

ADVANCE HEALTH CARE DIRECTIVES

Your Rights to Decide
About Your Health Care





Dear Friend of Beebe,

Thank you for your interest in Beebe Medical Center's policy on Advance Directives. As you may know, Delaware passed the "Death with Dignity" Act in December of 1991. It was then amended as the "Health Care Decisions" Act in June of 1996 to better reflect the needs expressed by health care providers, potential patients and clergy. Basically, there are two types of Advance Directives in Delaware: End of Life Decisions (formerly the Living Will) and Power of Attorney for Health Care. Beebe Medical Center has had formal policies on Advance Directives since 1991 that are available for you to review.

Because medical decision making is such a personal matter, and because many states have varying laws regarding this topic, many aspects are still a matter of legal interpretation. Beebe encourages you to learn as much about Advance Directives as possible. There are two resources available, the Division of Aging at 800-223-9074 or 302-424-7310, or the Delaware Office of the Public Guardian at 302-856-5313. Another option is to contact your personal attorney.

If you have a question about our policy or would like assistance completing your Advance Directive, contact the Patient Advocate at 302-645-3547. If and when you execute this document, we ask that you keep the original and provide the hospital with a photocopy each time you are admitted. Be sure to make additional copies for your physicians, family members, clergyman, etc.

We applaud you for taking the initiative to become educated about Advance Directives. At Beebe Medical Center we believe that our best patient is an informed patient.

Sincerely,

Ellen Tolbert
Director, Patient Relations

Ercilia Arias, M.D.
Chairman, Bioethics Committee

ADVANCE HEALTH CARE DIRECTIVE

YOUR RIGHTS TO DECIDE ABOUT YOUR HEALTH CARE

Who decides what health care I get?

As a competent adult, you have the legal right to make your own health care decisions. Your doctor or another health care professional may advise you and make recommendations about treatment. You have the right to receive this information in a way you can understand. You have the authority to say “yes” to any treatment that is offered to you, and to say “no” to any treatment that you do not want.

What if my medical condition makes me unable to decide?

In Delaware, if you are at least 18 years old you may make a written “Advance Health Care Directive” to accept or refuse most health care treatments or procedures. Your Advance Health Care Directive will tell your doctor what you want if you become unable to decide yourself.

What is an Advance Health Care Directive?

Under Delaware law there are two types of Advance Health Care Directives:

- 1) End of Life Instructions (Living Will) or
- 2) A Power of Attorney for Health Care

An **End of Life Instruction**, previously referred to as a living will, is a written statement of your wishes about health care treatment if you have a terminal illness or are permanently unconscious for at least four weeks.

A **Power of Attorney for Health Care** allows you to name another person as an agent to make health care decisions for you if your medical condition makes you unable to do so. You can appoint any adult over the age of 18 to be your agent. However, if you are a resident of a long-term care facility, the agent cannot be an employee of the facility unless he/she is related to you.

If you do not have an Advance Health Care Directive, a member of your family will be asked to make health care decisions for you when you are unable to do so. If you want to initiate an Advance Health Care Directive, you must do so while you are still capable and competent to make health care decisions. Two witnesses who are at least 18 years old must watch you sign the Advance Health Care Directive. You must choose witnesses who are not members of your family, will not inherit anything from you when you die, and do not have to pay for your care. If you are in a hospital, nursing home or similar facility when you sign your written instruction, you must choose witnesses who are not employees of the facility. In addition, if you are in a nursing home or similar facility, one of the witnesses must be a Long-Term Care Ombudsman or the Public Guardian.

Does an Advance Health Care Directive apply when I am pregnant?

Delaware law provides that life-sustaining procedures cannot be withheld or withdrawn from a pregnant patient, so long as it is probable that the child will develop to the point of live birth with the application of life-sustaining treatment.

Where should I keep my Advance Health Care Directive?

You should keep the original and give copies to your family members, your doctor, and other health care providers. It will become part of your medical record. If you want, you can also give copies to close friends, your lawyer, or your clergyman.

What if I change my mind?

You can revoke your Advance Health Care Directive at any time by destroying it, by making a new one, or by telling two people at the same time that you no longer wish your Advance Health Care Directive to be effective. You should also, in writing, inform your doctor or any other health care provider and any health agent you have named of your decision to revoke the directive.

Will my Advance Health Care Directive be valid in another state?

State laws vary considerably on Advance Health Care Directives. While the Advance Health Care Directive you make in one state may be good in another state, there is no guarantee of that. If you move to another state, you should make a new Advance Health Care Directive in that state. If you have a valid Advance Health Care Directive from another state, it will be valid in Delaware to the extent it is consistent with Delaware law.

What happens if I make no Advance Health Care Directive?

You are not required to make an Advance Health Care Directive. However, without an Advance Health Care Directive, a member of your family, who may be referred to as a surrogate, will be asked to make health care decisions for you. The following family members, if available, will be asked in this order:

- 1) Spouse (husband or wife)
- 2) Adult child
- 3) A parent
- 4) An adult brother or sister, or,
- 5) Adult grandchild
- 6) An adult niece or nephew

If none of these family members are available to make health decisions for you, a guardian may be appointed by the Court.

Where can I obtain more information?

If you would like more information, please contact Beebe Medical Center at 302-645-3547. In addition, you can consult:

- ◆ Delaware Department of Health & Social Services, Division of Services for Aging with Physical Disabilities
- ◆ Delaware Office of the Public Guardian

ADVANCE HEALTH CARE DIRECTIVE

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, an agent may not have a controlling interest in or be an operator, or employee of a residential long-term health care institution at which you are receiving care.

If you do not have a qualifying condition (terminal illness/injury or permanent unconsciousness), your agent may make all health care decisions for you except for decisions providing, withholding or withdrawing a life sustaining procedure. Unless you limit the agent's authority, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.
- (b) Select or discharge health care providers and health care institutions;

If you have a qualifying condition, your agent may make all health care decisions for you including but not limited to:

- (c) The decisions listed in (a) and (b).
- (d) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.
- (e) Direct the providing, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write any additional health care wishes.

Part 3 of this form lets you express an intention to donate your body organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is required that two other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health Care Directive or replace this form at any time.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individuals as my agent to make health care decisions for me:

(Name and relationship of individual you choose as agent)

(Address)

(City)

(State) (Zip Code)

(Home phone)

(Work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(Address)

(City)

(State) (Zip Code)

(Home phone)

(Work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

(Address)

(City)

(State) (Zip Code)

(Home phone)

(Work phone)

(2) AGENT'S AUTHORITY: If I am not in a qualifying condition, my agent is authorized to make all health care decisions for me, except decisions about life-sustaining procedures and as I state here; and if I am in a qualifying condition, I am authorized to make all health care decisions for me, except as I state here:

(Add additional sheets if necessary)

- (3) **WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:** My agent’s authority becomes effective when my primary physician determines I lack the capacity to make my own health care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my agent’s authority becomes effective when my primary physician determines I lack the capacity to make my own health care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.
- (4) **AGENT’S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.
- (5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, (please check one):
- I nominate the agent(s) whom I named in this form in the order designated to act as guardian.
- I nominate the following to be guardian in the order designated:
- _____
- _____
- I do not nominate anyone to be guardian.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

- (6) END-OF-LIFE DECISIONS. If I am in a qualifying condition, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life I do not want my life to be prolonged if: (please check all that apply)

- (A) I have a **terminal condition** (an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life sustaining procedures, there can be no recovery), I make the following specific directions:

	I want used	I do not want used
1. Artificial nutrition through a conduit (feeding tube)	_____	_____
2. Hydration through a conduit (IV therapy)	_____	_____
3. Cardiopulmonary Resuscitation (CPR)	_____	_____
4. Ventilator/Respirator (breathing machine)	_____	_____

- (B) I become **permanently unconscious** (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment; the term includes, without limitation, a persistent vegetative state or irreversible coma), I make the following specific directions:

	I want used	I do not want used
1. Artificial nutrition through a conduit (feeding tube)	_____	_____
2. Hydration through a conduit (IV therapy)	_____	_____
3. Cardiopulmonary Resuscitation (CPR)	_____	_____
4. Ventilator/Respirator (breathing machine)	_____	_____

Choice To Prolong Life (Cross out, initial and date if you have completed A & B)

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(7) OTHER MEDICAL INSTRUCTIONS: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) **I direct that:**

(Add additional sheets if necessary)

RELIEF FROM PAIN: Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if necessary)

**PART 3: ANATOMICAL GIFTS AT DEATH
(OPTIONAL)**

(8) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate spaces and words filled into the blanks below indicate my desires.

I give: my body; any needed organs or parts; the following organs or parts

To the following person or institutions the physician in attendance at my death; the hospital in which I die; the following named physician, hospital, storage bank or other medical institution _____; the following individual for treatment _____; for the following purposes: any purpose authorized by law; transplantation; therapy; research; medical education.

(10) SIGNATURES OF WITNESSES:

Statement of Witnesses

SIGNED AND DECLARED by the above-name declarant as and for his/her written declaration under 16 Del. C. §§2502, 2503, in our presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. That the Declarant is mentally competent.
- B. That neither of them:
 - 1. Is related to the declarant by blood, marriage or adoption;
 - 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the Advance Health Care Directive, is so entitled by operation of law then existing;
 - 3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
 - 4. Has a direct financial responsibility for the declarant's medical care;
 - 5. Has a controlling interest in or is an operator or an employee of a health care institution where the declarant is a patient; or
 - 6. Is under eighteen years of age;
- C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

**Delaware Law does not require notarization, but it is recommended.

(11)EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURE: Sign and date the form here: I understand the purpose and effect of this document.

(date) (sign your name)

(print your name)

(address) (city) (state) (zip code)

First Witness:

(print name)

(address) (city) (state) (zip code)

(signature of witness) (date)

I am not prohibited by §2503 of Title 16 of the Delaware Code from being a witness.

Second Witness:

(print name)

(address) (city) (state) (zip code)

(signature of witness) (date)

I am not prohibited by §2503 of Title 16 of the Delaware Code from being a witness.