



Advance Healthcare Directive

Life Choices Surrounding Critical Illness

St. Mary Medical Center is a member organization of Catholic Health East. As a ministry of the Catholic Church in the United States, this facility abides by the Ethical and Religious Directives for Catholic Healthcare Services.

St. Mary provides care in a manner consistent with beliefs and practices of the Catholic faith.

As a faith-based organization, St. Mary Medical Center supports your right to make informed decisions regarding your healthcare. We created this booklet to make these complex issues easier to understand. The booklet includes an Advance Healthcare Directive form to make your wishes known.

In the event that this hospital is unable to comply with a directive given by a patient or his/her delegated decision-maker, the hospital will assist in the efforts of the patient and family to transfer to a compatible provider.

Frequently Asked Questions

► **What is an Advance Healthcare Directive?**

It is a healthcare power of attorney, living will, or written combination of a healthcare power of attorney and living will. It is a document that states your choices about medical treatment or names someone to make decisions about your medical treatment if you are unable to make these decisions yourself.

► **What is a healthcare power of attorney?**

It is a document in which you designate an individual to make healthcare decisions for you. This person is called your healthcare agent.

► **What is a living will?**

It is a document that expresses your wishes and instructions for healthcare when you are incompetent and have an end-stage medical condition or are permanently unconscious.

► **To whom should I give my Advance Healthcare Directive?**

You should give a copy to your doctor(s), hospital, nursing home, hospice, or any other healthcare provider. You should also provide your healthcare agent (if you have named one), family, friends, or other trusted loved ones with a copy.

► **Does my healthcare provider have to tell me if he/she will not honor my living will?**

The law requires your healthcare provider to advise you or your agent (if you are unable to make decisions) if the provider cannot comply with your living will. The provider who cannot honor your wishes must then help transfer you to another provider willing to carry out your directions.

► **Can my doctor be sued or prosecuted for carrying out a valid living will?**

No. Pennsylvania law states that no physician, healthcare facility, or any person acting under the direction of the physician can be subject to criminal prosecution, civil action, or can be found guilty of unprofessional conduct for carrying out a valid living will.

► **Whom can I select to be my healthcare agent?**

You can appoint almost any adult to be your agent. You should select a person knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about your healthcare. You should discuss your wishes with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

The only people who **cannot** be appointed as your healthcare agent are: **1)** your attending physician or other healthcare provider unless he/she is related to you by blood, marriage, or adoption; and **2)** an owner, operator, or employee of a healthcare facility in which you are receiving care unless he/she is related to you by blood, marriage, or adoption.

► **What decisions can my healthcare agent make?**

Unless you limit his/her authority, your agent will be able to make almost every treatment decision that you could make if you were able to do so. If your wishes are not known, your agent has the duty to act in your best interests. These decisions can include authorizing, refusing, or withdrawing treatment, even if it means that you will die. The appointment of an agent is a serious decision on your part.

► **Under what circumstances does a healthcare agent make healthcare decisions on my behalf?**

Your healthcare agent may make healthcare decisions on your behalf when your doctors have decided that you are unable to make your own healthcare decisions and your agent consents to start making those decisions.

► **Does an Advance Healthcare Directive have to be signed and witnessed?**

Yes, you must sign (or have someone sign the document in your presence and at your direction if you are physically unable to sign) and date the Advance Healthcare Directive. Then it must be witnessed by two people, 18 years or older. If you are unable to physically sign and someone signed on your behalf, that same person cannot witness the directive.

► **When does a living will take effect?**

It takes effect when: **1)** your doctor has a copy of it; **2)** your doctor has concluded that you are no longer able to make or communicate decisions about medical care; and **3)** your doctor has determined that you have an end-stage medical condition or are permanently unconscious.

► **What does it mean to have an end-stage medical condition?**

It is defined as an incurable and irreversible medical condition in an advanced state caused by injury, disease, or physical illness that will in the opinion of your doctor result in death despite the introduction or continuation of medical treatment.

► **What does it mean to be permanently unconscious?**

It is defined as total and irreversible loss of consciousness and capacity for interaction with the environment.

► **What is life-sustaining treatment?**

Any medical procedure or intervention that when administered to an individual who has an end-stage medical condition or is permanently unconscious will serve only to prolong the process of dying or maintain the individual in a state of permanent unconsciousness.

► **Will I receive medication for pain?**

Yes, unless you state otherwise in your living will, medication for symptom management will be provided where appropriate to make you comfortable and will not be discontinued.

► **Is a living will the same as a Do Not Resuscitate (DNR) or Allow Natural Death (AND) order?**

No. A living will covers almost all types of life-sustaining treatments and procedures. A Do Not Resuscitate (DNR), also known as Allow Natural Death (AND), covers two types of life-threatening situations: cardiac arrest (your heart stops beating) and respiratory arrest (you stop breathing). An AND order is written by your physician at your direction, placed in your medical record, and goes into effect immediately. This means that if your heart stops beating or you stop breathing, your healthcare providers will not try to revive you.

► **What if I change my mind after writing an Advance Healthcare Directive?**

You may revoke an Advance Healthcare Directive at any time. To cancel your directive, simply destroy the original document and tell your family, friends, doctor, and anyone else who has copies that you have canceled it.

To change your Advance Healthcare Directive, simply write and date a new one. Inform your healthcare provider, healthcare agent, and family members that you have changed your mind and provide them a copy of your new Advance Healthcare Directive.

► **Will my Advance Healthcare Directive be honored in another state?**

The laws differ from state to state, so your Advance Healthcare Directive might not be honored in another state.

► **What does my doctor have to tell me about my care and treatment?**

Your doctor should provide you with all the information a person in your situation reasonably would want to know in order to make an informed decision about a proposed procedure or course of treatment. Your doctor should tell you about the risks and benefits of the medical procedure or course of treatment, possible side effects, and alternatives.

► **What if I do not leave instructions or do not name a person who will make decisions for me?**

If you cannot speak for yourself and you do not have an Advance Healthcare Directive, your healthcare provider will look to the following people in the order listed for decisions about your care: **1)** your spouse, unless an action for divorce is pending, and your adult child(ren) who are not your spouse's child(ren); **2)** your adult child(ren); **3)** your parent(s); **4)** your adult sibling(s); **5)** your adult grandchild(ren); or **6)** any adult who has knowledge of your preferences, values, religious and moral beliefs.

If the members of a class (i.e. your children) do not agree on a healthcare decision, your doctor or healthcare provider may rely on the decision of a majority of the members of that class.

If the members of the class of healthcare representatives are evenly divided concerning a healthcare decision, no decision can be made until the parties resolve their disagreement. Notwithstanding such disagreement, you will continue to receive healthcare treatment in accordance with accepted standards of medical practice.

If you have additional questions regarding your Advance Healthcare Directive, please contact St. Mary Medical Center Spiritual Care at 215.710.5902 or St. Mary Medical Center Palliative Care at 215.710.5036.

For more information about Advance Healthcare Directives, living wills, or healthcare agents, contact:

► Bucks County Area Agency on Aging
215.348.0510

► Pennsylvania Department of Aging
717.783.1924

Definitions

These definitions are intended as guidance only. Please speak with your physician for detailed information on how these would apply to an end-stage medical condition.

- ▶ **Artificial nutrition and hydration** – Supplements or replaces ordinary eating and drinking. Fluids or liquid foods are given by a tube in the stomach (PEG tube), or a tube passed through the nose to the stomach (nasogastric or NG tube), or through a vein (intravenous). May only have to be provided on a temporary basis, but also can be required permanently.

- ▶ **Cardiopulmonary resuscitation (CPR)** – A group of treatments used when someone’s heart and/or breathing stops. CPR is used in an attempt to restart the heart and restore breathing. It may consist only of ventilation or it can include external compressions on the chest to mimic the heart’s function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

- ▶ **Dialysis** – Used to provide artificial replacement for lost kidney function due to kidney failure. It may be used for very sick patients who have suddenly but temporarily lost their kidney function (acute renal failure) or for stable patients who have permanently lost their kidney function (chronic kidney disease). The procedure involves pumping the person’s blood through a machine. The cleansed blood is then returned to the body. The procedure takes three to five hours and is done at a dialysis center, typically three times per week.

- ▶ **Intubation** – The insertion of a tube through the mouth or the nose into the trachea (windpipe) to create and maintain an open airway to assist breathing. Used when someone has a complete respiratory arrest (stops breathing) or when someone is in respiratory distress (difficulty breathing). After insertion, the tube is then connected to a respirator.

- ▶ **Life-sustaining treatment** – Treatments (medical procedures) that replace or support an essential bodily function (also called life-support treatments). Life-sustaining treatments include CPR, mechanical ventilation, artificial nutrition and hydration, and dialysis. They also may include procedures, surgeries, and other treatments such as blood products.

- ▶ **Mechanical ventilation** – Used to support or replace the function of breathing. A machine called a ventilator (or respirator) forces air and oxygen into the lungs by way of a tube inserted into the nose or mouth and down into the trachea (windpipe). May only have to be provided on a temporary basis, but also can be required permanently.

Introductory Remarks On Healthcare Decision-Making

You have the right to decide the type of healthcare you want. Should you become unable to understand, make, or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

- (1) naming a healthcare agent to decide treatment for you; and
- (2) giving healthcare treatment instructions to your healthcare agent or healthcare provider.

An Advance Healthcare Directive is a written set of instructions expressing your wishes for medical treatment. It may contain a healthcare power of attorney, where you name a person called a “healthcare agent” to decide treatment for you, and a living will, where you tell your healthcare agent and healthcare providers your choices regarding the initiation, continuation, withholding, or withdrawal of life-sustaining treatment and other specific directions.

You may limit your healthcare agent’s involvement in deciding your medical treatment so that your healthcare agent will speak for you only when you are unable to speak for yourself, or you may give your healthcare agent the power to speak for you immediately. This combined form gives your healthcare agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make, or communicate healthcare decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your healthcare agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your healthcare in advance, and if later you become unable to understand, make, or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A healthcare provider who cannot honor your wishes about healthcare must tell you and help transfer you to a healthcare provider who will honor your wishes.

You should give a copy of your Advance Healthcare Directive (a living will, healthcare power of attorney, or a document containing both) to your healthcare agent, your physicians, family members, and others who you expect would likely attend to your needs if you become unable to understand, make, or communicate decisions about medical care. If your healthcare wishes change, tell your physician and write a new Advance Healthcare Directive to replace your old one.

It is important in selecting a healthcare agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your healthcare agent and discuss your beliefs and values with him or her so that your healthcare agent will understand your healthcare objectives.

You may wish to consult with knowledgeable, trusted individuals, such as family members, your physician, or clergy, when considering an expression of your values and healthcare wishes. You are free to create your own Advance Healthcare Directive to convey your wishes regarding medical treatment.

The form provided is an example of an Advance Healthcare Directive that combines a healthcare power of attorney with a living will.

Notes About The Use Of This Form

If you decide to use this form or create your own Advance Healthcare Directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law. If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or healthcare agent decide your medical care. This form is designed to give your healthcare agent broad powers to make healthcare decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your healthcare agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. ***You also should use a different form if you wish to express your preferences in more detail than this form allows or if you wish for your healthcare agent to be able to speak for you immediately.*** In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed. This form allows you to tell your healthcare agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your healthcare agent to be bound by your instructions or whether you want your healthcare agent to be able to decide at the time what course of treatment the healthcare agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a healthcare decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) will be physically harmful to you; or
- (3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant. Pennsylvania law protects your healthcare agent and healthcare providers from any legal liability for following in good faith your wishes as expressed in the form or by your healthcare agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

Durable Healthcare Power Of Attorney

I, _____, of _____ County, Pennsylvania, appoint the person named below to be my healthcare agent to make health and personal care decisions for me. Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make healthcare treatment decisions for me, I authorize all healthcare providers or other covered entities to disclose to my healthcare agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected, or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make, or communicate a choice regarding a health or personal care decision as verified by my attending physician. My healthcare agent may not delegate the authority to make decisions.

My healthcare agent has all of the following powers subject to the healthcare treatment instructions that follow in the living will. (Cross out any powers you do not want to give your healthcare agent.)

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a Do Not Resuscitate (DNR) or Allow Natural Death (AND) order, including an out-of-hospital DNR or AND order, and sign any required documents and consents.

Appointment Of Healthcare Agent

I appoint the following healthcare agent:

Healthcare Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Work _____

E-Mail: _____

If you do not name a healthcare agent, healthcare providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment. Note that you may not appoint your doctor or other healthcare provider as your healthcare agent unless related to you by blood, marriage, or adoption.

If my healthcare agent is not readily available or if my healthcare agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative healthcare agents.)

First Alternative Healthcare Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Work _____

E-Mail: _____

Second Alternative Health Care Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home _____ Work _____

E-Mail: _____

Guidance For Healthcare Agent (OPTIONAL)

Goals

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows: (Insert your personal priorities such as comfort, care, preservation of mental function, etc.)

Severe Brain Damage or Brain Disease

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my healthcare agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials _____ I agree

Initials _____ I disagree

Healthcare Treatment Instructions In The Event Of End-Stage Medical Condition Or Permanent Unconsciousness (Living Will)

The following healthcare treatment instructions exercise my right to make my own healthcare decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment decisions:

If I have an end-stage medical condition (that will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious, such as an irreversible coma or irreversible vegetative state, and there is no realistic hope of significant recovery, all of the following apply: (Cross out any treatment instructions with which you do not agree.)

- 1.** I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.
- 2.** I direct that all life-prolonging procedures be withheld or withdrawn.
- 3.** I specifically do not want any of the following as life-prolonging procedures: *(If you wish to receive any of these treatments, write "I do want" after the treatment.)*

cardiopulmonary resuscitation (CPR) _____

mechanical ventilator (breathing machine) _____

dialysis (kidney machine) _____

surgery _____

chemotherapy _____

radiation treatment _____

antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery. *(Initial only one statement.)*

Tube Feedings

No Tube Feedings

_____ I want tube feedings to be given.

_____ I do not want tube feedings to be given.

Healthcare Agent's Use Of Instructions

(INITIAL ONE OPTION ONLY)

_____ My healthcare agent must follow these instructions.

- OR -

_____ These instructions are only guidance. My healthcare agent shall have final say and may override any of my instructions. *(Indicate any exceptions)*

If I did not appoint a healthcare agent, these instructions shall be followed.

Legal Protection

Pennsylvania law protects my healthcare agent and healthcare providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my healthcare agent's direction. On behalf of myself, my executors, and heirs, I further hold my healthcare agent and my healthcare providers harmless and indemnify them against any claim for their good faith actions in recognizing my healthcare agent's authority or in following my treatment instructions.

Organ Donation

(INITIAL ONE OPTION ONLY)

_____ **I consent** to donate my organs and tissues at the time of my death for the purpose of transplant, medical study, or education. *(Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)*

- OR -

_____ **I do not consent** to donate my organs or tissues at the time of my death.

Having carefully read this document, I have signed it on this _____ day of _____, 20____, revoking all previous healthcare powers of attorney and medical healthcare treatment instructions.

(Signature)

WITNESS: _____

Address of Witness: _____

WITNESS: _____

Address of witness: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. *(It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your healthcare providers.)*

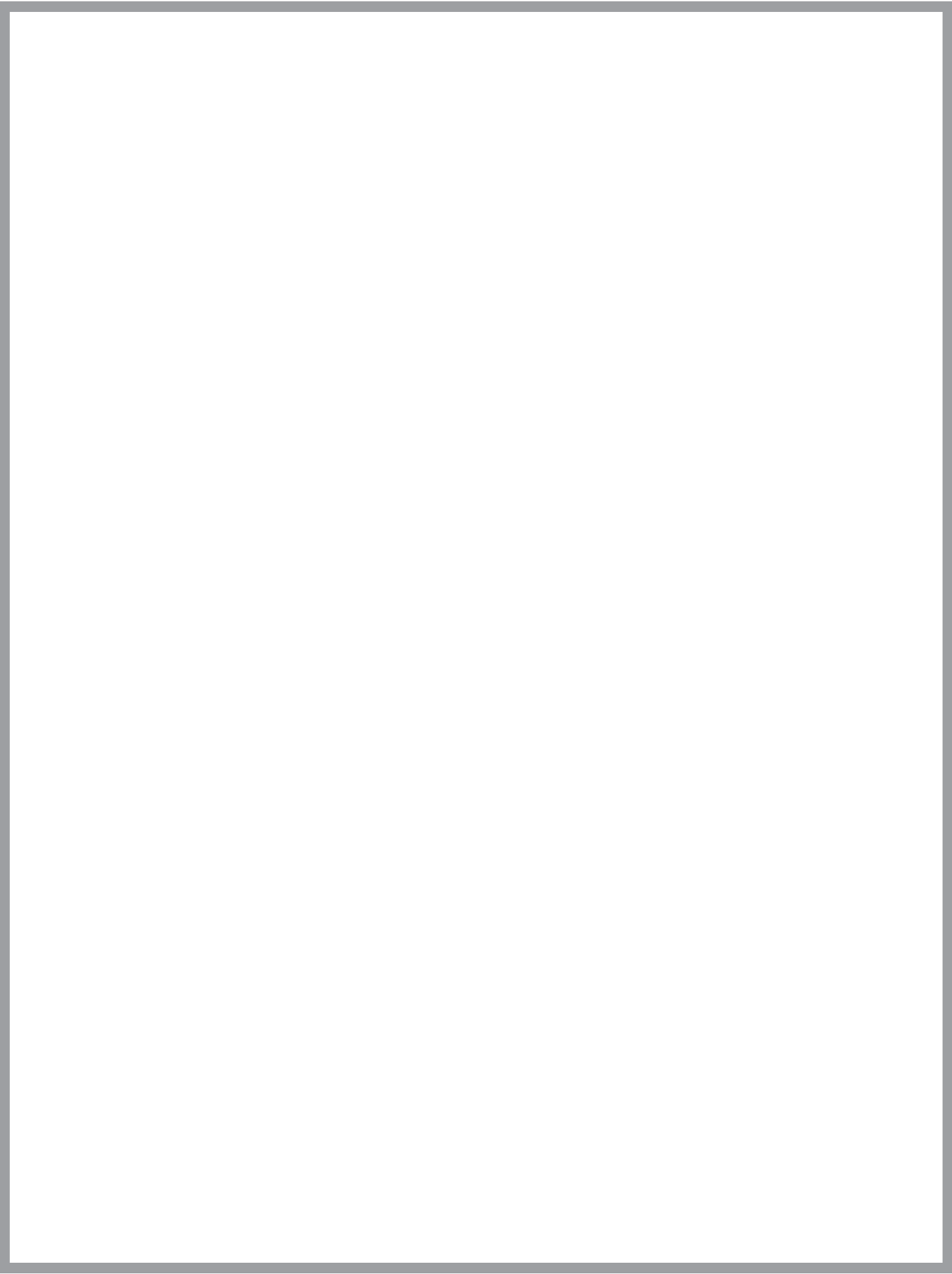
Notarization
(OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this _____ day of _____, 20____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____ the day and year first above written.

Notary Public My commission expires _____.





It's your health. Expect more.

1201 Langhorne-Newtown Rd., Langhorne, PA 19047

215.710.2000

www.stmaryhealthcare.org