Advance Directives

"Your Right to Decide"

Purpose

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

The Importance of Advance Directives

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

What is an Advance Directive?

"Advance Directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives. Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf. Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

Are Advance Directives Required?

Advance Directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

What Happens if You Do Not Have an Advance Directive?

If you do not have an advance and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

What Types of Advance Directives Are Recognized in Indiana?

- Talking directly to your physician and family.
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric Advance Directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney.

Talking to Your Physician and Family

One of the most important things to do is talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing them with your physician, he or she will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician so that he may place it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitations (CPR), your physician will need to write a “do not resuscitate” (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have

several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important that you discuss your wishes with you family and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in during an emergency. They are the best source of providing advance directives to a health care provider.

Organ and Tissue Donation

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found in Indiana Code 29-2-16. A person that wants to donate organs may include their choice in their will, living will, on a card or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

Health Care Representative

A "health care representative" is a person you choose to receive health care information and to make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act found in Indiana Code 16-36-1. The advance directive naming a health care representative must be in writing, signed by you and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

Living Will

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator and blood transfusions. The Indiana Living Will Act is found at Indiana Code 16-36-4. This law allows you to write one of two kinds of advance directives:

Living Will Declaration: This document tells your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatment used to extend your life.

Both of these documents can be cancelled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell you physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone who has permission to sign your name in your presence.

Psychiatric Advance Directive

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code 16-36-1.7 provides the requirements for this type of advance directive.

Out of Hospital Do Not Resuscitate Declaration and Order

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are home when an emergency occurs, there is no medical chart or physician's order. For situations outside of a hospital or health facility, the "Out of Hospital Do Not Resuscitate Declaration and Order" is used to state your wishes. This order is found at Indiana Code 16-36-5. The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital or a health facility. This declaration may override other advance directives. This declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document or by communicating to heath care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

Power of Attorney

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority or both. By giving this power to another person, you give this person your power of attorney.

The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

- Name the person you want as your attorney in fact;
- List the situations which give the attorney in fact the power to act;
- List the powers you want to give; and
- List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

- Make choices about your health care;
- Sign health care contracts for you
- Admit or release you from hospitals or other health facilities
- Look at or get copies of your medical records; and
- Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

Which Advance Directives Should be Used?

The choice of advance directives depends on what you are trying to do. The advance directives listed may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

Can I Change My Mind After I Write an Advance Directive?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

Are There Forms to Help in Writing These Documents?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed.

What Should I Do with My Advance Directive if I Choose to Have One?

Make sure that your health care representative, immediate family members, physician, attorney and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to him or her. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located and who to contact for your attorney in fact or health care representative, if you have named one.

Final Thoughts About Advance Directives

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.
- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.
- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.
- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

Disqualification of Persons to Consent to Healthcare

I,_____ disqualify the following individuals, who may be able to consent to my healthcare under IC 16-36-1-5, from consenting to my healthcare in the event that I am unable to consent to my own healthcare.

_____

The above-named individuals are not authorized to consent to my healthcare in the event that I have not appointed a Healthcare Representative under IC 16-36-1-7 or my appointed Healthcare Representative is unwilling or unable to act on my behalf.

Any remaining authorized persons under IC 16-36-1-5 must try to discuss my healthcare decisions with me prior to consenting to the healthcare. However, I if I am unable to communicate, any authorized persons may make such a decision for me, after consultation with my physician or physicians and other relevant healthcare givers.

This disqualification is to be exercised in good faith and in my best interest subject to the following terms and conditions (if any):

_____

This Disqualification of a Person to Consent to Healthcare of patient supercedes and revokes any and all prior disqualifications.

Dated this _____ day of _____(month, year)

Signature _____

Printed _____

Address _____

_____

I declare that I am an adult at least 18 years of age and that, at the request of the above-named individual making the appointment, I witnessed the signing of this document by the above-named individual or a person authorized to sign on his or her behalf on the date noted above.

Witness Signature _____

Printed _____

Address _____

_____

Living Will Declaration

Declaration made this _____ day of _____(month, year).
I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:
If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care and to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.. (Indicate your choice by initialing or making your mark before signing this declaration):
_____I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.
_____I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.
_____I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my healthcare representative appointed under IC16-36-1-7 or my attorney in fact with the healthcare powers under IC 30-5-5.
In absence or my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of my refusal.
I understand the full import of this declaration. This living will supercedes and revokes any and all prior living wills.

Signed_____

City, County, and State of Residence _____

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

Life-Prolonging Procedures Declaration

Declaration made this _____ day of _____(month, year).
I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if, at any time I have an incurable injury, disease or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication and the performance of all other medical procedures necessary to extend my life, to provide comfort care or to alleviate pain.
In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.
I understand the full import of the declaration.

Signed_____

City, County, and State of Residence _____

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

Appointment of a Healthcare Representative

I, _____voluntarily appoint _____,

Whose telephone number and address are: _____

_____,

As my healthcare representative who is authorized to act for me in all matters of healthcare in accordance with I.C. 16-36-1-7 and I.C. 30-5 et. seq., except as otherwise specified below.

I authorize my healthcare representative to make decisions in my best interest concerning withdrawal or withholding of healthcare. If at any time, based on my previously expressed preference and the diagnosis and prognosis, my healthcare representative is satisfied that a certain healthcare is not or would not be beneficial, or that such healthcare is or would be expressly burdensome, then my healthcare representative may express my will that such healthcare be withheld or withdrawn and may consent on my behalf that any and all healthcare be discontinued or not instituted, even if my death may result.

My healthcare representative must try to discuss this decision with me. However, if I am unable to communicate, my healthcare representative may make such a decision for me, after consultation with my physician or physicians and other relevant healthcare givers. To the extent appropriate, my healthcare representative may also discuss this decision with my family and others to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions (if any):

This appointment becomes effective and remains effective if I am incapable of consenting to my healthcare. I do authorize my healthcare representative hereby appointed to delegate decision-making power to another. This appointment supercedes and revokes any and all prior powers and appointments.

Dated this _____ day of _____(month, year)

Signature _____

Printed _____

Address _____

I declare that I am an adult at least 18 years of age and that, at the request of the above-named individual making the appointment, I witnessed the signing of this document by the above-named individual or a person authorized to sign on his or her behalf on the date noted above.

Witness Signature _____

Printed _____

Address _____