Martha Jefferson Hospital

Charlottesville, Virginia
(434) 654-7000

TALKING ABOUT YOUR HEALTH CARE CHOICES

ADVANCE DIRECTIVE

INFORMATION, FORM AND GUIDELINES

Adults have a right to accept or refuse medical care. You have the legal right to make an advance directive. In the advance directive you can:

- name someone to make decisions for you
- tell others about your wishes for care you might need in the future
- help others make decisions the way you would if you could speak

What is an Advance Directive?

As long as you can make health care decisions for yourself, doctors must talk with you about what you want. But if you are injured or have a serious illness, you may become unable to make decisions. An advance directive is a document that lets your doctors, family and others know the health care you want and do not want.

If two physicians (or a physician and licensed clinical psychologist) determine you are incapable of making an informed decision, this document speaks for you. Your advance directive guides your loved ones and doctors in making decisions that you would want. You are not required to do this. All health care organizations must tell patients about these rights. This brochure provides information and a form you may wish to use.

Agent for Health Care Decisions

Section 1 of the advance directive names a person to speak for you if you can't speak for yourself. If you choose to name someone, this person is called an agent for health care decisions. It goes into effect any time you can't make treatment decisions for yourself. For example, you might have an accident or need medicine that makes you unconscious. Your agent speaks for you when you are expected to recover and can also speak for you at the end of life. Your agent's powers are listed in the advance directive form. The agent must make decisions based on your values to the degree they can be known. Naming an agent does not make that person liable for your hospital bills.

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Section 2 gives details of the *Powers of My Agent*. You are not required to give your agent all of these powers. Read each one carefully. New in 2009 are powers about overriding your protest of decisions and about clinical research. If there were any concerns or disagreements related to decisions while you were a patient at Martha Jefferson Hospital, we would involve our Ethics Consult Service to protect your rights. In Section 3 you can provide guidelines for your agent and your doctor about your treatment choices.

Living Will (End of Life Instructions)

Section 4 of the advance directive, called the living will, tells about care you do or do not want at the end of your life. It is used only if you have a terminal condition and are unable to speak for yourself. Terminal condition means you are expected to die soon. This may be because of an incurable condition in which death is expected within six months. It might also be a persistent vegetative state where you have no awareness of yourself or your surroundings. This is sometimes called a permanent coma. The living will provides instructions to allow death to occur naturally while having pain and comfort managed.

In this section you may provide specific instructions if death is imminent or if you are in a persistent vegetative state. This part of the advance directive is about health care, not about how your property is distributed after your death (that document is called a legal will). If you have a terminal condition you can legally tell your wishes orally instead of writing them down in an advance directive. Having the information in writing can prevent confusion or disagreements.

What are the benefits of an Advance Directive?

No one knows what may happen in the future. At some point, nearly everyone may need someone to make medical decisions for them. It is best to think ahead about your values, goals, and wishes. While you are not required to make an advance directive, choosing someone you trust and talking to them about your choices will help them direct your care. It is more likely that the decisions that are made about your health care will be what you would choose. Legally, no one can override decisions you have made known in an advance directive before you become unable to speak for yourself.

What happens if I do not have an Advance Directive?

Virginia law tells who will make decisions if you do not have an advance directive or a guardian appointed by the court. The order of who would make these decisions (surrogate) is: spouse, if divorce is not filed; majority of adult children; parents; adult siblings; other relatives. If no listed person is available to decide for you a judge might decide what treatment is best. Virginia law does not recognize common law marriage or life partnerships. Your partner would only be able to make decisions for you if named in an advance directive.

What if I don't know specifically what I want or how to say it?

You may let your agent make decisions for you. You may also write a letter about your values and beliefs. This letter could help loved ones and doctors make decisions on your behalf.

What are some kinds of decisions I should consider?

Your doctor can talk with you about your medical condition and treatment choices. Use of life-prolonging procedures is the most common decision to be made. These procedures include: cardiopulmonary resuscitation (CPR) to try to restart breathing and/or heartbeat; hydration (water) and nutrition by tube; use of respirators (machines that breathe for you); IV antibiotics, and kidney dialysis. Thinking about how long you would want these treatments continued if you were not getting better is also important. How long do you think it's reasonable to continue? It is very helpful to doctors and your family if you put these thoughts in your advance directive.

Another decision to think about is what treatments you would want for pain and other symptoms. Palliative care at any time and hospice care at the end of life are two methods of focusing on comfort. You may request these in your advance directive if you want that kind of care.

You may also think about options after your death. In Section Five you can provide information about your wishes to donate your eyes or organs or other tissue for transplant. You might want to donate your body for research or study. You might want an autopsy to help your doctor and family understand what happened to you.

Will having an Advance Directive affect my insurance? What about emergency care?

Health insurance and life insurance will not be affected by an advance directive. Refusing life-prolonging treatment will not void a life insurance policy. If an advance directive is followed and a patient dies, the death is not considered suicide. Emergency medical personnel such as rescue squads are required to provide emergency efforts to save your life. An advance directive cannot change this. If you do not want resuscitation attempted, talk to your doctor about a DDNR *(durable do not resuscitate)* order. This is a special doctor's order that says you will not get CPR if your heart or breathing stop. You may get other treatments but no efforts will be made to restart your heart.

How do I complete an Advance Directive?

A suggested form and instructions are included with this booklet. You do not need a lawyer but you might find one helpful. In Virginia the advance directive form does not need to be notarized. In Section 6 you must sign and date the form. Your signature must be witnessed by two adults (age 18 or older). Copies can be made and would be honored by health care providers. There is a wallet card for you to carry with you. Your Virginia advance directive will be honored in other states.

What if I change my mind?

You may cancel (revoke) or change your advance directive at any time. You should let everyone know your new wishes and destroy any old forms.

How will my doctor know I have an Advance Directive?

Our hospital staff must ask patients if they have an advance directive. If you give your advance directive to hospital staff, a copy is put in your medical record. The wallet card would let emergency providers know that you have an advance directive. When you complete an advance directive you should give copies to your agent, your family, and your doctor. You may give a copy to any hospital where you might receive care to put on file even if you have not been a patient there before.

What else should I know?
Filling out an advance directive is part of *advance care planning*. This process helps you:
- get information to understand your medical condition and choices for care;
- think about your beliefs, values, and goals for treatment;
- discuss these thoughts with family, friends, clergy, physicians, and agents;
- write down your plan as described in this booklet; and
- review your plan every year to be sure it still reflects your wishes.

Where can I go for more information?
For more information you may speak to your physician, hospital staff, or lawyer. If you have questions and want help in completing an advance directive, please call our Case Management Department at 434-654-8475 or our Chaplain at 434-654-8407. The Chaplain can help with situations regarding spiritual, ethical, and emotional concerns. The Ethics Consult Service is available to help resolve ethical dilemmas. Forms and information are available at www.marthajefferson.org.

For information about:
- Organ, tissue, or eye donation, call LifeNet at 1-800-847-7831.
- Donating your body to science, call State Anatomical Program at 1-804-786-2479.
- Durable DNR orders, call your physician or Virginia Office of EMS, 1-800-523-6019.
- Advance directive forms from other states visit the website www.caringinfo.org
- Virginia Health Care Decisions Act, see Virginia Code 54.1-2984 at http://leg1.state.va.us

Definitions according to Virginia Law:

The term ***"health care"*** means providing services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability, including but not limited to medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase ***"incapable of making an informed decision"*** means:
- unable to understand the nature, extent and probable consequences of a proposed health care decision;
- unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision; OR
- unable to communicate such understanding in any way.

STEPS FOR COMPLETING THE ADVANCE MEDICAL DIRECTIVE FORM

1. Read this booklet carefully. Think about your personal values, beliefs, health, and goals.
2. Ask questions. Hospital staff can help. See the preceding page for contact information. Read and consider each section. **Complete or cross off statements and provide information according to your wishes.**
3. SECTION 1 – Agent for health care decision - Choose someone over 18 who will speak for you if you are unable and will be your advocate or surrogate.
   - Ask this person if he or she is willing to accept this responsibility and if he or she will:
     - ask questions of your doctors to get the information needed to make decisions
     - make decisions according to your wishes even if he or she does not agree with your wishes
   - 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".
4. SECTION 2 - Powers granted to your agent (A-L).
   If you wish to grant to your agent the powers listed in subsection F and/or G, check these boxes and have your doctor sign the box indicated in the form.
5. SECTION 3 – Guidelines to your agent about your treatment choices.
6. SECTION 4 – Instructions about care at the end of life (living will)
7. SECTION 5 – Anatomical gift and autopsy instructions.
8. SECTION 6 - Sign and date the form. Your signature must be witnessed by two adults.
9. **Give a copy to your doctor (s), hospital (any hospital at which you might be a patient), agent, family, friends. Keep a list of who has a copy. Bring a copy to any hospital when admitted.**

10. Complete the attached *Notice to Health Care Providers* and put it with your driver's license or insurance card in your wallet.

11. Review your advance directive once a year. If your wishes, health, family status, and/or contact information change, complete a new form. Destroy any old forms.

Carry this card in your wallet.
Please print full name.

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NOTICE TO HEALTH CARE PROVIDERS

I, ______________________________ have an

Please print full name.

Advance Medical Directive and have named the following my agent for health care decisions:

Primary agent ______________________________

Phone numbers: ______________________________

Substitute agent: ______________________________

Phone numbers: ______________________________

FOLD HERE WITH THIS SIDE OUT.

FOLD HERE WITH THIS SIDE OUT

A copy of this document is on file with Name/Address or Hospital.

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My doctor's name and phone number:

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Carry this card in your wallet. Add comments or details on the back.

Martha
Jefferson Hospital

Charlottesville, Virginia
(434) 982-7000

If you have questions about the Advance Medical Directive, call:
Case Management - (434) 654-8475
Chaplain - (434) 654-8407

VIRGINIA ADVANCE MEDICAL DIRECTIVE

Brief Explanation – For more information see "Talking About Your Health Care Choices"

- *You have the right to name someone to make health care decisions for you if you are unable to make them for yourself.*
- *You have the right to give instructions about what types of health care you want or do not want.*
- *You may use this whole form or any part to tell your wishes.*
- *To be legal, this form must be signed and dated and two adults must sign as witnesses to your signature.*

I, ______________________________, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision.
(Please print first, middle, last name.)

You may complete any or all of the sections and add comments. Cross off and initial anything that does not apply to your wishes.

Section 1: APPOINTMENT OF AN AGENT FOR HEALTH CARE DECISIONS

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document: *(please print)*

Primary agent name ____________________ Day/cell phone ____________________

Address ______________________________ Evening phone ____________________

Email: ______________________________ Relationship to patient ______________

If my primary agent is not reasonably available or is unable or unwilling to make health care decisions for me, I appoint the following person as my substitute agent.

Substitute agent ______________________ Day/cell phone ____________________

Address ______________________________ Evening phone ____________________

Email: ______________________________ Relationship to patient ______________

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Section 2: POWERS OF MY AGENT

Cross through and initial any powers you do NOT want to give your agent. The powers of my agent include:

TREATMENT

A. **To consent to, or refuse or withdraw consent to**, any type of health 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, artificially administered nutrition and hydration, and cardio-pulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastening my death or is in excess of commonly recommended dosages;

HEALTH RECORDS AND PROVIDERS

B. **To request, receive and review any information** (whether verbal, written, printed or electronically recorded) regarding my current physical or mental health, including but not limited to medical, hospital and other records; and to consent to the disclosure of such information for medical or insurance purposes;

C. **To employ and discharge** my health care providers;

ADMISSION and DISCHARGE

D. To authorize my **admission to or discharge** from any hospital, hospice, nursing home, assisted living **facility or other medical care facility for services other than treatment of mental illness.** Admission for mental health treatment is listed as a separate power below.

E. To authorize my **admission to a health care facility for the treatment of mental illness** for no more than 10 calendar days provided that **I do not protest** the admission and provided that a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

F. To **authorize my admission to a health care facility for the treatment of mental illness** for no more than 10 calendar days, **even if I protest**, if a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility. *(If you give your agent the power described in this subsection F, your physician* ***must*** *sign the box at the end of this section.)*

Powers continued on page 3

*Name (Please print first, middle and last)*______________________________

Section 2, Powers of My Agent Continued

WISHES ABOUT SPECIFIC TREATMENTS

G. To authorize the following specific types of health care identified in this advance directive **even if I protest**. ______________________________

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(If you give your agent the power described in this subsection G, your physician must sign the box at the end of this section.)

RESEARCH

H. To authorize my participation in any health care study approved by an institutional review board or research review committee if the study **offers the prospect of direct therapeutic benefit to me.**

I. To authorize my participation in any health care study approved by an institutional review board or research review committee that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though the study **offers no prospect of direct benefit to me.**

VISITATION

J. To make decisions about **who may visit me**, subject to physician orders and policies of any institution to which I am admitted. Specific requests: ______________________________

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OTHER POWERS

K. **To continue to serve as my agent even if I protest** the agent's authority after I have been determined to be incapable of making an informed decision; (If incapacitated patients at Martha Jefferson Hospital protest their agent's authority, we will involve the Ethics Consult Service to protect patient rights.)

L. To take any **lawful actions** that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

Add here any additional powers you give your agent, limits you impose on your agent or other information to guide your agent. ______________________________

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If you wish to provide the powers listed in subsection F and/or G above, check these boxes and have your doctor sign this. If incapacitated patients at Martha Jefferson Hospital protest their agent or treatment decisions, we will involve our Ethics Consult Service. ❒ F ❒ G

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

Physician Signature______________________________ Date_______________

Physician Name Printed ______________________________

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Section 3. GUIDELINES FOR MY AGENT ABOUT MY TREATMENT CHOICES

If you choose not to provide any instructions, your health care agent will be obligated to make decisions based on his/her understanding of your wishes or what he/she considers to be in your best interest. ***You are not required to make any selections. You may cross through this section and initial if you wish.***

MY INSTRUCTIONS ABOUT CARE IF I HAVE A SERIOUS ILLNESS OR INJURY.

Initial ONLY ONE box in this section.

If my illness or injury is life threatening:

- ❒ I choose to provide no written guidelines. My agent should make decisions based on my known values and wishes. **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. I understand that my physician has the responsibility to inform my agent when he/she judges that these limits have been reached. At that time, any instructions in Section 4 would be followed. **OR**
- ❒ If it is reasonably certain that I will not recover my ability to be aware of myself or to interact with others, I want to stop or withhold all treatments that might prolong my existence. I would not want tube feedings, IV fluids, CPR, respirator (breathing machine), kidney dialysis, or antibiotics. Only treatment for relief of distressing symptoms (palliative treatment) may be continued.

I consider _________________________ to be a suggested time after which such care should be stopped. The exact time period is at the discretion of my agent in consultation with my physician. **You do not have to suggest a time. If you do not wish to suggest a time, you may cross through this paragraph.**

Other health care instructions: *You may add statements about care that you want to receive, if medically appropriate, or list care that you do not want under any circumstances.*

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Section 4. INSTRUCTIONS ABOUT END OF LIFE CARE (LIVING WILL)

Cross through and initial this section if you do not want to give instructions about your health care if you have a terminal condition (death is imminent or you are in a persistent vegetative state).

If at any time my attending physician should determine that I have a terminal condition where using life- prolonging procedures (including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration) would serve only to prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. Other instructions: You may include wishes about certain medical treatments, hospice care, and/or statements about moral and religious beliefs that affect your care.

continued on page 5

*Name (Please print first, middle and last)*____________________________________

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

Section 5. ANATOMICAL GIFTS and AUTOPSY

Cross through and initial this section if you do not want to give instructions.

You have the right to decide whether or not to donate any part of your body after you die. No one has the legal right to go against your stated wishes. Wishes for organ donation may be made in this section of the document, through the Department of Motor Vehicles, or on the LifeNet website www.save7lives.org.

Please initial the boxes to indicate your directions.

- ❒ Upon my death I do NOT want an anatomical gift to be made. **OR**
- ❒ Upon my death, I direct that an anatomical gift be made as follows, according to Virginia law.

I wish to donate for transplant to other patients:

- ❒ any needed organs ❒ tissues such as skin or bones
- ❒ corneas from the eyes **OR**

- ❒ I wish to donate my body for research or educational programs.

I understand that my physician might request an autopsy after my death. If this request is made my preference would be:

- ❒ I do not give permission for autopsy ❒ I do give permission for autopsy
- ❒ I want my agent to decide

Section 6. SIGNATURE

You must complete this section.

This advance medical directive shall not terminate in the event of my disability. A copy of this advance medical directive may be provided to any physician or institution treating me. By signing below, I indicate that I am emotionally and mentally capable of making this advance medical directive and that I understand the purpose and effect of this document. I understand that I may revoke all or part of the document at any time by destroying this form or creating a new advance medical directive.

Signature ________________________________ Date _______________

Address__________________________________ Date of Birth __________

I have seen this person sign this advance medical directive in my presence.

Witness _________________________ Witness ________________________

(Witnesses must be adults. We suggest that they not be the persons you are appointing as your agents for health care decisions.)

If you wish, you may provide more details about any section in this space.