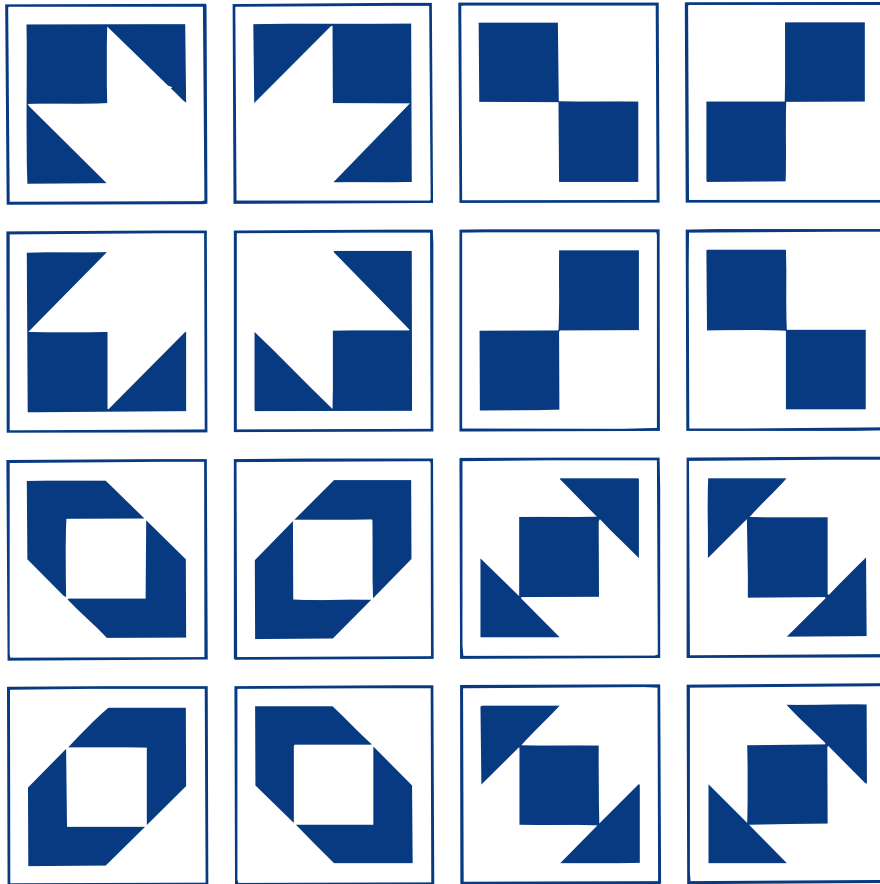
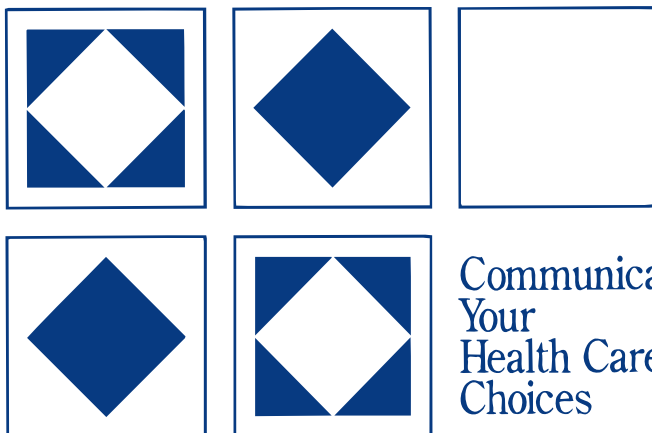


*Martha*  
*A Caring Tradition* **Jefferson Hospital**

459 Locust Avenue  
Charlottesville, Virginia 22902  
(434) 982-7000



# Your Right To Decide



Communicating  
Your  
Health Care  
Choices

## INTRODUCTION

Martha Jefferson Hospital supports your right to make decisions about your future medical care. We want to know your wishes so we can provide the care you desire. In 1990, Congress passed the Patient Self-Determination Act. It requires health care institutions to tell patients and people in their communities about their rights, under Virginia law, to make decisions about their medical care. These rights include the right to accept or refuse care and the right to make Advance Medical Directives about their care.

We never know when an accident or serious illness will leave us incapable of making our own health care decisions. For peace of mind, it is important to think about and talk about your values and wishes for medical care and to put those wishes in writing.

## IMPORTANT TERMS

### *Advance Medical Directive:*

A legal document for persons 18 years or older providing written instructions about future medical care. The Advance Directive form contains sections to name an Agent for Health Care Decisions (Medical Power of Attorney) and to complete a Living Will. The Advance Directive becomes effective only when you are incapable of expressing your own wishes.

### *Agent for Health Care Decisions (Medical Power of Attorney):*

Names an adult agent to make health care decisions for you if you are unable to make them for yourself. This takes effect anytime you are unable to make decisions about your care; it is not limited to end-of-life situations. The persons named are not liable for your medical bills. (A power of attorney for business and financial matters is a separate document).

### *Living Will:*

Explains your wishes regarding medical care if you have a terminal condition or if you are in a persistent vegetative state. You can specify life prolonging procedures you do not want to receive in a hospital. A living will related to medical care has nothing to do with the distribution of your personal property.

## QUESTIONS AND ANSWERS ABOUT ADVANCE MEDICAL DIRECTIVES

### *What are "life-prolonging" procedures?*

These are treatments that are not expected to cure a terminal condition or make you better and that may only prolong dying. They include cardiopulmonary resuscitation (CPR) used to restore stopped breathing and/or heartbeat, hydration (water) or nutrition (food) by tube, use of respirators (machines that breathe for you), IV antibiotics, kidney dialysis, and other medical and surgical treatments. Life-prolonging procedures do not include treatment needed to make you comfortable or to ease pain.

### ***When is my Advance Medical Directive used?***

An Advance Medical Directive is used when you are incapable of making an informed decision. It is used if you are unable to understand the likely results of a medical decision, to weigh the risks and benefits of that decision, or to communicate in any way. Your doctor and another physician or psychologist will decide if this is the case. As long as you are capable, you will be asked about decisions and your Advance Medical Directive will not be used.

### ***How should I choose a person to name as Agent for Health Care Decisions?***

You should name two people so that if the first is not available the second can serve. Choose someone who is willing to speak for you. Communicate your instructions and wishes to these people and to your family so that everyone understands your wishes. This can be done through talking, specific written instructions, or through a letter outlining your personal values, thoughts, and feelings. The law says the person you choose cannot make decisions that he or she knows are against your religious beliefs, basic values and stated preferences.

### ***Will my Advance Medical Directive be followed in an emergency when I can not make my wishes known?***

Emergency medical personnel, including rescue squads, cannot follow your wishes in an Advance Directive if they are called to help you in an emergency. In Virginia, under certain circumstances you may make decisions in advance about resuscitation (emergency medical help) if your heart or breathing stop. Ask your doctor about completing a "Durable Do Not Resuscitate Order," a form approved by the state, to make your wishes known to emergency medical personnel.

### ***If I die because I refused life-prolonging treatment, will my death be considered a suicide?***

No. The Health Care Decisions Act specifically says that, if an Advance Directive is followed and the patient dies, the death is not suicide and will not void a life insurance policy.

### ***Must I have an Advance Medical Directive?***

No, you are not required to complete an Advance Directive. An Advance Directive is one way of being sure your doctors and loved ones know what health care you want when you cannot tell them yourself. You may have one or both of the two types of Advance Directives. You may also provide your wishes orally in front of witnesses if you have a terminal condition. The law requires that health care providers not discriminate against people based on whether they have or do not have an Advance Directive.

### ***What happens if I cannot make decisions and I have no Advance Medical Directive?***

Virginia law lists persons who can make decisions about your medical care in the absence of an Advance Directive. The legal order of persons to make decisions is: court appointed guardian, spouse if divorce has not been filed, majority of adult children, parents, adult siblings, other relatives. If no listed person is available, a judge can decide what treatment is best. Virginia law does not recognize common law marriage.

### ***Do I need a lawyer to help me make an Advance Medical Directive?***

You do not need a lawyer to prepare an Advance Directive, but you may find it helpful, since this booklet is not intended as legal advice. The form in this booklet meets the requirements of the Virginia statute. Steps for completing Advance Directives are listed on the last page. Laws differ somewhat from state to state, so you need to learn about the laws in the state in which you primarily live. In Virginia the Advance Directive form does not need to be notarized. Copies can be made and the copies will be honored.

### ***What if I change my mind after I sign an Advance Medical Directive?***

You may revoke an Advance Directive at any time by completing a new one, by verbally stating your desire to revoke, or by destruction of your Advance Directive by you or at your direction. You should review your Advance Directive periodically to make sure it still reflects your wishes.

### ***How will my doctor know I have an Advance Medical Directive?***

All hospitals and health care facilities must ask patients if they have an Advance Directive and provide documentation of the form and/or its contents. It is your responsibility to give a copy to your doctor, hospital, and anyone else you think needs to know what medical treatment you do or don't want.

### ***What else should I know?***

Completing an Advance Directive is part of a process called Advance Care Planning. This includes understanding your medical condition and your choices for care; thinking about your beliefs, values, and goals for treatment; discussing these thoughts with family, friends, clergy, physician(s), agent; and then making a plan and providing copies as explained in this booklet. Review your plan annually to be sure it still reflects your wishes

### ***Where can I get more information about Advance Medical Directives?***

For more information or assistance you may speak with your physician, hospital staff, or lawyer. For assistance at Martha Jefferson Hospital, please call the Case Management Department at (434) 982-8475 or the Chaplain at (434) 982-8407. To voice concerns, contact the Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection at 1-800-955-1819. For more information about organ/tissue/eye donation, call LifeNet at 1-800-847-7831.

# VIRGINIA ADVANCE MEDICAL DIRECTIVE

I want to make my wishes known in advance in case I become unable to make an informed decision about my medical care. I, \_\_\_\_\_, willfully and voluntarily make known my desire and do hereby declare, as clear and convincing evidence of my wishes:

(Cross through this box and initial if you do not want to appoint an agent for future medical care.)

## Appointment of an Agent for Health Care Decisions (Medical Power of Attorney)

I hereby appoint the following as my primary agent to make health care decisions for me:  
(please print)

Primary agent name \_\_\_\_\_ Day phone \_\_\_\_\_

Address \_\_\_\_\_ Evening phone \_\_\_\_\_

If my primary agent is unavailable, unable or unwilling to make decisions for me, I appoint the following as my substitute agent.

Substitute agent name \_\_\_\_\_ Day phone \_\_\_\_\_

Address \_\_\_\_\_ Evening phone \_\_\_\_\_

As per Virginia law the powers of my agent include: (Cross through and initial any power you do NOT give your agent.)

- A. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication, and the use of mechanical or other procedures that affect any bodily function; including, but not limited to artificial respiration (being put on a respirator), artificially administered nutrition and hydration using an IV or feeding tube, and cardiopulmonary resuscitation (CPR). This includes the power to consent to amounts of pain-relieving medication in excess of recommended dosages in order to relieve pain, even if such doses may make me addicted or unintentionally hasten my death.
- B. To request, receive, and review any information, verbal or written, regarding my physical or mental health; and to consent to the use or disclosure of this information;
- C. To employ and discharge my health care providers;
- D. To make decisions regarding visitation;
- E. To consent to any participation in human research (clinical research) consisting of (1) therapeutic research and (2) non-therapeutic research that creates no more than a minor increase over minimal risk to me.
- F. To agree to my admission to or discharge from any hospital, hospice, nursing home, adult home or other medical care facility, other than for treatment of mental illness requiring admission procedures provided in Va. Code Section 37.1-63 et seq; and
- G. To take any lawful actions to carry out these decisions including granting releases of liability to those who provide my medical care.

## GUIDELINES FOR MY AGENT ABOUT MY TREATMENT CHOICES

*You are not required to provide any written instructions or make any selections. If you choose not to provide any instructions, your health care agent will make decisions based on his/her understanding of your wishes or what he/she considers to be in your best interest.*

(TURN TO OTHER SIDE OF THIS PAGE TO COMPLETE)

**My instructions about life prolonging treatment:** *(Initial only ONE box in this section.)*

- If it is reasonably certain that I will not recover my ability to be aware of myself or others or to interact with others, I want to stop or withhold **all** treatments that might prolong my existence. Treatments I would not want include tube feedings, IV fluids, CPR, respirator (breathing machine), kidney dialysis, antibiotics. **OR**
- I choose to continue treatment. I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. *(If you choose this option, please cross through and initial the Living Will portion below to avoid confusion about your instructions.)* **OR**
- I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

**My instructions about pain and symptom control:** *(Initial only ONE box in this section.)*

- I want pain medicine and symptom treatments to keep me comfortable, even if it means I am unable to interact with others. I want treatment for such things as shortness of breath, agitation, and seizures. **OR**
- I choose to forego all pain control measures. **OR**
- I choose to provide no written guidelines, directing my agent to make decisions based on my known values and wishes.

**Other instructions or limitations:** *(You may include any other instructions, such as stopping treatments after a certain amount of time if you are not getting better, or about any medical treatment, or about comfort care. You may include information about organ, tissue, or eye donation, religious or cultural considerations, autopsy, etc.)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIVING WILL PORTION OF ADVANCE MEDICAL DIRECTIVE**

*(Cross through this box and initial if you do not want to make a living will in this form.)*

If at any time my physician should determine that I have a **terminal\*** condition, where life-prolonging treatment would serve only to artificially prolong the dying process, I direct that all life-prolonging treatments be withheld or withdrawn, and that I be allowed to die naturally. I want pain medication and any other care needed to make me more comfortable. (\*Terminal means either (1) it is reasonably probable that I cannot recover and my death will occur very soon or (2) I am in a "persistent vegetative state" or permanently unconscious.) **OPTION:** I specifically direct that the following procedures or treatments be provided to me: \_\_\_\_\_

\_\_\_\_\_

This advance directive shall not terminate in the event of my disability. A copy of this advance directive may be provided to any physician or institution treating me. By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Witness \_\_\_\_\_ Witness \_\_\_\_\_

*(Witnesses must be adults and may not be persons you are appointing as agents for health care decisions.)*

## STEPS FOR COMPLETING THE ADVANCE MEDICAL DIRECTIVE FORM

1. Read this booklet carefully. Think about your values, beliefs, health, and goals for treatments.
2. Ask questions. Doctors, nurses, social workers, and chaplains can provide answers or assistance with completing the form. See page 3 for phone numbers. The Chaplain can also help with situations regarding spiritual, ethical and emotional concerns.
3. Choose an agent for health care decisions. Choose someone over 18 who will speak for you and be your advocate, who can ask questions of your doctors to get information needed to make decisions, and who can deal with stressful situations. When you select your agent, be sure to:
  - Ask this person if she/he is willing to accept this responsibility.
  - Talk to this person about your wishes for future medical treatment. Talking clarifies your wishes and keeps your agent from struggling about “doing the right thing.”
  - Ask your agent if he/she will make decisions according to your wishes even if they would not want to make the same choices you have made.
4. Complete any or all of the form and cross out any box that you do not wish to complete.
5. Sign and date the form. Your signature must be witnessed by two adults who are not being appointed as your health care agents.
6. Give a copy to your doctor, person you have named as Medical Power of Attorney, family, friends. Give a copy to hospital staff to place in your file. Keep a list of who has a copy. Keep the original in a safe place at home and tell those you live with where it is.
7. Complete the attached cards. Carry the *Notice to Health Care Providers* in your wallet. Give the *Being A Health Care Agent* card to the person you have chosen to speak for you.

Carry this card in your wallet. Please print full name.	<h3 style="text-align: center; margin: 0;">NOTICE TO HEALTH CARE PROVIDERS</h3> <p>I, _____ have executed an Advance Medical Directive dated _____.</p> <p>I have designated the following as my Medical Power of Attorney for Health Care:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____</td> <td style="width: 50%; border: none;">_____</td> </tr> <tr> <td style="text-align: center; border: none;">Primary Name</td> <td style="text-align: center; border: none;">Phone</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="text-align: center; border: none;">Secondary Name</td> <td style="text-align: center; border: none;">Phone</td> </tr> </table>	_____	_____	Primary Name	Phone	_____	_____	Secondary Name	Phone	A copy of this document is on file with: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">_____</td> <td style="width: 50%; border: none;">_____</td> </tr> <tr> <td style="text-align: center; border: none;">Name</td> <td style="text-align: center; border: none;">Phone</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="text-align: center; border: none;">Address</td> <td style="text-align: center; border: none;">City State Zip</td> </tr> <tr> <td style="border: none;">_____</td> <td style="border: none;">_____</td> </tr> <tr> <td style="text-align: center; border: none;">Signature of Declarant</td> <td style="text-align: center; border: none;">Date</td> </tr> </table>	_____	_____	Name	Phone	_____	_____	Address	City State Zip	_____	_____	Signature of Declarant	Date
_____	_____																					
Primary Name	Phone																					
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Secondary Name	Phone																					
_____	_____																					
Name	Phone																					
_____	_____																					
Address	City State Zip																					
_____	_____																					
Signature of Declarant	Date																					
Give this card to your primary health care agent.	<h3 style="text-align: center; margin: 0;">BEING AN AGENT FOR HEALTH CARE DECISIONS</h3> <p>To: _____ You have been chosen by _____ to be his/her health care agent. You may be asked to make medical decisions if the person becomes unable to make his/her own decisions. It is important to talk together so you will understand preferences for future medical care.</p>	The decisions you may be asked to make, according to this person’s stated wishes, basic values, and religious beliefs, include: <ul style="list-style-type: none"> <li>• To stop or start medical care or services, like tests, medicine and surgery;</li> <li>• To review and release medical records if needed and to move the person to another facility;</li> <li>• To decide which health professionals and organizations should provide care and who may visit;</li> <li>• To consent to any participation in human research or organ donation.</li> </ul>																				

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