relate to:

- CPR (cardiopulmonary resuscitation)
- ventilator use
- artificial nutrition (tube feeding) or artificial hydration (intravenous fluids)
- comfort care

**CPR**

CPR (cardiopulmonary resuscitation) might restore your heartbeat if your heart stops or is in a life-threatening abnormal rhythm. The heart of a young, otherwise healthy person might resume beating normally after CPR. An otherwise healthy older person, whose heart is beating erratically or not beating at all, might also be helped by CPR. CPR is less likely to work for an older person who is ill, can’t be successfully treated, and is already close to death. It involves repeatedly pushing on the chest with force, while putting air into the lungs. This force has to be quite strong, and sometimes ribs are broken or a lung collapses. Electric shocks known as defibrillation and medicines might also be used as part of the process.

**Ventilator Use**

Ventilators are machines that help you breathe. A tube connected to the ventilator is put through the throat into the trachea (windpipe) so the machine can force air into the lungs. Putting the tube down the throat is called intubation. Because the tube is uncomfortable, medicines are used to keep you sedated (unconscious) while on a ventilator. If you can’t breathe on your own after a few days, a doctor may perform a tracheotomy or “trach” (rhymes with “make”). During this bedside surgery, the tube is inserted directly into the trachea through a hole in the neck. For long-term help with breathing, a trach is more comfortable, and sedation is not needed. People using such a breathing tube aren’t able to speak without special help because exhaled air goes out of the trach rather than past their vocal cords.

**Artificial Nutrition or Artificial Hydration**

A feeding tube and/or intravenous (IV) liquids are sometimes used to provide nutrition when a person is not able to eat or drink. These measures can be helpful if you are recovering from an illness. However, if you are near death, these could actually make you more uncomfortable. For example, IV liquids, which are given through a plastic tube put into a vein, can increase the burden on failing kidneys. Or if the body is shutting down near death, it is not able to digest food properly, even when provided through a feeding tube. At first, the feeding tube is threaded through the nose down to the stomach. In time, if tube feeding is still needed, the tube is surgically inserted into the stomach.
**Comfort Care**

Comfort care is anything that can be done to soothe you and relieve suffering while staying in line with your wishes. Comfort care includes managing shortness of breath; offering ice chips for dry mouth; limiting medical testing; providing spiritual and emotional counseling; and giving medication for pain, anxiety, nausea, or constipation. Often this is done through hospice, which may be offered in the home, in a hospice facility, in a skilled nursing facility, or in a hospital. With hospice, a team of healthcare providers works together to provide the best possible quality of life in a patient’s final days, weeks, or months. After death, the hospice team continues to offer support to the family. Learn more about providing comfort at the end of life.

**More About Hospice Care and Palliative Care**

As mentioned previously, hospice care is intended to provide comfort to a patient and their family during a life-threatening illness, rather than provide treatments to cure the illness. Palliative care is similar to comfort care in hospice, but it is offered along with any medical treatments you might be receiving for a life-threatening illness, such as chemotherapy for cancer or dialysis for kidney failure. The main goal of both hospice and palliative care is to keep you comfortable. In addition, you can always choose to move from hospice to palliative care if you want to pursue treatments to cure your illness.

**Getting Started**

Start by thinking about what kind of treatment you do or do not want in a medical emergency. It might help to talk with your doctor about how your present health conditions might influence your health in the future. For example, what decisions would you or your family face if your high blood pressure leads to a stroke?

If you don’t have any medical issues now, your family medical history might be a clue to thinking about the future. Talk to your doctor about decisions that might come up if you develop health problems similar to those of other family members.

In considering treatment decisions, your personal values are key. Is your main desire to have the most days of life, or to have the most life in your days? What if an illness leaves you paralyzed or in a permanent coma and you need to be on a ventilator? Would you want that?

What makes life meaningful to you? You might want doctors to try CPR if your heart stops or to try using a ventilator for a short time if you’ve had trouble breathing, if that means that, in the future, you could be well enough to spend time with your family. Even if the emergency leaves you simply able to spend your days listening to books on tape or gazing out the window watching the birds and squirrels compete for seeds in the bird feeder, you might be content with that.
But, there are many other scenarios. Here are a few. What would you decide?

- If a stroke leaves you paralyzed and then your heart stops, would you want CPR? What if you were also mentally impaired by a stroke—does your decision change?
- What if you develop dementia, don’t recognize family and friends, and, in time, cannot feed yourself? Would you want a feeding tube used to give you nutrition?
- What if you are permanently unconscious and then develop pneumonia? Would you want antibiotics and a ventilator used?
- For some people, staying alive as long as medically possible is the most important thing. An advance directive can help make sure that happens.

Your decisions about how to handle any of these situations could be different at age 40 than at age 85. Or they could be different if you have an incurable condition as opposed to being generally healthy. An advance directive allows you to provide instructions for these types of situations and then to change the instructions as you get older or if your viewpoint changes.

**Do You or a Family Member have Alzheimer's Disease?**

Many people are unprepared to deal with the legal and financial consequences of a serious illness such as Alzheimer's disease. Advance planning can help people with Alzheimer's and their families clarify their wishes and make well-informed decisions about health care and financial arrangements.

**Making Your Wishes Known**

We will discuss this further in your course, but there are two elements in an advance directive—a living will and a durable power of attorney for health care. There are also other documents that can supplement your advance directive or stand alone. You can choose which documents to create, depending on how you want decisions to be made. These documents include:

- living will
- durable power of attorney for health care
- other documents discussing DNR (do not resuscitate) orders, organ and tissue donation, dialysis, and blood transfusions, etc

**Living Will**

A living will is a written document that helps you tell doctors how you want to be treated if you are dying or permanently unconscious and cannot make decisions about emergency treatment. In a living will, you can say which of the procedures described above you would want, which ones you wouldn’t want, and under which conditions each of your choices applies.
**Durable Power of Attorney for Health Care**

A durable power of attorney for health care is a legal document naming a healthcare proxy, someone to make medical decisions for you at times when you might not be able to do so. Your proxy, also known as a surrogate or agent, should be familiar with your values and wishes. This means that he or she will be able to decide as you would when treatment decisions need to be made. A proxy can be chosen in addition to or instead of a living will. Having a healthcare proxy helps you plan for situations that cannot be foreseen, like a serious auto accident.

A durable power of attorney for health care enables you to be more specific about your medical treatment than a living will.

Some people are reluctant to put specific health decisions in writing. For them, naming a healthcare agent might be a good approach, especially if there is someone they feel comfortable talking with about their values and preferences.

**Other Advance Care Planning Documents**

You might also want to prepare separate documents to express your wishes about a single medical issue or something not already covered in your advance directive. A living will usually covers only the specific life-sustaining treatments discussed earlier. You might want to give your healthcare proxy specific instructions about other issues, such as blood transfusion or kidney dialysis. This is especially important if your doctor suggests that, given your health condition, such treatments might be needed in the future.

Two medical issues that might arise at the end of life are DNR orders and organ and tissue donation.

**A DNR (do not resuscitate)** order tells medical staff in a hospital or nursing facility that you do not want them to try to return your heart to a normal rhythm if it stops or is beating unevenly. Even though a living will might say CPR is not wanted, it is helpful to have a DNR order as part of your medical file if you go to a hospital. Posting a DNR next to your bed might avoid confusion in an emergency situation. Without a DNR order, medical staff will make every effort to restore the normal rhythm of your heart. A non-hospital DNR will alert emergency medical personnel to your wishes regarding CPR and other measures to restore your heartbeat if you are not in the hospital. A similar document that is less familiar is called a DNI (do not intubate) order. A DNI tells medical staff in a hospital or nursing facility that you do not want to be put on a breathing machine.

**Organ and tissue donation** allows organs or body parts from a generally healthy person who has died to be transplanted into people who need them. Commonly, the heart, lungs, pancreas, kidneys, corneas, liver, and skin are donated. There is no age limit for organ and tissue donation. You can carry a donation card in your wallet. Some states allow you to add this decision to your driver’s license. Some people also include organ donation in their advance care
planning documents. At the time of death, family may be asked about organ donation. If those close to you, especially your proxy, know how you feel about organ donation, they will be ready to respond.

**What About Pacemakers and ICDs?**

Some people have pacemakers to help their hearts beat regularly. If you have one and are near death, it may not necessarily keep you alive. But, you might have an ICD (implantable cardioverter-defibrillator) placed under your skin to shock your heart back into regular beatings if the rhythm becomes irregular. If other life-sustaining measures are not used, the ICD may also be turned off. You need to state in your advance directive what you want done if the doctor suggests it is time to turn it off.

**Selecting Your Healthcare Proxy**

If you decide to choose a proxy, think about people you know who share your views and values about life and medical decisions. Your proxy might be a family member, a friend, your lawyer, or someone with whom you worship. It’s a good idea to also name an alternate proxy. It is especially important to have a detailed living will if you choose not to name a proxy.

You can decide how much authority your proxy has over your medical care—whether he or she is entitled to make a wide range of decisions or only a few specific ones. Try not to include guidelines that make it impossible for the proxy to fulfill his or her duties. For example, it’s probably not unusual for someone to say in conversation, “I don’t want to go to a nursing home,” but think carefully about whether you want a restriction like that in your advance directive. Sometimes, for financial or medical reasons, that may be the best choice for you.

Of course, check with those you choose as your healthcare proxy and alternate before you name them officially. Make sure they are comfortable with this responsibility.

**Making It Official**

Once you have talked with your doctor and have an idea of the types of decisions that could come up in the future and whom you would like as a proxy, if you want one at all, the next step is to fill out the legal forms detailing your wishes. A lawyer can help but is not required. If you decide to use a lawyer, don’t depend on him or her to help you understand different medical treatments. That’s why you should start the planning process by talking with your doctor.

Many states have their own advance directive forms. Your local Area Agency on Aging can help you locate the right forms. You can find your area agency phone number by calling the Eldercare Locator toll-free at 1-800-677-1116 or going online at www.eldercare.gov.

Some states want your advance directive to be witnessed; some want your signature notarized. A notary is a person licensed by the state to witness signatures. You might find a notary at your bank, post office, or local library, or call your insurance agent. Some notaries charge a fee.
Some people spend a lot of time in more than one state—for example, visiting children and grandchildren. If that’s your situation also, you might consider preparing an advance directive using forms for each state—and keep a copy in each place, too.

**Future Directions**

A number of states are developing or starting to use an advance care planning form known as POLST (Physician Orders for Life-Sustaining Treatment) or MOLST (Medical Orders for Life-Sustaining Treatment). These forms serve in addition to your advance directive. They make it possible for you to provide more detailed guidance about your medical care preferences. Your doctor will talk with you and/or your family for guidance, but the form is filled out by the doctor or, sometimes, a nurse practitioner or physician’s assistant. Once signed by your doctor, this form has the force of any other medical order. These forms are often printed on brightly colored paper so they are easily found in a medical or hospital file. Check with your state department of health to find out if this form is available where you live.

**After You Set Up Your Advance Directive**

There are key people who should be told that you have an advance directive. Give copies to your healthcare proxy and alternate proxy. Give your doctor a copy for your medical records. Tell key family members and friends where you keep a copy. If you have to go to the hospital, give staff there a copy to include in your records. Because you might change your advance directive in the future, it’s a good idea to keep track of who receives a copy.

Review your advance care planning decisions from time to time—for example, every 10 years, if not more often. You might want to revise your preferences for care if your situation or your health changes. Or, you might want to make adjustments if you receive a serious diagnosis; if you get married, separated, or divorced; if your spouse dies; or if something happens to your proxy or alternate. If your preferences change, you will want to make sure your doctor, proxy, and family know about them.

**Still Not Sure?**

What happens if you have no advance directive or have made no plans and you become unable to speak for yourself? In such cases, the state where you live will assign someone to make medical decisions on your behalf. This will probably be your spouse, your parents if they are available, or your children if they are adults. If you have no family members, the state will choose someone to represent your best interests.

Always remember, an advance directive is only used if you are in danger of dying and need certain emergency or special measures to keep you alive but are not able to make those decisions on your own. An advance directive allows you to continue to make your wishes about medical treatment known.
Looking Toward the Future

Nobody can predict the future. You may never face a medical situation where you are unable to speak for yourself and make your wishes known. But having an advance directive may give you and those close to you some peace of mind.

Advance Directive Wallet Card

You might want to make a card to carry in your wallet indicating that you have an advance directive and where it is kept. Here is a slightly revised example of the wallet card offered by the Office of the Attorney General in Maryland. It uses the phrase “healthcare agent” instead of “healthcare proxy.” You might want to print this one to fill out and carry with you. It can also be found online at www.oag.state.md.us/Healthpol/adDir_cards.pdf (PDF, 178K).

Printable wallet card specifying advance directive information

An Advance Health Care Directive, which includes a Living Will, is only useful if it can be found and read when you are unable to make medical decisions for yourself. Typically, if you are unable to make medical decisions for yourself, you are not able to tell your doctor or your family where your Advance Directive is located. That is why the Attorney General’s Office has developed a small card that you can keep in your wallet to document the location of your Advance Health Care Directive.

Two cards are provided for so each spouse has one. They each should cut out a card, fill it in, fold it, and put it in their wallet or billfold.

These cards are not the same as a Do Not Resuscitate or DNR order. If you want emergency medical services personnel to refrain from resuscitating you, you need a Medical Orders for Life-Sustaining Treatment (MOLST) form. That form has to be filled out by a physician or a nurse practitioner. Copies are available from your State’s Emergency Medical Services Systems. You can Google “MOLST Form” and click on the link.

For more information about Advance Health Care Directives, you can visit the Attorney General’s website for your state.
<table>
<thead>
<tr>
<th>I HAVE AN ADVANCE DIRECTIVE.</th>
<th>OTHER COPIES ARE HELD BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>My Physician’s Name:</td>
<td>Phone #s:</td>
</tr>
<tr>
<td>Physician’s Phone #:</td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Phone #s:</td>
</tr>
<tr>
<td></td>
<td>I ALSO HAVE A HEALTHCARE AGENT.</td>
</tr>
<tr>
<td></td>
<td>Agent’s Name:</td>
</tr>
<tr>
<td></td>
<td>Phone #s:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I HAVE AN ADVANCE DIRECTIVE.</th>
<th>OTHER COPIES ARE HELD BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>My Physician’s Name:</td>
<td>Phone #s:</td>
</tr>
<tr>
<td>Physician’s Phone #:</td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Phone #s:</td>
</tr>
<tr>
<td></td>
<td>I ALSO HAVE A HEALTHCARE AGENT.</td>
</tr>
<tr>
<td></td>
<td>Agent’s Name:</td>
</tr>
<tr>
<td></td>
<td>Phone #s:</td>
</tr>
</tbody>
</table>
Lesson 2 Objectives

Upon completion of this section, you will:

- Learn about or be reminded about specific famous cases and end of life decisions.
- Learn about and gain further insight by looking at:
  - Whitney Houston's daughter and the family's life support decision
  - Joan Rivers Case
  - Key Legal Cases
- Become better aware of what happens when there are no directives
  - Karen Ann Quinlan
  - Nancy Beth Cruzan
  - Michael Martin
  - Theresa ("Terri") Maria Schindler Schiavo

2 Spotlight on End-of-Life Decisions

Whitney's Daughter: Family's Heartbreaking Life Support Decision

In April of 2015 as Bobbi Kristina Brown entered her third month in a coma, her family faces an excruciating choice: Keep the 24-year-old alive on machines with little hope for recovery, or withdraw life support and let nature take its course.

The agonizing decision is one faced by many families, and each situation is unique, a top expert tells Newsmax Health.

But one thing is common to all end-of-life situations: They are easier if the patient has left instructions about how they want to be treated.

Brown, the daughter of the late singer Whitney Houston, was found face-down in her bathtub on Jan. 31 and now is being kept alive in a critical care facility.

Like most people, especially patients so young, Bobbi Kristina apparently did not have an end-of-life directive that would instruct her family of her wishes, according to reports.
“Whether they’re young, old, or in-between – people need to make their wishes known,” Marc Leavey, M.D., told Newsmax Health.

“Years ago, we didn’t have the means to keep people alive this way. If something happened, you were going to die. But now, we can use machinery to take care of a person’s life functions.

“We can keep them breathing, their heart beating, and their kidneys functioning. The only thing we really can’t fix is their brain. But if the body is otherwise intact, we can keep someone going indefinitely, and that’s actually a real problem,” said Dr. Leavey, an internist at Mercy Medical Center in Baltimore.

Part of the problem is that we as a society have become more distanced from death, and more convinced that it is the job of doctors and hospitals to keep us alive no matter what, said Dr. Leavey.

“Before modern technology came along, when mom and dad got old and sick, they’d be kept in the back bedroom and the family would take care of them and the kids would see that death was a part of life.

“Now mom or dad is hooked up to a machine in a hospital and their children are notified by a phone call that they’ve died. We’ve distanced it, and as a result, people don’t want to talk about it anymore,” Dr. Leavey said. “We need to start talking about it.”

There are myths about end-of-life directives that keep people from executing them, Dr. Leavey said.

“People think it’s an order to die, but it can be the opposite. You can say, ‘I don’t want to live under certain circumstances, or you can say, ‘Do everything you can to keep me alive,’” he said.

Such directives can be changed in the event that people decide differently later, he noted. “People do that all the time,” he added.

And age should not be a factor. “We ask teenagers when they get their first driver’s license if they want to become organ donors. That may seem odd if you think about it, but this is not that different,” said Dr. Leavey.

“Bobbi Kristina may have not wanted to be kept alive, hooked up to a machine and tubes, or she might have wanted to be kept alive no matter what. But we’ll never know because she didn’t say. And now it’s too late,” he said.

End-of-life instructions are usually put into a legal document known as an advance directive. States vary in their requirements, but such directives can include:
- **A living will:** This tells your doctor how you want to be treated if you are dying or unconscious and cannot make decisions about emergency treatment. You can stipulate which procedures you would want, which ones you don’t, and under which conditions each of your choices applies.

- **A durable power of attorney for healthcare:** This legal document names a healthcare proxy, which is someone such as a family member to whom you give authority to make medical decisions for you when you are not able to do so.

- **A DNR or “do not resuscitate” order:** This document tells the medical staff in a hospital or nursing facility that you do not want them to try to return your heart to a normal rhythm if it stops or is beating unevenly. You can also execute a non-hospital DNR to keep ambulance personnel from resuscitating you. There are similar forms for CPR and also a DNI (on not intubate) order if you do not want to be put on a breathing machine.

You can download forms for an advance directive in your state by going here. [http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289](http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289)

**Joan Rivers**

According to Charlotte Libov of Newsmax.com, Joan Rivers was the most energetic 81-year-old you could imagine. Her work schedule would have worn out people half her age. Suddenly, while seeming to be the picture of health, she suffered cardiac arrest while under sedation for a minor medical procedure. She was put on life support and eventually died on Sept. 4.

The comic legend’s without-warning death should motivate people to put their end-of-life instructions in writing before it is too late, a top doctor told Newsmax Health.

“What happened to Joan Rivers should be a wake up call for the baby boomer generation which too often thinks, ‘I’m fine, I’m doing wonderfully well. I don’t have to worry about such things,’” says Marc Leavey, M.D.

“This is a real problem for a generation that likes to think young. They have to be realistic and consider the question: ‘What if something happens to me and I don’t come out of it?’” added Dr. Leavey, an internist at Mercy Medical Center in Baltimore.

Shortly before her death, the machines keeping Rivers alive were disconnected so that she could die peacefully surrounded by family, according to reports. Her daughter Melissa is thought to have made any decisions in accordance to Rivers’ wishes. The pair was very close and Melissa was Rivers’ only child.

Written end-of-life instructions make it much easier for a family to cope when a loved one is dying, Dr. Leavey said.
Instead of making a heartbreaking decision that could leave regrets, loved ones are able to follow the patient’s specific instructions with a clear mind, knowing it’s what they want, said Dr. Leavey.

And contrary to popular belief, end-of-life instructions don’t always specify that a patient doesn’t want to be kept on life support. Often, they stipulate “Do everything you can for me,” Dr. Leavey said.

An understanding of major court cases can help you better understand the pitfalls that caused other individuals and families problems. There are literally hundreds of court cases of related to advance directives and treatment decision-making, but only a few of the more notable cases are presented here.

**Key Legal Cases**

**What Happens When There are NO Directives**

**Karen Ann Quinlan**

According to LifecareDirectives, LLC, in their article “Key Legal Cases-What Happens When There are NO Directives”, Karen Ann Quinlan was a 22-year-old woman who fell into a coma on April 15, 1975 following an apparent overdose of drugs and alcohol. She suffered severe brain damage from oxygen deprivation as she was unable to breathe properly following the overdose. Upon arrival at a hospital, it was found that she could not maintain an adequate breathing rate, and so she was attached to a breathing machine (i.e., a "respirator" or "ventilator").

The coma did not improve, nor did her breathing, and Karen remained in an "persistent vegetative" state having never regained consciousness. After many months, her physicians agreed that there was no hope for improvement and her family requested that the breathing machine be removed.

Karen's physicians, however, were concerned about the legality of stopping a breathing machine in so young a patient, particularly when she was not otherwise in an immediately terminal condition. So the courts were petitioned to authorize the removal of the respirator. This was the first time that any higher court had ever been required to address whether or not life-sustaining medical treatment could be stopped in a persistently vegetative (i.e., permanently unconscious) patient. In 1976 the New Jersey court ruled that artificial life support could be discontinued in this case -- but only because Ms. Quinlan had previously and specifically made known her wish not to have her life maintained indefinitely by the use of a breathing machine.

**Key Learning:** The courts allowed the removal of the breathing machine specifically and only
because there was appropriate evidence of Karen's prior wishes. Of note, however, there was no such evidence about her wishes regarding the use of feeding tubes. Therefore her father did not agree to have the tube feedings stopped, even though the court order also allowed for this. After more than a year of assisted breathing Karen's breathing reflexes had stabilized enough to sustain her lung function even after the breathing machine was removed. Consequently, she lived an additional 10 years in her persistent vegetative condition, sustained by feeding tubes.

**Nancy Beth Cruzan**

Also according to LifecareDirectives, LLC, in their article “Key Legal Cases-What Happens When There are NO Directives”, Nancy Beth Cruzan was a 33-year old woman who sustained severe brain damage following an automobile accident in January, 1983. In the accident, she not only suffered overwhelming head injuries, but she also landed face down in water at the roadside causing further brain damage from oxygen deprivation. Nancy never regained consciousness and her life was sustained by the continuous use of tube feeding. Over time her physicians concluded that she would never recover consciousness. Four years later, her family requested that the tube feedings be stopped. After the hospital refused, Nancy's parents petitioned the courts for the necessary authorization.

During the hearings, however, the state argued persuasively against the family's request. In particular it was noted that Ms. Cruzan had "never specifically told her friends or family that she would not want to be fed through such a tube."

The family appealed to the United States Supreme Court. There it was ruled that a "constitutional right to refuse medical care, including feeding tubes" did exist. However, the Court also ruled that "a state could require 'clear and convincing evidence' that removal of the tube is what the patient would have wanted."

It took the family until June of 1990 (almost seven years) to gather enough evidence from relatives, friends and others before the Courts finally ruled that sufficient evidence did exist. Ms. Cruzan's feeding tube was then removed on December 15th, and she died on December 27th.

**Key Learning:** Clear and convincing evidence of ones wishes may well be required. Therefore, you must speak plainly about what you do or do not want done if you wish to ensure that your desires will be honored.

**Michael Martin**

Further according to LifecareDirectives, LLC, in their article “Key Legal Cases-What Happens When There are NO Directives”, on January 16, 1987, 35-year old Michael Martin was badly injured in a car-train accident, including major injuries to his brain. The injuries left him severely mentally impaired, unable to walk or talk, as well as dependent on the use of feeding tubes to
sustain his life. He was not, however, left in a "vegetative" condition. He recovered to the point of being able to respond to some simple requests, and appeared able to recognize faces.

His wife, Mary, was appointed as his legal guardian. Five years passed, and Michael's condition did not improve. Mary noted that Michael had made numerous statements in the past about not wanting his life artificially sustained in a highly debilitated condition. Thus, on March 19, 1992, Mary filed a petition in the courts requesting authorization to remove Michael's feeding tubes.

However, Michael's mother, Leeta Martin, and his sister, Patricia Major, opposed the request and filed a petition of their own, asking that Mary be removed as Michael's guardian. Allegations were made that Mary only wanted the life-sustaining treatments discontinued in order to obtain settlement funds from a lawsuit against the railroad. Mary countered that the money was not a factor, noting that the funds substantially increased over time and thus extending Michael's life would be the goal if that were the case.

During the court proceedings, Mary testified that Michael was "a private but active person before the accident." She further explained that had always found it difficult to be around people "who were disabled or dependent on others" and had frequently stated that "he would rather die than be dependent on people and machines." His wife testified of several "discussions between Mike and me regarding...our wishes...if either of us was ever involved in a serious accident, had a disabling or terminal illness or was dying of old age."

She noted that the discussions "began approximately eight years ago," and that they spoke of these things "on many different occasions." Specifically, "several were triggered by movies which we saw together. Mike's position was always the same: he did not want to be kept alive on machines and he made me promise that I would never permit it." Two co-workers also testified that "he had remarked to them that "he would not want to continue living in a vegetative state." However, Mr. Martin was not in a vegetative condition, and thus such testimony was deemed insufficient.

His sister also acknowledged that "Michael once told her that he would not want to be kept alive by a respirator if he were in a coma." But, again, he was not now in a coma. On October 30, 1992, the trial court ruled on the basis of Mary's testimony that "clear and convincing evidence had been presented," and the court appeared satisfied that Michael would not want his life artificially prolonged in this situation.

However, the court further ruled that Michael's past wishes "could not be considered because they were not expressed in writing." In addition, although the court specifically found that withdrawing the feeding tubes appeared to be "in Michael's best interests," his wishes could not be honored because he was not "terminally ill." Therefore, the petition was denied. The case was appealed to the Michigan Court of Appeals (which ruled in favor of Mary), and from there to the Michigan State Supreme Court. The state supreme court concluded that Michael's prior statements were insufficient to prove his wishes
Specifically, his past statements were ruled "general, vague and casual..." Regarding comments made to his wife after seeing debilitated people, movies, etc, it was noted that "...Michael's purported remarks...were 'no different than those that many of us might make.'" in such situations, but they could not be deemed conclusive statements as to his future wishes. Thus, the court ordered that the tube feedings must be continued.

**Key Learning:** Casual statements made to loved ones may well not be sufficient evidence for your wishes to be honored. Even the appearance of secondary motives (financial gain, etc) can greatly complicate the process, potentially causing other genuine concern. It is essential, therefore, that you clearly document your wishes in a written advance directive, both to ensure that your desires are unequivocally known and will be honored and to protect those you love from unnecessarily painful negative allegations and distress.

**Theresa ("Terri") Maria Schindler Schiavo**

Finally, according to Lifecare Directives, LLC, in their article “Key Legal Cases-What Happens When There are NO Directives”, the case of Theresa ("Terri") Maria Schindler Schiavo is unquestionably the best known of all legal end-of-life cases. The case was pursued in the courts over the course of 12 years and was followed through the media by a world-wide audience.

In February of 1990 at the age of 26, Terri reportedly collapsed at home. Because she was being treated for bulimia (an eating disorder), it was suggested that a related potassium imbalance may have caused her heart to stop. Regardless, Terri suffered severe brain damage from a lack of oxygen, and was left unable to eat, walk, or talk, and required tube feeding to survive.

In 1991 her husband, Michael Schiavo, flew Terri to California for experimental therapy. However, the therapy produced no measurable success. He also moved her at times from one nursing home to another in search of better rehabilitation and care.

For the first three years, all accounts indicate that Michael remained very involved in his wife's care and that he and her parents, the Schindlers, enjoyed an amicable relationship.

However, the amicability apparently ended in 1993, shortly after Michael won a $1.3 million malpractice settlement over the treatment of Terri’s potassium imbalance. $750,000 was awarded in Terri's name and for her care. The rest was awarded to Michael for his loss of "spousal consortium."

Michael claims that in February 1993 Terri's father came to him and requested "his share" of the award. Michael allegedly declined, stating that the funds were to be used for Terri's care.
Terri’s father disputes this account, stating he had only requested access to Terri’s funds to secure further rehabilitation, which he claimed Michael was no longer pursuing.

Later, in July 1993, Terri’s parents tried to have Michael removed as guardian and themselves appointed in his stead. They alleged poor care by Michael, and also voiced suspicions that he may have originally tried to strangle her. They speculated that this, rather than the potassium imbalance may have been the cause of her debilitating injury. They further alleged that Michael was the source of Terri’s bulimia, noting that Terri had been ‘heavy’ in high school and was extremely self-conscious about her weight. They claimed that Michael had pressured her to stay thin with statements such as, “If you ever get that fat again, I'll divorce you.”

Michael denied the allegations of assault and claimed he never made disparaging statements or threats. The case was ultimately dismissed.

In 1998 Michael became engaged to a woman who was eventually to become his second spouse. Together they had two children. At this juncture, the Schindlers again sued for guardianship. They based the suit upon grounds of adultery and upon renewed allegations of neglect and abuse. Their efforts again failed. By many accounts, Michael remained devoted to Terri and to her care. Indeed, it was noted by some that he was found more frequently her bedside than Terri’s other family members.

Yet, there was no discounting the considerable concern and effort of the Schindlers. In particular they were devoted to Terri’s continuing rehabilitation. This aroused considerable controversy. Some professionals felt that the kinds of "stimulus-based" therapies they were pursuing could cause Terri unnecessary distress and disruption, and potentially do more harm than good. Eventually Michael sought to prevent Terri’s parents from further involvement in this regard. Their response was to secure covert “telephone ‘tough love’ rehabilitation” when they were denied other options.

As the years passed Michael became increasingly convinced that Terri’s condition would not improve. Drawing upon statements he claimed Terri had made to him, he petitioned the courts for removal of her feeding tube. In particular, he testified about a past conversation they’d had about a disabled uncle. During the discussion Terri had told him never to prolong her life in a severely disabled condition. A girlfriend of Terri’s provided additional supporting testimony. Thus, on February 11, 2000, 10 years after Terri’s original collapse, a circuit court judge approved the request.

The parents sued for an injunction. They also cited prior conversations with Terri, along with her religious affiliation and beliefs. They added their own conviction that she was not truly comatose, and thus could yet improve, as injunctive grounds. They also produced testimony from a woman who had dated Michael between 1992 and 1993 who claimed to have once asked him what he knew about Terri’s wishes. She stated that he had responded, “We never spoke about this. My God, I was only 25 years old. ... We were young. We never spoke of this.”
Finally, they alleged that Michael only wanted the feeding tube removed because he wanted to retain the remainder of the malpractice award.

Over the next five years, a total of six court battles and multiple investigations ensued. Ultimately, 33 experts were sought out by the Schindlers to support their claim that Terri was still aware, able to communicate, and might yet benefit from rehabilitation. A similar number of counter-opinions were obtained from other experts, in rebuttal. Ultimately, by some reports, over half of the total funds awarded for Terri's care were eventually spent on legal fees. A legal defense organization temporarily covered the Schindler's considerable legal costs for some two years, followed by additional funds and representation from a religiously-based legal group. One businessman offered Michael Schiavo $1 million to walk away from Terri, and a "pledge fund" was set up for a similar purpose which claimed $6 million in donations. Michael consistently declined any such offers.

Equally devoted right-to-die groups took up Michael's cause and condemned all legal and government intrusions. The television media picked up the case along with the family's disputes. This resulted in endless news reports and finally culminated in appearances by Michael Schiavo on the television show "Larry King Live," and by Terri's sister on the "Oprah" television show.

Over the years Terri's feeding tube was repeatedly removed and reinserted, depending upon current court orders. During one period of removal, the Florida governor’s office received upwards of 165,000 e-mails through a petition drive requesting that the governor intervene. Calls also came from disabled rights activist Joni Tada, from actor Mel Gibson, from Focus on the Family founder Dr. James Dobson, and from the Vatican.

The result was "Terri's Law," passed in October 2003, which allowed Gov. Jeb Bush and the Florida Attorney General to step in.

The ACLU enjoined these efforts, and the Florida Supreme Court eventually struck down the law. In the Spring of 2005, state and federal congressional hearings were held and various bills proposed and passed.

During the month of March of 2005 the 11th Circuit Court of Appeals, the Florida State Supreme Court, and the United States Supreme Court either denied appeals or refused to further intervene. Eventually Terri's husband prevailed and her feeding tube was removed. On March 31, 2005, she died with Michael at her bedside.

After Terri's death, a much anticipated autopsy was performed. The results: profoundly severe "atrophy" (withering away) of the brain, reduced to half its normal size; cortical (brain damage induced) blindness; and, findings consistent with a diagnosis of "persistent vegetative state." It was concluded that no amount of therapy could correct the damage. Finally, it was also noted that there was no evidence of strangulation or other neck injury.
Even so, the Schindlers issued a statement regarding the autopsy, noting that it had also confirmed that "Terri was not terminal, that Terri had no living will, that Terri had a strong heart, and that Terri was brutally dehydrated to death." An attorney (who was not also a physician) specializing in "medical ethics cases" also pointed out her belief that, "The frontal temporal and temporal poles and insular-cortex demonstrated relative preservation," and concluding by saying, "What this tells us is that her cortex retained function and that her brain was more normal in the area that controls higher-level thinking" -- in short, underscoring the parents' belief that Terri had retained the capacity for substantial cognitive awareness.

Clearly the court rulings and the autopsy did not end the controversy.

After all was said and done, perhaps the most enduring final words came from Michael Schiavo himself. On Terri’s grave stone he had the following words engraved, "I kept my promise."

**Key Learning:** There is much to learn from this case. Failing to make your wishes openly known, particularly in writing, can pull your family apart and can cost you and your loved ones’ untold burdens in suffering, financial expense, public airing of private lives, and emotional burdens beyond measure.

It remains possible that both parties to the litigation were "right" in that they believed in what they were doing.

Money, remarriage, emotional attachment, divergent religious views, and disagreements over recollections of statements can lead to very different perspectives. When this occurs, great sorrow and even outright injustice can be carried out by otherwise well-meaning participants.

Regardless of who was right, three indisputable facts remain: 1) Terri lived for a decade and a half in a profoundly debilitated state; 2) Terri died after the removal of a medical treatment (feedings by tube) that could have been continued (if she had wished this); and, 3) of the $750,000.00 awarded for Terri's care, $456,816.00 was eventually expended on legal fees. Even that was not the total cost involved, as many organizations, legal foundations, and private donors contributed many thousands more.

Only by properly documenting your desires can such profound burdens and contentions be avoided.
 Lesson 3 Objectives

Upon completion of this section, you will:

- Learn the basics facts about advanced medical directives.
- Be better versed on the importance of an advance directive.
- Become aware of the history of advance directives.
- Gain knowledge of the types of health care documents.
- Learn about what is an advance directive for health care.
- Be able to express treatment preferences for a terminal condition or state of permanent unconsciousness in an ADHC.
- Be able to determine options for treatment preferences for a terminal condition or state of permanent unconsciousness.
- Be able to tell the difference between an ADHC and a living will.

3 The Basics

If you're like most people, you and your clients aren't eager to spend time thinking about what would happen if you or they became unable to direct your own medical care because of illness, an accident, or advanced age. However, if you don't do at least a little bit of planning - writing down your wishes about the kinds of treatment you do or don't want to receive and naming someone you trust to oversee your care - these important matters could wind up in the hands of estranged family members, doctors, or sometimes even judges, who may know very little about what you would prefer.

Advance Medical Directive Facts

Advance directives are designed to outline a person's wishes and preferences in regard to medical treatments and interventions. When a patient is incapable of making his/her own medical decisions, a health-care proxy can act on the patient's behalf to make decisions consistent with and based on the patient's stated will. Advance directive policies may differ from one state to another. Drafting a proper advance directive form may require assistance from your personal physician and an attorney. Advance directives are important documents that should be included with each individual's personal medical records.
Introduction to Advance Medical Directives

Advance Directives

The term "advance directives" refers to treatment preferences and the designation of a surrogate decision-maker in the event that a person should become unable to make medical decisions on her or his own behalf.

Advance directives generally fall into three categories: living will, power of attorney, and health-care proxy.

Living will: This is a written document that specifies what types of medical treatment are desired should the individual become incapacitated. A living will can be general or very specific.

The most common statement in a living will is to the effect that:

- if I suffer an incurable, irreversible illness, disease, or condition and my attending physician determines that my condition is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or discontinued.

More specific living wills may include information regarding an individual's desire for such services such as:

- Analgesia (pain relief),
- Antibiotics,
- Artificial (intravenous or IV) hydration,
- Artificial feeding (feeding tube),
- CPR (cardiopulmonary resuscitation),
- Life-support equipment including ventilators (breathing machines),
- Do not resuscitate (DNR).

Health-care Proxy

This is a legal document in which an individual designates another person to make health-care decisions if he or she is rendered incapable of making their wishes known. The health-care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.

Durable Power of Attorney (DPOA)

Through this type of advance directive, an individual executes legal documents that provide the power of attorney to others in the case of an incapacitating medical condition. The durable power of attorney allows an individual to make bank transactions, sign social security checks,
apply for disability, or simply write checks to pay the utility bill while an individual is medically incapacitated.

DPOA can also specifically designate different individuals to act on a person's behalf for specific affairs. For example, one person can be designated the DPOA of health-care or medical power of attorney, similar to the health-care proxy, while another individual can be made the legal DPOA

**Importance of an Advance Directive**

Advance directives were developed as a result of widespread concerns over patients undergoing unwanted medical treatments and procedures in effort to preserve life at any cost. As outlined in the following section (history of advance directives), remarkable efforts were made to institute advance medical directives as a component of medical care in the United States over the last few decades.

From a practical standpoint, medical directives and living wills facilitate a person's medical care and decision making in situations when they are temporarily or permanently unable make decisions or verbalize their decisions. By having previously documented personal wishes and preferences, the family's and physicians' immense decision-making burden is lightened. At the same time, patient autonomy and dignity are preserved by tailoring medical care based on one's own choices regardless of mental or physical capacity.

*Instructive directives (advance directives, living wills, and health-care proxy designation) are completed by a person with decision-making capacity. They only become effective when a person loses his/her decision-making capacity (mentally incapacitated). While a person maintains ability to make decisions, he/she is the ultimate decision-maker rather than the health-care proxy or surrogate decision-maker.*

**History of Advance Directives**

*According to Medicine.Net, advance directives began to be developed in the United States in the late 1960s.*

**The First Living Wills**

In 1967, an attorney named Luis Kutner suggested the first living will. Kutner's goal was to facilitate "the rights of dying people to control decisions about their own medical care."

In 1968, the first living will legislation was presented to a state legislature. Walter F. Sackett, a doctor elected to the Florida legislature, introduced a bill that would allow patients to make decisions regarding the future use of life-sustaining equipment. The bill failed to pass in 1968. Sackett reintroduced the bill in 1973 and it was again defeated.
While Dr. Sackett was introducing living will legislation in Florida, Barry Keene was presenting similar bills in the California legislature. Keene’s interest in living wills was based on personal experience. In 1972, Keene’s mother-in-law was unable to limit medical treatment for a terminal illness even after having signed a power of attorney. Keene was elected to the California State senate in 1974. The living will legislation he designed was defeated that same year. Keene reintroduced the bill in 1976 and in September of that year California became the first state in the nation to legally sanction living wills.

**The States**

Within a year, 43 states had considered living will legislation and seven states had passed bills. Advance directive legislation has subsequently progressed on a state-by-state basis. By 1992, all 50 states, as well as the District of Columbia, had passed legislation to legalize some form of advance directive.

The first court decision to validate advance directives was at the state level. The decision was handed down by the New Jersey Supreme Court in 1976. In Case 70 N.J. 10, 355 A 2nd 647, Chief Justice Robert Hughes upheld the following judicial principles:

- If patients are mentally unable to make treatment decisions, someone else may exercise their right for them.
- Decisions that can lead to the death of a mentally incompetent patient are better made not by courts but by families, with the input of their doctors.
- Decisions about end-of-life care should take into consideration both the invasiveness of the treatment involved and the patient’s likelihood of recovery.
- Patients have the right to refuse treatment even if this refusal might lead to death.

The case in which Judge Hughes ruled was the request by Joe Quinlan to make legally binding health-care decisions for his daughter, Karen Ann Quinlan. As a result of the case, Karen Ann Quinlan was gradually weaned from mechanical ventilation.

The federal government: The U.S. federal government has evidenced its interest in advance directives through two of its bodies, the Congress and the Supreme Court.

The U.S. House of Representatives in 1991 enacted the Patient Self-Determination Act. The Act stipulates that all hospitals receiving Medicaid or Medicare reimbursement must ascertain whether patients have or wish to have advance directives. The Patient Self-Determination Act does not create or legalize advance directives; rather it validates their existence in each of the states.

It was not until 1990 that the United States Supreme Court agreed to hear a case on the legality of advance directives. The Supreme Court had been reticent to hear cases on advance directives, reflecting to some degree the belief that advance directives are determined at the
state rather than federal level. In 1990, the Court heard Cruzan vs. Director. The case, similar to that of Karen Ann Quinlan, involved the desire to discontinue the percutaneous gastrostomy feedings of Nancy Cruzan. The United States Supreme Court decided in favor of the individual right to refuse treatment, even life-sustaining treatment. The Supreme Court refused to hand down a specific decision on medical treatment in the case. Following the opinion of the Supreme Court, the case was referred back to the Missouri Supreme Court. The Missouri Supreme Court heard testimony of a verbal advance directive that was deemed to be sufficient evidence to support the refusal of medical treatment.

The landmark Quinlan and Cruzan cases emerged out of similar situations and similar needs. Both cases dealt with the medical care of young, physically strong people in a persistent vegetative state. While similar in these regards, the two judicial decisions dealt with different types of advance directives. The case of Karen Ann Quinlan dealt with the ability of the individual to appoint a health-care proxy. The case of Nancy Cruzan addressed the right of a healthy individual to establish a binding living will.

**The Current Situation**

In the United States, four out of every five adults have no advance directive, a situation that some have likened to taking your car to the mechanic and saying, "I think it needs a tune-up, but if you find something really wrong with it, just go ahead and fix it, even if it won't run afterward? And by the way, please charge me for the work and if I can't pay for it, I'm sure my estate will!"

When asked what would provide a good death, the majority of Americans answer, in essence; "Quick, painless, at home, and surrounded by family."

In 1950, about half of Americans who died did so at home. Now, about 85% of Americans die in a health-care setting: a hospital, a nursing home, or a rehabilitation center. At least 12% die in an intensive-care unit.

Over the past three decades, the United States - all 50 states and the District of Columbia -- have passed laws to legalize the use of living wills, health-care proxies, and/or the durable power of attorney. The U.S. federal government has validated state laws on advance directives through the 1991 Patient Self- Determination Act. And the U.S. Supreme Court has handed down an opinion acknowledging the congruence of the Constitution of the United States with state laws on the right to designate future medical treatment.

**Types of Health Care Documents**

There are two basic documents that allow you to set out your wishes for medical care: a living will and a durable power of attorney for health care. It's wise to prepare both. In some states, the living will and the power of attorney are combined into a single form -- often called an advance directive. (In fact, both of these documents are types of health care directives -- that is,
documents that let you specify your wishes for health care in the event that you become unable to speak for yourself.)

Living Wills

First, you need a written statement that details the type of care you want (or don't want) if you become incapacitated. This document is most often called a living will, though it may go by a different name in your state. A living will bears no relation to the conventional will or living trust used to leave property at death; it's strictly a place to spell out your health care preferences.

You can use your living will to say as much or as little as you wish about the kind of health care you want to receive.

Powers of Attorney for Health Care

You'll also want what's usually called a durable power of attorney for health care. In this document, you appoint someone you trust to be your health care agent (sometimes called an attorney-in-fact for health care, health care proxy, or surrogate) to make any necessary health care decisions for you and to see that doctors and other health care providers give you the type of care you wish to receive.

According to the Fiduciary Law Section of the State Bar of your state, you have the right to control all aspects of your personal care and medical treatment, including the right to insist upon medical treatment or direct that medical treatment be withheld or withdrawn. If you cannot (or do not want to) communicate your health care decisions for yourself, you have the right to choose someone to make health care decisions for you. You also have the right to state your treatment preferences if you have a terminal condition or are in a state of permanent unconsciousness.

The Advance Directive for Health Care Act gives you an opportunity to choose someone to make health care decisions on your behalf and to make a clear expression of your decisions regarding health care if you are in a terminal condition or state of permanent unconsciousness by executing an advance directive for health care.

What is an advance directive for health care?

An advance directive for health care (ADHC) is a legal document in which you:

1. appoint your health care agent, and/or

2. direct the withholding or withdrawal of life-sustaining procedures and/or the provision of nourishment or hydration if you are in a terminal condition or a state of permanent unconsciousness. (Since 2007, the ADHC has replaced the
legal documents called durable power of attorney for health care and living will in your state.)

Is any particular form of ADHC required?

You may use any form of ADHC that complies with your state law. However, the law provides a standard form of ADHC that will be treated as complying with state law if it is properly executed. An attorney can provide you a form of ADHC and help you understand it, complete it and properly execute it. An ADHC must be in writing, signed by you, and attested and signed by two adult witnesses. You may revoke or amend your ADHC at any time.

Who may execute an ADHC?

Any adult who is of sound mind may execute an ADHC.

What is a health care agent?

A health care agent is a person appointed by you in an ADHC to act on your behalf to make decisions related to the consent to, refusal of or withdrawal of any type of health care. A health care agent may also be given the authority to make decisions related to autopsy, anatomical gifts and the final disposition of your body after your death. A physician or health care provider who is directly involved in your care may not be your health care agent.

What is meant by health care?

Health care means any care, treatment, service or procedure to maintain, diagnose, treat or provide for your physical or mental health or personal care.

What powers does my health care agent have?

Your health care agent will make health care decisions for you only when you are unable to communicate your health care decisions or you choose to have your health care agent communicate your health care decisions. Your health care agent will have the same authority to make any health care decision that you could make. The health care agent's authority includes the power to admit you to or discharge you from any hospital, skilled nursing facility, hospice or other health care facility or service; the power to request, consent to, withhold or withdraw any kind of health care; and the power to contract for any health care facility or service for you and to obligate you to make arrangements for these services. Your health care agent may accompany you in an ambulance and may visit or consult with you in person while you are in a hospital, skilled nursing facility, hospice or other health care facility. If you choose, your health care agent will also have the power to authorize an autopsy of your body after your death,
make a disposition of all or any part of your body for medical purposes and make decisions about the final disposition of your body.

**Does my health care agent have access to medical records?**

Your health care agent will be your personal representative for all purposes of federal or state laws relating to privacy of medical records and will have the same access to your medical records that you have and can disclose the contents of your medical records to others for your ongoing health care.

**How does my health care agent make decisions?**

When making health care decisions for you, your health care agent should think about what action would be consistent with past conversations the two of you have had, your treatment preferences as expressed in your ADHC, your religious and other beliefs and values and how you have handled medical and other important issues in the past. If what you would decide is still unclear, then your health care agent should make decisions for you that your agent believes are in your best interest, considering the benefits, burdens and risks of your current circumstances and treatment options.

**Am I required to appoint a health care agent in my ADHC?**

You are not required to appoint a health care agent in an ADHC. If you wish, you may use an ADHC only to express your treatment preferences if you have a terminal condition or are in a state of permanent unconsciousness.

**How do I express my treatment preferences for a terminal condition or state of permanent unconsciousness in my ADHC?**

In an ADHC you may express your treatment preferences for either or both of two conditions: if you are in a terminal condition or if you are in a state of permanent unconsciousness. Your condition will be determined in writing by your attending physician and a second physician in accordance with currently accepted medical standards. Your treatment preferences in your ADHC will be followed only if you can no longer communicate your treatment preferences after appropriate efforts have been made to communicate with you about your treatment preferences. Treatment preferences are your decisions as to the withholding or withdrawal of life-sustaining procedures and/or the provision of nourishment and hydration (nutrition and fluids).

**What is a terminal condition?**

A terminal condition is an incurable or irreversible condition which would result in your death in a relatively short period of time.
What is a state of permanent unconsciousness?

A state of permanent unconsciousness is an incurable or irreversible condition in which you are not aware of yourself or your environment and in which you show no behavioral response to your environment.

What are life-sustaining procedures?

Life-sustaining procedures are medications, machines or other medical procedures which, when applied to you in a terminal condition or state of permanent unconsciousness, could in reasonable medical judgment keep you alive but cannot cure you and where, in the judgment of the attending physician and a second physician, your death will occur without such procedures or interventions. Life-sustaining procedures do not include administration of medication to alleviate pain or the performance of any medical procedures deemed necessary to alleviate pain. Life-sustaining procedures also do not include the provision of nourishment or hydration (nutrition and fluids), but you may direct the withholding or withdrawal of nourishment or hydration in an ADHC.

What are my options for treatment preferences for a terminal condition or state of permanent unconsciousness?

The form of ADHC provided by the law allows you to express any one of three preferences for treatment if you are in a terminal condition or state of permanent unconsciousness: (1) Try to extend your life as much as possible, using all life-sustaining procedures, and if you are unable to receive nourishment or hydration (nutrition and fluids) by mouth, then you want to receive artificial nourishment or hydration (by tube or other medical means); (2) Allow your natural death to occur; you do not want any life-sustaining procedures or artificial nourishment or hydration; (3) You do not want any life-sustaining procedures except as you specifically indicate in the form, and you can choose to receive artificial nourishment and/or hydration, a ventilator and/or CPR. No matter which of the three options you choose, you may also provide additional treatment preferences on the form.

Can my health care agent make decisions regarding my treatment in a terminal condition or state of permanent unconsciousness?

Unless you provide otherwise in your ADHC, the treatment preferences expressed in your ADHC are ineffective so long as you have a health care agent who is available and willing to make decisions on your behalf regarding the withholding or withdrawal of life-sustaining procedures and/or the provision of nourishment or hydration. However, your health care agent is required to take any treatment preferences expressed in your ADHC into account when making decisions about your health care.
Am I required to express my treatment preferences for a terminal condition or state of permanent unconsciousness in my ADHC?

You are not required to express treatment preferences for a terminal condition or state of permanent unconsciousness in an ADHC. If you wish, you may use an ADHC only to appoint a health care agent.

Is my health care provider required to honor my ADHC?

If your health care provider receives your ADHC, your health care provider has the responsibility to enter the ADHC in your medical records, to grant your health care agent adequate access to you, to consult with your health care agent, to comply with the decisions of your health care agent and to give your health care agent the same right to examine and copy your medical records that you would have. A health care provider who fails or refuses to comply with your treatment preferences regarding the withholding or withdrawal of life-sustaining procedures and/or the provision of nourishment or hydration must advise your health care agent (if you have one) or your next of kin or guardian and, if directed to do so, must allow you to be transferred to another physician who will comply with your treatment preferences.

What effect does my marriage or divorce have on my ADHC?

Unless you provide otherwise in your ADHC, if you get married after executing an ADHC, the marriage revokes the designation of anyone other than your spouse as your health care agent. And unless you provide otherwise in your ADHC, if you get divorced after executing an ADHC, the divorce revokes the designation of your former spouse as your health care agent.

What is the difference between an ADHC and a durable power of attorney for health care?

State’s law used to provide for the appointment of a health care agent in a document called a durable power of attorney for health care. In the last several years the ADHC has replaced the durable power of attorney for health care in many states. Your durable power of attorney for health care executed under the old law remains effective, but it would be a good idea for you to replace it with an ADHC.

What is the difference between an ADHC and a living will?

State laws used to provide for the declaration of treatment preferences for a terminal condition and state of permanent unconsciousness in a document called a living will. The ADHC has replaced the living will in many states. Your living will executed under the old law remains effective, but it would be a good idea for you to replace it with an ADHC.
What is a guardian?

A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. In an ADHC, you may nominate a person to serve as your guardian in the event a court decides that a guardian should be appointed. You may (but are not required to) nominate your health care agent to be your guardian. A guardian does not have the power to manage your property or financial affairs.

*This is not intended to be a comprehensive statement of law. Its purpose is to inform, not to advise on any specific legal problem. If you have specific questions regarding any matter contained in this pamphlet, you are encouraged to consult an attorney.*
Lesson 4 Objectives

Upon completion of this section, you will:

- Gain better understanding of powers of attorney and advance directives.
- Know about the rules a client’s agent should follow when acting on their behalf.
- Be able to answer the most common questions asked about powers of attorney and advanced directives.

4 Powers of Attorney and Advance Directives

According to an article by Hurley Elder Care Law which provides solutions for families and individuals as they address the complex process of growing older, in general, a power of attorney is a legal document that authorizes a person to act on your behalf as your “agent” or “attorney-in-fact.” These actions given to your agent or attorney-in-fact can be over your financial affairs and/or over health care matters.

You have the ability to give the agent a very broad sweeping or general power or you can limit the powers granted to the agent. The powers granted to the agent will end upon your death. A power of attorney is an instrument that everyone should have in place because unexpected events can suddenly change your circumstances drastically. Life rarely gives us fair warning. With powers of attorney in place, your agent/attorney-in-fact can immediately handle your transactions or make decisions on your behalf.

Financial Power of Attorney

What is a financial power of attorney?

A financial power of attorney is the grant of legal rights, powers and authority by a person known as the “principal” to another person who is known as the “agent” or “attorney-in-fact.” The agent or attorney-in-fact in effect stands in the shoes of the principal and acts for him or her on financial and business matters. The attorney-in-fact can do whatever the principal may do—withdraw funds from bank accounts, trade stock, pay bills, cash checks—except as limited in the power of attorney. This does not mean that the attorney-in-fact can just take the principal’s money and run. The attorney-in-fact must use the principal’s finances as the principal would for his or her benefit, and it does not remove the principal’s authority to
continue to act on his or her own behalf. The agent/attorney-in-fact only has the authority to act at the same time in accordance with the powers granted in the power of attorney. It is very important that the financial power of attorney be “durable.” Durable means that it is a continuing power that survives the principal’s future legal incapacity. So, in the future, if you are no longer able to handle your own affairs then your agent/attorney-in-fact can step-in and handle them for you.

What are the typical powers granted under a Durable Power of Attorney?

Truthfully, there are no standard powers granted to an agent/attorney-in-fact but there are some common powers needed to adequately represent a person with their financial matters. An agent/attorney-in-fact needs to have the authority to deal with banking and other financial institution matters, which include checking accounts, savings accounts, money market accounts and certificate of deposit accounts. Also, the ability to sale the home place or other real estate may be needed so the agent/attorney-in-fact needs to have the authority to handle any real property transactions. Also, authority needs to be granted to deal with personal property (cars, boats, and household furnishings), retirement plan transactions (IRA’s), life insurance products (life insurance policies and annuities), stocks and bond transactions, and tax matters (income and gift taxes).

We recommend that a power of attorney also grant the agent/attorney-in-fact the authority to make gifts in any amount, not limited to the annual gift tax exclusion of $13,000.00 per person, in case the assets needed to be shifted in a greater amount to qualify for public benefits. The power also needs to include the ability for the agent/attorney-in-fact to create and administer trusts if again needed to qualify for public benefits. And finally, the power of attorney needs to grant the ability to apply for and receive public benefits on behalf of the principal.

What Rules should my agent follow when acting on my behalf?

The agent or attorney-in-fact must adhere to the fiduciary standards in our state. The agent or attorney-in-fact has a duty of loyalty to the person for whom he or she is acting for (principal). The duty of loyalty requires that the agent or attorney-in-fact acts solely in the best interest of the principal, free of any self-dealing, conflicts of interest, or other abuse of the principal for a personal advantage. In other words, this person must have your best interest in mind and cannot intentionally receive a personal gain at your detriment.

What if there is more than one attorney-in-fact?

Depending on the wording of the power of attorney, the co-agents may or may not have to act together on all transactions. In most cases, when there are multiple agents/attorneys-in-fact, the power of attorney document specifies that they can each act independently of one another. Nevertheless, it is important for them to communicate with one another to make certain that their actions are consistent.
When does the power of attorney take effect?

Unless the power of attorney is “springing,” it takes effect as soon as it is signed by the principal. A “springing” power of attorney takes effect only when the event described in the instrument itself takes place. Typically, this is the incapacity of the principal as certified by one or more physicians.

Does the power of attorney take away a principal’s rights?

No, absolutely not. Only a court can take away a principal’s rights in a conservatorship or guardianship proceeding. An agent/attorney-in-fact simply has the power to act along with the principal.

Can the principal change his or her mind?

Certainly. A principal may revoke a power of attorney at any time. All a principal needs to do is send a letter to his or her agent/attorney-in-fact telling them that their appointment has been revoked. From the moment the agent/attorney-in-fact receives the letter, he or she can no longer act under the power of attorney.

Can an attorney-in-fact be held liable for his or her actions?

Yes, but only if he or she acts with willful misconduct or gross negligence.

Can an attorney-in-fact be compensated for his or her work?

Yes, if the principal has agreed to pay the attorney-in-fact. In general, the agent/attorney-in-fact is entitled to “reasonable” compensation for his or her services. However, in most cases, the agent/attorney-in-fact is a family member and does not expect to be paid. If an agent/attorney-in-fact would like to be paid, it is best that he or she discuss this with the principal, agree on a reasonable rate of payment, and put that agreement in writing. That is the only way to avoid misunderstandings in the future.

Can the attorney-in-fact be fired?

Certainly. The principal may revoke the power of attorney at any time. All he or she needs to do is send the agent/attorney-in-fact a letter to this effect. The appointment of a conservator or guardian does not immediately revoke the power of attorney. But the conservator or guardian, like the principal, has the power to revoke the power of attorney.

What kind of records should the attorney-in-fact keep?

It is very important that the agent/attorney-in-fact keep good records of his or her actions.
under the power of attorney. That is the best way to be able to answer any questions anyone may raise. The most important rule to keep in mind is not to commingle the funds the attorney-in-fact is managing with his or her own money. Keep the accounts separate. The easiest way to keep records is to run all funds through a checking account. The checks will act as receipts and the checkbook register as a running account.

**Advance Directive for Healthcare/Healthcare Power of Attorney:**

**In General**

Many people have or previously had a Living Will and a Durable Power of Attorney for Healthcare.

The Living Will is a legal document allowing an individual to choose whether or not he or she wants to die naturally, without death being artificially prolonged by various medical procedures. The Living Will is an authorization to your medical professionals to withhold or withdraw certain medical procedures, such as a ventilator, respirator, feeding tube, hydration solutions, and pain medication.

The Durable Power of Attorney for Healthcare is a legal document appointing and naming another person to make health related decisions on one’s behalf and it gives this person called the agent, some idea of what we may or may not want regarding potential medical procedures that may need to be administered in the future.

In many states, the new Advance Directive for Healthcare replaced the laws on the Living Will and the Durable Power of Attorney for Healthcare. The newest document is called the Advance Directive for Healthcare. The intent of this instrument is cover the same territory as the Living Will and Durable Power of Attorney for Healthcare but also is to avoid the confusion created by the overlap and contradiction of the former documents.

The Advance Directive for Health Care in many states now provides that individuals have the right to control all aspects of their medical care – including the right to insist on medical treatment, request it to be withdrawn or to refuse treatment. The new legal document allows individuals to appoint an agent to make medical treatment decision on their behalf, if direct communication is not possible, and it authorizes an individual’s medical professionals to withhold or withdraw certain treatments or procedures. In addition, the document contains specific privacy-related release language as required by HIPAA (Health Insurance Portability and Accountability Act).

**Is the Advance Directive for Healthcare the same as a Durable Power of Attorney for Healthcare or my Living Will?**

As stated, the Advance Directive for Healthcare combines these two documents into a single
legal document and makes it easier for individual’s wishes to be known. Durable Powers of Attorney and Living Wills made previously are still valid and you may continue to use them effectively. However, if possible, the new document should be executed because additional considerations can be addressed that were not covered in your current documents.

**What type of medical procedures and treatments are you talking about?**

Treatments and procedures that may extend life for otherwise terminal patients such as a ventilator, CPR, artificial nutrition (feeding tubes), hydration (IV fluids) and kidney dialysis.

**Why do I need to complete an Advance Directive for Healthcare?**

This legal document allows individuals to express their wishes about their own end of life care even when they can’t communicate. It lets the family and the medical professionals know what they want and what they do not want to happen when they are near the end of their lives. If this document is not in place, individuals who cannot make their own decision have to abide by the priority designations under the state’s “next-of-kin” law. The law states that the following persons can make medical decisions for patients who do not have capacity to decide for themselves, in the following order of priority: (a) an adult child for a parent; (b) a parent for an adult child; (c) an adult for a brother or sister; (d) a grandparent for a grandchild; (e) an adult grandchild for a grandparent; (f) an adult niece, nephew, aunt, or uncle in the first degree; or (g) an adult friend. **Also, under this law, an Advance Directive for Healthcare has complete priority over any of the afore-stated relationships so this is why it is needed.**

**What is a “Do Not Resuscitate” (DNR) order?**

A DNR order is a written order from a physician that informs medical personnel that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. There are DNR orders in the hospital and then there are DNR orders written for out in the community. Community can mean a home, assisted living facility, personal care home and skilled nursing home. Just because a person has a DNR order in the hospital does not mean it will transfer out of the hospital. If a person wants a DNR order once leaving the hospital another one needs to be filled out for use in the community.

**When does a physician write a DNR order?**

A physician can write a DNR for a patient after a verbal conversation with a competent adult patient or the person’s healthcare agent. Both the agent and the doctor should try to abide by the person’s wishes, which are listed in the Advance Directive for Healthcare. In some instances, a physician will write a DNR order when resuscitation will not alter the outcome of the disease or if resuscitation will cause unnecessary suffering. Two physicians signatures are required for a DNR to be followed at the necessary time to act on it. In other words, an attending physician with the concurrence (agreement) of another physician must determine
that the person is a “candidate for nonresuscitation” before the DNR order can be written by an attending physician.

**How will medical personal know that a DNR order is in place?**

In a hospital or out in the community, there will be a large notice on the front of the chart. In the community, identification necklaces and bracelets are available and can be worn to make sure all medical personnel recognize and adhere to patient’s wishes.

**Does a DNR order stop medical personal from treating a patient completely?**

No, a DNR only refers to resuscitation (CPR) efforts and does not interfere with other treatments. For example, transfusions, kidney dialysis, use of a ventilator and antibiotic therapy. Treatment that keeps a person free of pain and comfortable should always be given.

**Can a DNR order be revoked?**

Yes, DNR orders should be reviewed periodically by the doctor and revoked if appropriate. A person can revoke his DNR at any time.

**What is a “code”?**

A code is a word that hospital and nursing homes use to mean resuscitation efforts should be initiated.

**What is a “no code”?**

A “no code” is an informal name for a DNR.

**Is there a form of the Advance Directive for Healthcare?**

Yes. The Advance Directive for Health Care form (see Chapter 7) contains four (4) parts. The first part provides for an individual to appoint a healthcare agent to make healthcare decisions on his or her behalf upon incapacity. Typically, a spouse and/or child, or children, are named as the healthcare agent(s). Other scenarios include a trusted friend who is named and will have your best interest in mind. Further, the first part of the form can give the healthcare agent the ability to make decisions after one’s death with respect to an autopsy, organ donation, body donation for medical study, and final disposition of the body. In making these decisions, the agent should consider conversations with the patient, which includes medical treatment preferences, and religious, cultural and other beliefs of the patient. Next, the second part of the form lays out specific scenarios relating to medical conditions such as a terminal illness with imminent death, and a state of permanent unconsciousness. For each medical condition, the
specific medical treatment preferences may be selected by the individual; thus, making his or her wishes known to the health care agent and physician who may provide the treatment. Further, the third part of the form allows an individual to nominate a guardian in the event a court decides that one should be needed. It is always preferable to have an advance directive in place that indicates who you want to make significant responsible decisions for you regarding your personal support, safety, or welfare. And finally, the fourth part of the form provides the signature and witness requirements necessary to evidence that the decisions made in the advance directive are clear, effective and genuinely one’s own.
Lesson 5 Objectives

Upon completion of this section, you will:

- Be more aware and more capable of knowing about things you should do.
- Be more aware and more capable of knowing about things you should know.

5 What to Know and Do

Things You Should Do

In order to have a legal document that expresses your wishes for the health care you want to receive at the end of your life, you should complete an Advance Directive for Health Care. In completing the Advance Directive for Health Care, you will do two things:

- Legally appoint someone as your Health Care Agent to make health care decisions for you when you cannot or do not want to speak for yourself, and
- Formally state your preferences for the medical treatments you do or do not want to receive.

Things You Should Know

- You do not need to hire a lawyer to complete an Advance Directive for Health Care. The document includes instructions on how to complete the form. However, you are encouraged to consult your lawyer, doctor, or other professionals to help you make informed decisions.
- As a competent adult, you have the right to refuse any unwanted treatments or procedures for any reason, even treatments that could keep you alive (unless you are pregnant with a viable fetus).
- The Advance Directive for Health Care covers only health care decisions. It has no effect over financial affairs that are unrelated to your health care.
- You or your Health Care Agent are responsible for notifying your doctor and other health care providers that you have an Advance Directive for Health Care.
If you choose not to complete an Advance Directive for Health Care, there may be restrictions on the health care decisions that relatives or friends can make for you.

If a doctor or other health care provider has direct knowledge of your preferences as documented in your Advance Directive for Health Care or expressed by your Health Care Agent, he is required to abide by your preferences as long as your preferences are legal.

If the doctor or health care provider is unwilling to honor your preferences, he must assist in transferring your care to another provider.

State’s law protects a doctor or health care provider who, in good faith, follows your preferences as documented in the Advance Directive for Health Care or directed by your Health Care Agent.

It is against many state’s law for any person willfully to hide, cancel or alter another person’s health care directive, its amendments or cancellation.

Another person can complete an Advance Directive for Health Care for you but only with your expressed consent and in your presence. Once you have been determined to be incapable of making your own decisions, you cannot complete an Advance Directive for Health Care, nor can someone else complete one for you.

A hospital, nursing facility, home health company, or hospice program cannot refuse to admit you because you do not have an Advance Directive for Health Care.

Completing an Advance Directive for Health Care will have no effect on your ability to buy, pay premiums on, or collect on any type of insurance, including health, life, and disability insurance. You cannot be required to have an Advance Directive for Health Care in order to obtain health insurance.

The laws on honoring health care directives differ from state to state. Because the Advance Directive for Health Care you complete in your state expresses your preferences about medical care, it will influence that care no matter where you are treated. However, there is a possibility that your Advance Directive for Health Care may not be honored in another state. If you spend a great deal of time in another state, you may want to complete a document that meets all the requirements of that state.

If you have an emergency and your Advance Directive for Health Care is not readily available, life sustaining treatments may be started. Treatment can be stopped if it is discovered that it is not what you want.

The Advance Directive for Health Care is not connected to any government health care program, such as Medicare or Medicaid. Any competent adult may complete a Advance Directive for Health Care regardless of how they pay for their health care.

The Advance Directive for Health Care allows you to appoint a Health Care Agent – this is a person who will have the legal power to make decisions regarding your health care – but ONLY when you are incapable of making those decisions yourself or choose not to make your own decisions.
You may be *incapable* of making your own decisions because you are unconscious, mentally ill, in a coma, in the advanced stages of Alzheimer’s Disease or are otherwise unable to make your own decisions. *You do not have to be terminally ill or near death for your Health Care Agent to be able to make decisions for you, but you must be incapable of making your own decisions or choose not to make your own decisions.*

State laws protects your Health Care Agent as long as he or she acts in “good faith” and in accordance with your instructions.

Your Health Care Agent cannot be held responsible for the cost of your medical care. However, if you have named your spouse as your Health Care Agent, your spouse may be responsible for the cost of your medical care because he or she is your spouse.

A change in your marital status may revoke the appointment of your Health Care Agent.

The Advance Directive for Health Care also will give you the option to nominate someone to serve as your *guardian*. A court may appoint a guardian if it determines that you are not able to make significant responsible decisions for yourself.

You may nominate the same person you designated as your Health Care Agent to serve as your guardian. However, if you chose to nominate someone else to be your guardian, you should be aware that the person named as your Health Care Agent would have priority over your guardian in making your health care decisions, unless a court determines otherwise.

The person you name as your Health Care Agent will have broad powers to make health care decisions for you, including the power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition.

Your Health Care Agent can agree to admit or discharge you from any hospital, nursing home, or other institution.

State law, where applicable, does not allow your Health Care Agent to put you in a mental hospital against your will or to make decisions about sterilization or psychosurgery.

The law does not require the person you name as your Health Care Agent to act for you. You must ask that person if he or she is willing to accept this responsibility.

Your Health Care Agent must use due care to act for your benefit and in accordance with your Advance Directive for Health Care.

A court can take away the powers of your Health Care Agent if it finds that your Agent is not acting according to your preferences or that your Agent is not competent to make decisions.

You may appoint a Health Care Agent as well as one or more back-up Agents, in case your primary Agent is not available when decisions need to be made.
You can choose anyone who is over 18 years of age or older to be your Health Care Agent. The only restriction is that you cannot appoint your doctor or any other person who directly provides health care to you.

Unless you expressly limit the duration of or revoke your Advance Directive for Health Care, or a court acting in your behalf terminates it, your Health Care Agent may exercise the powers you have given him or her throughout your lifetime, even after you become disabled, incapacitated, or incompetent.

If you change your mind, your Advance Directive for Health Care can be easily amended or canceled.

Note: This information is a general summary of the rights of competent adults. It does not contain all the technical details of the law. Also, it does not deal with decisions for minors or for those who are now mentally incapable, nor does it apply to treatment outside of your state. It is not the intent of this document to provide specific legal or medical advice.

Individuals are encouraged to consult professionals such as physicians, clergy and lawyers to help them make informed decisions.
Lesson 6 Objectives

Upon completion of this section, you will:

- Learn more about the actual Advance Directive for Health Care.
- Learn more about the definitions about Advance Directive for Health Care.
- Be able to tell the difference between the advance directive form and the living will and durable power of attorney for health care.
- Gain insight into the three parts of the advance directive for health care.
- Learn about the requirements for the person making an advance directive for health care.
- Find out how to revoke an advance directive for health care.

6 Advance Directive for Health Care

Purpose:

In recognizing the right of individuals to (1) control all aspects of his or her personal care and medical treatment, (2) insist upon medical treatment, (3) decline medical treatment, or (4) direct that medical treatment be withdrawn, the General Assembly in most states has in the past, provided statutory forms for both the living will and durable power of attorney for health care. To help reduce confusion, inconsistency, out-of-date terminology, and confusing and inconsistent requirements for execution, and to follow the trend set by other states to combine the concepts of the living will and health care agency into a single legal document, the efforts of a significant number of individuals representing the academic, medical, legislative, and legal communities, state officials, ethics scholars, and advocacy groups produced the development of a consolidated advance directive for health care. This newly created form using understandable and everyday language is meant to encourage more citizens of many states to voluntarily execute advance directives for health care to make their wishes more clearly known.

The General Assembly of applicable states takes note that the clear expression of individual decisions regarding health care, whether made by the individual or an agent appointed by the individual, is of critical importance not only to citizens but also to the health care and legal communities, third parties, and families. In furtherance of these purposes, the General Assembly enact new laws. Those Chapters set forth general principles governing the expression of decisions regarding health care and the appointment of a health care agent, as well as a form of advance directive for health care.
Instructions


State’s laws on advance directives changed significantly over the last several years.

- Many state’s Advance Directives for Health Care Act will or have replaced their Living Will’s Official Codes.
- The Living Will and Durable Power of Attorney for Health Care will no longer be available as options for advance directives in those.
- Validly executed Living Wills created between certain dates will remain valid until revoked.
- Validly executed Durable Powers of Attorney for Health Care created between certain dates will remain valid until revoked.

To know if your current Living Will and/or Durable Power of Attorney for Health Care is valid, find a copy of the old code sections to confirm the witnessing requirements or consult an attorney who can compare it with the law in effect prior to their new law changes.

If one chooses to complete an Advance Directive for Health Care, it will replace any other advance directive for health care, durable power of attorney for health care, health care proxy, or living will that currently is in place. One may choose not to complete this form and his/her current Living Will and/or Durable Power of Attorney for Health Care form, if valid now, remains valid.

An Advance Directive for Health Care is Never Required.

Definitions

'Advance directive for health care' means a written document voluntarily executed by a declarant in accordance with the requirements of your state’s Code Section.

'Attending physician' means the physician who has primary responsibility at the time of reference for the treatment and care of the declarant.

'Declarant' means a person who has executed an advance directive for health care authorized by this chapter.

'Durable power of attorney for health care' means a written document voluntarily executed by an individual creating a health care agency in accordance with your state’s Code Chapter.
'Health care' means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for a declarant’s physical or mental health or personal care.

'Health care agent' means a person appointed by a declarant to act for and on behalf of the declarant to make decisions related to consent, refusal, or withdrawal of any type of health care and decisions related to autopsy, anatomical gifts, and final disposition of a declarant’s body when a declarant is unable or chooses not to make health care decisions for himself or herself. The term 'health care agent' shall include any back-up or successor agent appointed by the declarant.

'Health care facility' means a hospital, skilled nursing facility, hospice, institution, home, residential or nursing facility, treatment facility, and any other facility or service which has a valid permit or provisional permit issued under a Chapter of your state title or which is licensed, accredited, or approved under the laws of any state, and includes hospitals operated by the United States government or by any state or subdivision thereof.

'Health care provider' means the attending physician and any other person administering health care to the declarant at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

'Life-sustaining procedures' means medications, machines, or other medical procedures or interventions which, when applied to a declarant in a terminal condition or in a state of permanent unconsciousness, could in reasonable medical judgment keep the declarant alive but cannot cure the declarant and where, in the judgment of the attending physician and a second physician, death will occur without such procedures or interventions. The term 'life-sustaining procedures' shall not include the provision of nourishment or hydration but a declarant may direct the withholding or withdrawal of the provision of nourishment or hydration in an advance directive for health care. The term 'life-sustaining procedures' shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain.

Living will' means a written document voluntarily executed by an individual directing the withholding or withdrawal of life-sustaining procedures when an individual is in a terminal condition, coma, or persistent vegetative state in accordance with your state's chapter.

‘Physician' means a person lawfully licensed in your state to practice medicine and surgery pursuant to your state Code sections; and if the declarant is receiving health care in another state, a person lawfully licensed in such state.

'Provision of nourishment or hydration' means the provision of nutrition or fluids by tube or other medical means.
'State of permanent unconsciousness' means an incurable or irreversible condition in which the declarant is not aware of himself or herself or his or her environment and in which the declarant is showing no behavioral response to his or her environment.

'Terminal condition' means an incurable or irreversible condition which would result in the declarant’s death in a relatively short period of time.

Certification of a terminal condition or state of permanent unconsciousness

Before any action can be taken to withdraw or withhold life sustaining procedures or to withdraw or withhold nourishment or hydration for a declarant in a state of permanent unconsciousness or is in a terminal condition, that condition must be certified in writing. The attending physician and one other physician must personally examine the declarant and certify in writing based upon the declarant’s condition found during the course of their examination and in accordance with current accepted medical standards that the declarant does meet the criteria for terminal condition or state of permanent unconsciousness as defined above.

The difference between this advance directive form and the Living Will and Durable Power of Attorney for Health Care

The Advance Directive for Health Care is an attempt to combine the best features of the Living Will and Durable Power of Attorney for Health Care into one written document. An effort has also been made to make the execution (signing and witnessing) of this document easier and more convenient. The effect of this new document still does not constitute suicide, physician assisted suicide, homicide or euthanasia. Completing one has no affect on insurance, annuities or anything else contingent on the life or death of the person making the advance directive (hereafter, “the declarant”).

No limitation on the use of other advance directives forms

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care that substantially comply with this form may be used in applicable states.

This includes using forms from other states.

Three Parts of the Advance Directive for Health Care

Part One: allows an agent to be appointed to carry out health care decisions (formerly the Durable Power of Attorney for Health Care)
Part Two: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration (formerly the Living Will)

Part Three: allows one to nominate someone to be appointed as Guardian if a court determines that a guardian is necessary.

Requirements for the person making an advance directive for health care

- Must be of sound mind
- Must be 18 years of age or older Or An emancipated minor

Executing the advance directive for health care

- the declarant must sign or expressly direct someone else do it for him/her
- two witnesses required, who are:
  - of sound mind
  - 18 years of age or older
  - Witnesses do not have to see the declarant sign
  - Witnesses do not have to see each other sign the advance directive
- the declarant must see both witnesses sign
  - Restriction on witnesses
  - Not the health care agent
  - Not knowingly be in line to inherit anything from or benefit from the death of the declarant
  - Not directly involved in the health care of the declarant
  - Only one of the two witnesses can be an employee, agent or on the medical staff of the health care facility where the declarant is receiving his/her health care

Restrictions on the health care agent

A physician or health care provider directly involved in the care of the declarant may not serve as health care agent.

Duty of the health care agent to act

- A health care agent has no duty to act, even if named.
- If the health care agent does choose to act, s/he must not make decisions that are different or that contradict the decisions of the declarant.
- All of the health care agent’s actions must be consistent with the intentions and desires of the declarant.
- If those intentions and desires are not clear, the health care agent’s actions must be in the best interests of the declarant considering all of the benefits, burdens, risks and treatments options.

**Authorized responsibilities/duties of the health care agent related to the necessary care of the declarant**

- Consent to, authorize, withdraw consent from, refuse, withhold, any and all types of medical/surgical care, treatment, programs and/or procedures Sign and deliver all instruments (documents)
- Negotiate and enter into all agreements and contracts binding the declarant
- Accompany him/her in an ambulance or air ambulance
- Admit to or discharge the declarant from any health care facility
- Visit and consult with the declarant as necessary
- Examine, copy and consent to disclosure of all the declarant’s medical records deemed relevant
- Do all other acts reasonably necessary and carry out duties and responsibilities in person or through those employed by the health care agent; this does not include delegating the authority to make health care decisions
- Consent to an anatomical gift of the declarant’s body, in whole or part, an autopsy and direct the final disposition of declarant’s remains, including funeral arrangements, burial, or cremation (Note: the law states that the agent can bind the declarant to pay but does not expressly mention binding the estate of the declarant. It may be a good idea to make all arrangements prior to the death of the declarant.)

**Prohibited actions by the health care agent**

The health care agent may not consent to psychosurgery, sterilization, or involuntary hospitalization or treatment under the Mental Health Code.

**When the attending physician, health care provider and/or health care facility refuse to honor the advance directive for health care**

The law states:

For health care decisions with which health care providers are unwilling to comply, after this decision is communicated with the agent, the agent is responsible for arranging for the declarant’s transfer to another health care provider. This section of the law does not expressly include life-sustaining procedures, nourishment or hydration in “health care decisions.”

For a declarant’s decision to withhold or withdraw life-sustaining procedures or withhold or withdraw the provision of nourishment or hydration, attending physicians who fail or refuse to
comply are responsible for making a good faith attempt to effect the transfer of the declarant to another physician who will comply or must permit the agent, next of kin or legal guardian to obtain another physician who will comply.

If it is the health care facility that refuses to comply with the declarant’s decision to withhold or withdraw life-sustaining procedures or nutrition or hydration, the law does not expressly state whose responsibility it is to ensure the declarant is transferred to another health care facility.

**Revoking this advance directive for health care**

The Advance Directive for Health Care may be revoked at any time, regardless of the declarant’s mental state or competency. It remains effective even if a Guardian is appointed for the declarant unless a court specifically orders otherwise.

Revocation can occur in any of the following ways:

- By completing a new advance directive for health care
- By burning, tearing up, or otherwise destroying the existing advance directive for health care
- By writing a clear statement expressing the intent to revoke the advance directive for health care
- By orally expressing the intent to revoke the advance directive for health care in the presence of a witness 18 years of age or older who confirms this in writing within 30 days. The revocation is effective when the treating physician documents it in the medical record.
- Marrying after executing an advance directive for health care revokes any agent other than the declarant’s spouse
- Divorcing or otherwise dissolving a marriage after the execution of an advance directive for health care revokes the designation of the spouse as the health care agent

**What to do with the completed form**

You should give a copy of your completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review your completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Copies of this form and its instructions are available at no cost from most states and a copy of your state’s advanced Directive form, see a convenient link at: [http://www.caringinfo.org](http://www.caringinfo.org), click on “Download Your State specific Advance Directive”
Lesson 7 Objectives

Upon completion of this section, you will:

- Know what an Advance Directive for Health Care form looks like.
- Be able to complete your own Advance Directive form.
- Be able to summarize the important points about Advance Directives.

7

Advance Directive for Health Care – “Forms”

A lawyer can prepare these papers, or you can do them yourself. Forms are available from your local or State government, from private groups, or on the Internet. Often, these forms need to be witnessed. That means that people who are not related to you watch as you sign and date the paperwork and then sign and date it themselves as proof that the signature is indeed yours.

Make sure you give copies to your primary doctor and your healthcare proxy. Have copies in your files as well. Hospitals might ask for a copy when you are admitted, even if you are not seriously ill.

You should also give permission to your doctors and insurance companies to share your personal information with your healthcare proxy. This lets your proxy discuss your case with the doctor and handle insurance issues that may come up.

Sometimes, people change their minds as they get older or after they become ill. Review the decisions in your advance directives from time to time, and make changes if your views or your health needs have changed. Be sure to discuss these changes with your healthcare proxy and your doctor. Replace all copies of the older version with the updated ones, witnessed and signed if appropriate.

Do you live in one State, but spend a lot of time in another? Maybe you live in the north and spend winter months in a southern State. Or, perhaps your children and grandchildren live in a different State and you visit them often. Because States’ rules and regulations may differ, make sure your forms are legal in both your home State and the State you travel to often. If not, make an advance directive with copies for that State, too, and be sure your family there has a copy.
For a copy of your state’s advanced Directive form, Google your State Department/Agency on Aging to “Download Your State specific Advance Directive”

Advance Directive Form – “Sample”

Advance Directive for Health Care

By: ____________________________ Date of Birth: ____________________________
(Print Name) (Month/Day/Year)

This advance directive for health care has four parts:

PART ONE—Health Care Agent. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO—Treatment Preferences. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE—Guardianship. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR—Effectiveness and Signatures. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE—Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.
1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: ____________________________________________
Address: _________________________________________
Telephone Numbers: ________________________________
   (Home, Work, and Mobile)

2. Back-Up Health Care Agent

(This section is optional. PART ONE will be effective even if this section is left blank.)

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: ____________________________________________
Address: _________________________________________
Telephone Numbers: ________________________________
   (Home, Work, and Mobile)

Name: ____________________________________________
Address: _________________________________________
Telephone Numbers: ________________________________
   (Home, Work, and Mobile)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent’s authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.
I understand that under state law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent After Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent’s power by initialing below.

________ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Anatomical Gift Act, unless I have limited my health care agent’s power by initialing below.

Initial each statement that you want to apply.

________ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

________ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

________ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____________________________________________________________

Address: ___________________________________________________________.

Telephone Numbers: ________________________________________________

(Home, Work, and Mobile)
I wish for my body to be:

_________ (Initials) Buried

OR

_________ (Initials) Cremated

PART TWO—Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_________ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_________ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _________ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _________ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _________ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:
Initial each statement that you want to apply to option (C).

__________ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

__________ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

__________ (Initials) If I need assistance to breathe, I want to have a ventilator used.

__________ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO will be effective even if this section is left blank.

I understand that under state law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

__________ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE—Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) __________ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) __________ (Initials) I nominate the following person to serve as my guardian:

Name:
PART FOUR—Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_________ (Initials) This advance directive for health care will become effective on or upon ______________________ and will terminate on or upon ____________________.

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

• Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
• Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
• Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_________________________________________________________  __________________________
(Signature of Declarant)                                      (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_________________________________________________________  __________________________
(Signature of First Witness)                                  (Date)

Print Name: _______________________________________________
Address: ________________________________________________

_________________________________________________________  __________________________
(Signature of Second Witness)                                 (Date)

Print Name: _______________________________________________
Address: ________________________________________________

This form does not need to be notarized.
Lesson 8 Objectives

Upon completion of this section, you will:

- Gain increased awareness of types and classifications of annuities.
- How annuity types work and affect clients who own or buy them.

8

What to Do Now

Suggestions

Here are some suggestions to help ensure that your wishes for your final health care are followed:

- Make sure the person you have named as your Health Care Agent and your back-up Agent know what you want. If you have not shared your wishes with these individuals, talk to them the first chance you get.
- Keep your signed original Individual Worksheet and Advance Directive for Health Care some place where they can be found easily. Do not put them in a safe deposit box which requires a key or combination to open. Tell your Health Care Agent and other loved ones where to find your original documents.
- Give copies of your Individual Worksheet and Advance Directive for Health Care to your Agent, back-up Agents, and anyone else you think should know what you want (family members, lawyer, spiritual advisor, etc.). Keep a list of the people you give them to in case you change your mind.
- Tell your doctor you have completed a Advance Directive for Health Care and discuss your decisions with him or her. If you would like, have your doctor put a copy of your Advance Directive for Health Care in your medical record.
- Use a Wallet Card to indicate that you have completed a Advance Directive for Health Care and where it can be found. Carry it with you.
- If you are being admitted to a hospital or nursing home, take a copy of your Advance Directive for Health Care with you. Ask that it be placed in your medical record.
- Plan to review and update your Individual Worksheet and Advance Directive for Health Care occasionally. As the circumstances of your life change (growing older, being diagnosed with an illness, etc.), your views may change.
• Marriage, the birth of a child or the death of a loved one may also influence how you feel. Your loved ones will want to know that your Advance Directive for Health Care is a true expression of your wishes and may have questions about a document that is several years old. Initial and date the forms each time you review them so your loved ones will know you have not changed your mind.
• If you do change your mind, you can cancel your Advance Directive for Health Care at any time. Be sure to notify everyone who has copies that you are writing a new advance directive, thereby canceling the document they have.
• If you are terminally ill and wish to die at home, you should talk to your doctor, other caregivers, and family members about situations when you might or might not want an ambulance called. If an ambulance is called, the emergency team must give you life-prolonging care until you can get to a hospital and be evaluated by a doctor, unless you have a Do Not Resuscitate/Allow Natural Death order that is clearly visible in your home or you are wearing an orange arm band or necklace indicating that you have a Do Not Resuscitate/Allow Natural Death order.
• If you become terminally ill, you can call a hospice in your area and ask for information about the care they can give to you and your family. Many of these programs will work directly with your doctor to arrange for you to have hospice services in addition to your medical care.
• If you are traveling outside of your state, it is a good idea to take a copy of your Advance Directive for Health Care with you. Most states will honor an out-of-state document, but some require that it conform to their own laws. If you are going to receive medical care out of state, ask the medical facility where you will be treated to give you information about their laws and requirements.

Important Points to Remember About Advance Directives:

- A patient must be a fully competent adult to complete an Advance Directive.
- These documents are only in effect if you are not able to express your own thoughts and wishes about treatment issues.
- Advance Directives only cover healthcare decisions and have nothing to do with your financial affairs.
- You can change your mind at any time, by completing a new form, or telling someone that you have different wishes.
- You do not need a lawyer to complete the forms and they do not have to be notarized.
- You will need two competent adults to witness these forms and the witnesses can not be members of your family. By law, hospital employees can act as one of your witnesses but the other must be an objective third party.
Resources

For More Information about Getting Your Affairs in Order

AARP

1-888-687-2277 (toll-free)
1-877-434-7598 (TTY/toll-free)
1-877-342-2277 (español/línea gratis)
member@aarp.org (email)
www.aarp.org

CaringInfo

1-800-658-8898 (toll-free)
caringinfo@nhpco.org (email)
www.caringinfo.org

Centers for Medicare & Medicaid Services

1-800-633-4227 (1-800-MEDICARE/toll-free)
1-877-486-2048 (TTY/toll-free)
www.medicare.gov

Eldercare Locator

1-800-677-1116 (toll-free)
www.eldercare.gov

National Elder Law Foundation

1-520-881-1076
info@nelf.org (email)
www.nelf.org

For more information on health and aging, including their free booklets Long-Distance Caregiving: Twenty Questions and Answers and End of Life: Helping with Comfort and Care, contact:
National Institute on Aging
Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
niaic@nia.nih.gov
www.nia.nih.gov
www.nia.nih.gov/espanol

Sign up for regular email alerts about new publications and other information from the NIA.

Visit www.nihseniorhealth.gov, a senior-friendly website from the National Institute on Aging and the National Library of Medicine. This website has health and wellness information for older adults, including information about planning for end-of-life care. Special features make it simple to use. For example, you can click on a button to make the type larger.

National Institute on Aging
National Institutes of Health
U.S. Department of Health and Human Services

For More Information
Other federal and non-federal resources with information about advance directives include:

Caring Connections
National Hospice and Palliative Care Organization
1-800-658-8898 (toll-free)
1-877-658-8896 (toll-free/multilingual)
www.caringinfo.org

Caring Conversations
Center for Practical Bioethics
Harzfeld Building
1111 Main Street, Suite 500
Kansas City, MO 64105-2116
1-800-344-3829 (toll-free)
www.practicalbioethics.org

American Bar Association
321 North Clark Street
Chicago, IL 60654
1-800-285-2221
www.americanbar.org
(search for "Consumer's Tool Kit for Health Care Advance Planning")

Donate Life America
701 East Byrd Street, 16th floor
Richmond, VA 23219
1-804-377-3580
www.donatelife.net

National Legal Resource Center
www.nlrc.aoa.gov

OrganDonor.gov
Health Resources and Services Administration
1-888-275-4772 (toll-free)
www.organdonor.gov

POLST (Physician Orders for Life-Sustaining Treatment)
www.polst.org

Put It In Writing
American Hospital Association
155 North Wacker Drive
Chicago, IL 60606
1-800-424-4301 (toll-free)
www.putitinwriting.org

The Living Bank
P.O. Box 6725
Houston, TX 77265
1-800-528-2971 (toll-free)
www.livingbank.org

National Institute on Aging Information Center
P.O. Box 8057
Gaithersburg, MD 20898-8057
1-800-222-2225 (toll-free)
1-800-222-4225 (TTY/toll-free)
www.nia.nih.gov
www.nia.nih.gov/espanol