ADVANCE HEALTH CARE DIRECTIVES

Your Right to Decide
About Your Health Care

Beebe Healthcare

Updated: December 2016

Beebe Healthcare

Dear Friend of Beebe Healthcare:

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

Because medical decision-making is such a personal matter, and because many states have varying laws regarding the topic, many aspects are still a matter of legal interpretation. Beebe encourages you to learn as much about Advanced Directives as possible. You can contact the Division of Aging at 800-223-9074, 302-391-3505 (TDD) or DelawareADRC@state.de.us. You may also consult your personal attorney.

If you have a question about our policy or would like assistance completing your Advanced Directive, contact the Beebe Patient Advocate at 302-645-3547. When you have completed this document, we ask that you make additional copies for your physicians, family members, clergy, etc.

Beebe Healthcare encourages generosity through organ and tissue donation, please contact Gift of Life Donor Program at 800-366-6771 or visit their website at www.donors1.org for more information.

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

Sincerely,

Jeannie Briley-Wallo RN
Director, Patient Experience

Ercilia Arias, M.D.
Chair, Bioethics Committee

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ADVANCE HEALTH CARE DIRECTIVE

YOUR RIGHTS TO DECIDE ABOUT YOUR HEALTH CARE

Who decides what health care I get?

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

What if my medical condition makes me unable to decide?

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

What is an Advance Health Care Directive?

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

1) Instruction for Health Care Decisions (Living Will)
2) A Power of Attorney for Health Care

An **Instruction for Health Care Decisions**, previously referred to as a living will, is a written statement of your wishes about health care treatment. It includes your wishes for treatment when you are terminally ill, permanently unconscious or suffer from serious illness or frailty.

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

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

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

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

Where should I keep my Advance Health Care Directive?

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

What if I change my mind?

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

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

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

What happens if I make no Advance Health Care Directive?

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

1) The spouse, unless a petition for divorce has been filed; or unless the patient has filed a petition or complaints alleging abuse;
2) An adult child;
3) A parent;
4) An adult brother or sister;
5) An adult grandchild;
6) An adult niece or nephew;
7) An adult aunt or uncle.

If none of these family members are available to make health decisions for you, a close friend who is willing to become involved with your healthcare, who has maintained regular contact with you and is familiar with your activities, health, personal values, and morals may make decisions by executing and presenting to the healthcare provider an affidavit attesting to the above.

If no qualifying close friend is available, a guardian may be appointed by the Court.

Advance Health Care Directive
of

GENERAL INSTRUCTIONS

You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, you should strike the wording of that decision rather than leave it blank. You may not change the qualifications for witnesses or agents, even if you cross out the wording. You should write legibly.

You should retain your original Advance Health care Directive, and give copies to your doctor, agent, spouse, family members, and close friends, if you desire. You should explain to each person who receives a copy of your health care directive what choices you made on the form, and why. This will help if, while you lack capacity, there arises a need to make a health care decision that is not explicitly set forth on your advance health care directive form.

This form does not contain all of the types of health care decisions you are legally entitled to make. For example, the form does not give you the opportunity to nominate a guardian, in the event you become incompetent and need one. Also, the form does not give you the opportunity to designate a primary care physician, or another person, to certify that you lack the capacity to make your own decisions on health care. Finally, the form does not include a provision that accommodates a person's religious or moral beliefs. If you would like to exercise these options, you should talk to an attorney. If anything on the form conflicts with your religious beliefs, you should contact your clergy.

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. These instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." "Qualifying conditions" include serious illness or frailty, a terminal condition or permanent unconsciousness. If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces on the following page. You may cross out any wording you do not want.

A. END OF LIFE INSTRUCTIONS

1. Choice to Prolong Life

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

OR

2. Choice Not to Prolong Life

_____I do not want my life to be prolonged if my physician determines that: (please check all that apply)

____ (i) I have a **terminal condition** (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

_____ (ii) I become **permanently unconscious** (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

_____ (iii) I have a **serious illness or frailty** (means you have a condition in which a health care practitioner would not be surprised if you died within the next year.) In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

B. RELIEF FROM PAIN: Whether I choose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

C. OTHER MEDICAL INSTRUCTION: If you wish to add to the instructions you have given above, you may do so here.

_____

_____

_____

_____

_____

_____

(Use additional sheets if necessary)

PART II: POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions except the withholding or withdrawal of life sustaining procedures unless you are in a **qualifying condition**. (See Part I) You may appoint an alternate agent to make health care decisions for you if your first agent is not willing, able and reasonably available to make decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care. If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I designate_____ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate _____ as my agent to make health care decisions for me.

Agent_____
(Name of individual you choose as agent)

_____
(Address) (City) (State) (Zip code)

_____ _____
(Home phone) (Work phone)

Alternate Agent_____
(Name of individual you choose as alternate agent)

_____
(Address) (City) (State) (Zip code)

_____ _____
(Home phone) (Work phone)

B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent.

Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, except the withholding or withdrawal of life sustaining procedures unless I am in a qualifying condition. (See Part I);
2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
5. To hire and fire medical, social service, and other support personnel responsible for my care; and
6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part I of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent. To the extent that the agent knows or is able to determine, the agent's decision is to take into account, including, but not limited to, the following factors if applicable:

1. The patient's personal, philosophical, religious and ethical values;
2. The patient's likelihood of regaining decision making capacity;
3. The patient's likelihood of death;
4. The treatment's burdens on and benefits to the patient; and
5. Reliable oral or written statements previously made by the patient, including, but not limited to, statements made to family members, friends, health care providers or religious leaders.

EFFECT OF COPY: A copy of this form has the same effect as the original. I understand the purpose and effect of this document.

If you have chosen to be an organ and tissue donor, offering the gift of life to others, please inform your Power of Attorney for Health Care. If you would like to know more about the potential benefits of organ and tissue donation and learn about the Gift of Life Donor Program, please call 1-800-DONORS1, (800-366-6771) or visit http://www.donors1.org.

SIGNATURES

(Date) _____ (Sign your name) _____ (Print your name) _____

(Street address) _____

(City, state, zip code) _____

STATEMENT OF WITNESSES

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

A. The Declarant is mentally competent.
B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. Neither of us:
    1. Is related to the declarant by blood, marriage or adoption;
    2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
    3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
    4. Has a direct financial responsibility for the declarant's medical care;
    5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or
    6. Is under eighteen years of age.
C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness

(Print name) _____

(Street address) _____

(City, state, zip code) _____

(Signature of witness) (Date) _____

Witness

(Print name) _____

(Street address) _____

(City, state, zip code) _____

(Signature of witness) (Date) _____

NOTARY (Optional)

Sworn and subscribed to me this _____ day of _____.

My term expires: _____ _____ (Notary)