# Advance Health Care Directives: Living Will & Health Care Power of Attorney

**In Pennsylvania, adults have the right to decide if they want to accept, refuse or stop medical treatment.**

An Advance Health Care Directive, and/or an Advance Directive for Mental Health Care, allows you to designate persons to make health care decisions for you and allows you to state your wishes regarding medical treatment so they may be carried out if you become unable to make health care decisions or communicate your wishes. An Advance Directive may be a health care power of attorney, a living will, or a written combination of both.

## Why Prepare an Advance Directive?

An Advance Directive is a valuable tool that:

- Allows you to choose the persons you want to make health care decisions for you
- Helps protect your right to make medical choices that can affect your life
- Allows your family to know and understand your wishes
- Gives your doctor guidelines for your care
- Allows you to give special directions to your health care providers on topics such as pain relief
- Allows you to indicate your desire to forego certain life prolonging treatment (breathing machines, feeding tubes, dialysis), when there is little or no chance of recovery

## Common Questions

**Will my Advance Directive be used if I am able to make my own health care decisions?**

No. As long as you are able, you will make your own health care decisions.

**What is a Living Will?**

A Living Will is a written document that expresses your wishes and instructions for health care if you are in an end of life situation and you are unable to make or communicate your own decisions.

**When will my Living Will take effect?**

A Living Will only takes effect when:

- your doctor has a copy of it, and
- your doctor has concluded that you are unable to make or communicate your own medical decisions or you are unable to understand the benefits, risks and alternatives of suggested treatment, and
- your doctor has determined that you are in an end-stage medical condition or in a state of permanent unconsciousness

**Is my Living Will effective if I am pregnant?**

Pennsylvania law usually does not allow a doctor or health care provider to honor a Living Will of a pregnant woman if she has chosen not to prolong life.

The terms of a Living will may be honored if the woman's doctor determines that life-sustaining treatment:

- will not maintain the woman in a manner that will allow for the continued development and birth of the unborn child; or
- will physically harm the pregnant woman; or
- will cause her pain which could not be relieved by medication

**What is a Health Care Power of Attorney?**

This legal document allows you to name a person or persons to make health care decisions on your behalf if you become unable to make decisions for yourself. The person you name in a Health Care Power of Attorney is sometimes referred to as your "agent" or "proxy." A Health Care Power of Attorney also typically gives the agent the power to receive medical information regarding your care, to authorize your admission or discharge from a medical facility, and to authorize medical and surgical procedures.

**When will my Health Care Power of Attorney take effect?**

A Health Care Power of Attorney becomes operative when:

- your doctor has a copy of it, and
- your doctor determines that you are unable to make or communicate your own medical decisions and understand your treatment options

How will my health care decisions be made if I have no Advance Directive, or if the person I have named as my agent is unavailable or unwilling to act?

If you have no written Advance Directive, or if the person you have named to make decisions for you is unavailable or unwilling to act, you may still designate an adult individual to serve as your health care representative by a signed writing or by simply telling your doctor or other health care providers involved in your care.

If you become unable to make your own decisions, the hospital will look to this person for your health care decisions.

If you have no written Advance Directive and you do not name a health care representative, the law provides the following priority list indicating who may act as your health care representative to make decisions for you if you become unable to make them for yourself:

1. Your spouse (unless a divorce is pending) and your adult children from a prior spouse
2. Your adult children
3. Your parents
4. Your adult brothers and sisters
5. Your adult grandchildren
6. Any adult friend with knowledge of your preferences and values (including your religious and moral beliefs)

If the person with higher priority is unavailable or unwilling to act, the hospital will look to the next category of persons on the list. If there is more than one qualified person in a group, a majority of the members of that group must agree on a decision. If the qualified members of a group are evenly split, the dispute must be resolved before a decision can be made.

If you are of sound mind, you may change the order of priority in a signed writing, such as a Health Care Power of Attorney. You also may disqualify anyone from serving as your health care representative simply by telling your health care provider or by a signed writing.

Chambersburg Hospital and Waynesboro Hospital each have an Ethics Committee to help patients and their families. If you need to discuss an ethical issue regarding your care, tell your health care provider or call (717) 267-7156 at Chambersburg Hospital, and (717) 765-4000, ext. 5323, at Waynesboro Hospital.

Please note, however, if your doctor or staff member feels your wishes conflict with their own values or professional judgment, they may seek another caregiver for you who is able and willing to comply with your wishes.

**What is an Advance Directive for Mental Health Care?**

Pennsylvania law allows you to create a Mental Health Declaration and/or a Mental Health Power of Attorney. A Mental Health Declaration is a written document that expresses your wishes and instructions regarding mental health care, such as your choice of treatment facility, your preferences regarding medications for psychiatric treatment, and the type of interventions you would prefer in a crisis. A Mental Health Power of Attorney allows you to designate persons to make mental health care decisions for you.

If you suffer from a mental illness or if you wish to give your agent the right to authorize mental health treatment, you may want to indicate that in a Mental Health Declaration and/or a Mental Health Power of Attorney. Both a Mental Health Declaration and a Mental Health Power of Attorney automatically terminate two years after being signed.

**What if I change my mind?**

You may revoke (discontinue) an Advance Directive at any time. Simply inform your doctor or health care provider that you are revoking the document or sign a written document stating that you are revoking your Advance Directive.

If you want to change your Advance Directive, you should sign a new document and destroy all copies of your old document. Give a copy of the new Advance Directive to your doctor and to anyone else who had a copy of your old document.

**What about organ and tissue donation?**

You can donate specific organs or your entire body through your Living Will.

**What is a general power of attorney?**

This legal document designates one or more persons who have authority to handle your affairs. A general power of attorney typically refers to financial matters, but may include some medical decision-making authority such as the ability to authorize your admission to a medical facility or the power to consent to certain medical treatment on your behalf.

Consulting with an attorney can help ensure this document is sufficiently specific to meet your needs.

## Steps to Complete an Advance Directive

1. You can use any form as long as it is dated and signed by you and two witnesses. A sample form that combines a Living Will and a Health Care Power of Attorney is attached.
2. If you are unable to sign, you may have someone else sign on your behalf. This person should not be one of your witnesses and also should not be the person named as your agent (if any).
3. Give your doctor a copy of your Advance Directive for your medical record.
4. Discuss your Advance Directive with your loved ones, especially the person you have named as your agent (if any). Be sure to give them copies, too.
5. Give copies of your Advance Directive to someone likely to be contacted in an emergency.
6. Review your Advance Directive regularly, and make any changes you think are necessary. Make sure you provide your doctor, your family and your agent (if any) with an updated copy.
7. If you live outside of Pennsylvania, make sure your Advance Directive is consistent with Pennsylvania law.

If you have additional questions about preparing an Advance Directive, ask your doctor, attorney or caregiver for additional information.

# ADVANCE HEALTH CARE DIRECTIVE

**DURABLE HEALTH CARE POWER OF ATTORNEY**

I, _____, of _____ County, Pennsylvania, appoint the person named below to be my health care agent (proxy) to make health and personal care decisions for me when I lack the ability to understand, make or communicate a decision, as verified by my attending physician.

My health care agent has all of the following powers subject to the health care treatment instructions in my living will (cross out any powers you do not want to give your health care agent):

1. To receive medical information relevant to my health care.
2. To authorize, withhold, or withdraw medical care and surgical procedures.
3. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
4. 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 palliative care.
5. To hire and fire medical, social service, and other support personnel responsible for my care.
6. To take any legal action necessary to do what I have directed.
7. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

Name of health care agent: _____

Address and phone number: _____

_____

Name of alternate health care agent: _____

Address and phone number: _____

_____

**LIVING WILL DECLARATION**

I, _____, being of sound mind, willfully and voluntarily make this declaration regarding my health care treatment under certain circumstances. The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when my attending physician determines that I lack the capacity to understand, make, or communicate my health care decisions.

If I have an end-stage medical condition, which will result in my death, despite the introduction or continuation of medical treatment, or I am in a state of permanent unconsciousness such as an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, I direct that I be given health care treatment to relieve pain and provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming. I direct that all life prolonging procedures be withheld or withdrawn, and I feel especially strongly about the following as life prolonging procedures:

I ❑ do ❑ do not want heart-lung resuscitation (CPR).

I ❑ do ❑ do not want mechanical respiration (breathing machine or ventilator).

I ❑ do ❑ do not want dialysis (kidney machine).

I ❑ do ❑ do not want surgery.

I ❑ do ❑ do not want chemotherapy.

I ❑ do ❑ do not want radiation treatment.

I ❑ do ❑ do not want antibiotics.

I ❑ do ❑ do not want tube feeding, where nutrition (food) or hydration (water) is medically supplied by a tube into my nose, stomach, intestine, arteries, or veins.

My instructions regarding anatomical gifts are:

I ❑ do ❑ do not want to donate my organs and tissues at the time of my death for the purpose of transplant, medical study, or education, subject to the following limitations, if any:

**SIGNATURE**

I have signed this Advance Health Care Directive on this date: _____

_____

(Sign your full name here)

Witness' signature: _____

Witness' signature: _____

(Two witnesses at least eighteen (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 your behalf and at your direction may not be a witness. It is preferable if the witnesses are not your heirs, nor your creditors nor employed by any of your health care providers.)

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
To follow these orders, an EMS provider must have an order from his/her medical command physician

pennsylvania DEPARTMENT OF HEALTH

# Pennsylvania Orders for Life-Sustaining Treatment (POLST)

Last Name

First/Middle Initial

Date of Birth

**FIRST** follow these orders, **THEN** contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

**A** Check One

**CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.**

☐ CPR/Attempt Resuscitation ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

**B** Check One

**MEDICAL INTERVENTIONS: Person has pulse and/or is breathing**.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

***Transfer*** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

***Transfer*** *to hospital if indicated. Includes intensive care.*

*Additional Orders* _____

**C** Check One

**ANTIBIOTICS:**

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal

☐ Use antibiotics if life can be prolonged

*Additional Orders*

**D** Check One

**ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:**
Always offer food and liquids by mouth if feasible

☐ No hydration and artificial nutrition by tube.

☐ Trial period of artificial hydration and nutrition by tube.

☐ Long-term artificial hydration and nutrition by tube.

*Additional Orders*

**E** Check One

**SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:**

Discussed with
☐ Patient
☐ Parent of Minor
☐ Health Care Agent
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Other:

**Patient Goals/Medical Condition:**

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

| Physician /PA/CRNP Printed Name: | Physician /PA/CRNP Phone Number |
|---|---|
| Physician/PA/CRNP Signature (Required): | DATE |

Signature of Patient or Surrogate

| Signature (required) | Name (print) | Relationship (write "self" if patient) |
|---|---|---|
| | | |

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

**Other Contact Information**

| Surrogate | Relationship | Phone Number | |
|---|---|---|---|
| Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared |

## Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. www.health.state.pa.us

### Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary

### Using POLST

If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation"

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment.

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

### Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

### Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write "VOID" in large letters across the form, and sign and date the form.