Durable Power of Attorney for Health Care Choices and Health Care Choices Directive

Community Alliance for Compassionate Care

51092-000 01-01 REV 06-02

Community Alliance for Compassionate Care

Vision

Foster a supportive community to improve the quality of life's end for dying persons, their families and friends, and promote a healthy bereavement experience.

Goals

- A community that recognizes the dying process as a natural part of life and supports those affected in the context of cultural differences.
- A community that finds meaning in the dying process.
- A community that respects informed personal choices at life's end.
- A community that facilitates healthy grieving.

Core Values

- That death is part of the natural life process.
- That support from family, friends and community will reduce the sense of isolation and suffering often experienced at the end of life.
- That the fears, hopes, life stories, faith and dignity of individuals must be respected during the dying process.
- That developing a meaningful view of death requires the cooperation of diverse elements of society — the medical community, work environment, faith communities and educational institutions.

Community Alliance
for Compassionate Care at the End of Life:
PO Box 5067
Springfield, MO 65801-5067
417-865-4501

This booklet was developed and written by the members of the Community Alliance for Compassionate Care at the End of Life as a public service. It is not intended to provide legal or medical advice. The booklet may be used as a resource if you choose to consult with legal or other professionals.

The members of Community Alliance for Compassionate Care at the End of Life are grateful to the following institutions and organizations for working with the Alliance in support of this document.

AIDS Project of the Ozarks
Alzheimer's Association, Southwest Missouri Chapter
Back to Basics Therapeutic Massage, Springfield
Cedar County Memorial Hospital, El Dorado Springs
Community Hospices of America, Southwest Missouri
Cox Health System, Springfield
- Lester E. Cox Medical Centers North
- Lester E. Cox Medical Centers South
- Cox Walnut Lawn
- Cox Regional Physician Services
- Hulston Cancer Center
- Primrose Place
- Oxford Home Health
- Cox Monett Hospital, Monett

McCune-Brooks Hospital, Carthage
Missouri Department of Health, Southwest District #5
Missouri Nurses Association, 4th District
Nevada Regional Medical Center, Nevada
Ozarks Medical Center, West Plains
Ozark Riverview Manor, Ozark
Riverview Residential Place, Ozark
St. John's Health System, Springfield
- Aurora Community Hospital, Aurora
- Breech Regional Medical Center, Lebanon
- Carroll Regional Medical Center, Berryville, AR
- Ozarks Health Services, Rolla
- Premier Health Plans
- St. John's HospiceCare
- St. John's Mercy Villa
- St. John's Mid-America Cancer Center
- St. John's Physicians
- St. John's Premier Plus
- St. John's Regional Health Center
- St. John's Visiting Nurse Association
- St. Francis Hospital, Mountain View
- South Barry County Hospital, Cassville

St. John's Regional Medical Center, Joplin
- St. John's Homecare/Hospice

Skaggs Community Health Center, Branson
- Skaggs Professional Home Care
- Skaggs Professional Hospice

Southwest Center for Independent Living
Springfield/Greene County Health Department
Springfield Public Schools
Springfield Residential & Skilled Care Center
Texas County Memorial Hospital, Houston
- Home Health of the Ozarks
- Hospice of Care

Health care facilities that adopt this document and would like their names to appear on the list above should contact the Community Alliance.

Copies of this document can be downloaded free of charge from the following websites:

www.missouriendoflife.org, www.coxhealth.com, www.stjohns.com

Copies are also available to the members of general public from branches of the Springfield-Greene County Library.

Multiple copies for use in facilities are available in packets of 25 for $10.00.

Send orders to Springfield-Greene County Library District Business office, PO Box 760, Springfield, MO 65801, 417-874-8120.

Please include a check made out to Springfield-Greene County Library with order request.

Rev. June 2002

Definitions

- **ADVANCE DIRECTIVES:** ***DURABLE POWER OF ATTORNEY FOR HEALTH CARE CHOICES and HEALTH CARE CHOICES DIRECTIVE***

"Advance Directive" is a general term used in this brochure to apply to both the Durable Power of Attorney for Health Care Choices and the Health Care Choices Directive. It is a term also frequently used to refer to "living wills."

An advance directive is a document which communicates your health care treatment preferences in case a situation develops where you are physically or mentally unable to communicate. The U.S. Supreme Court decision (Cruzan) clearly says that all people have a constitutional right to refuse any medical treatment, including life-prolonging treatments. Further, the Court's decision affirms the right to name another person (agent) to be a surrogate decision-maker for health care issues in the event you lose the ability to make your own decisions. Thus, the U.S. Supreme Court has declared your legal right to make an advance directive. The Supreme Court's declaration is recognized and upheld by Missouri state law. This booklet contains two directives, meant to be used together:

1. A Durable Power of Attorney for Health Care Choices
2. Health Care Choices Directive

- **THE *DURABLE POWER OF ATTORNEY FOR HEALTH CARE CHOICES***

The Durable Power of Attorney for Health Care Choices provides a way for you to appoint another person (agent) to make health care decisions which you have not already covered in your Health Care Choices Directive. The Durable Power of Attorney for Health Care Choices document goes into effect only when you lack the ability to make or to communicate decisions for yourself, as determined by your physician.

- **THE *HEALTH CARE CHOICES DIRECTIVE***

The Health Care Choices Directive is a signed, dated, and witnessed document that allows you to state in advance your wishes regarding the use of life-prolonging medical treatment. It is similar to a living will, with which many people are familiar; however, it is far more comprehensive than most living wills. Further, the Health Care Choices Directive is not limited to use only when you are terminally ill. The Health Care Choices Directive goes into effect only when you can no longer make or communicate decisions for yourself.

Commonly Asked Questions About

Advance Directives

1. Why is it useful to have both a Durable Power of Attorney for Health Care Choices and a Health Care Choices Directive?

Due to the complexity of illnesses and treatment options, situations may arise when it is not clear from your Health Care Choices Directive what your decision in a particular situation would be. To provide for that event, you may wish to name a person you trust to make decisions for you. This is done in the Durable Power of Attorney for Health Care Choices.

2. How is the Durable Power of Attorney for Health Care Choices different from a regular Power of Attorney?

Generally powers of attorney refer to business and financial matters. A Durable Power of Attorney for Health Care Choices more clearly allows you to name another person (as agent) to make health care treatment decisions and does not cover business or financial matters. Many people choose to name separate agents for business and health care decisions and use separate documents to do so.

The document in this booklet addresses health care matters only.

3. Whom should I name as my agent?

It is important that you name an agent who knows your goals and values and whom you trust to act as you would wish. You may name a family member, but it is not necessary to do so. You might choose your spouse, an adult child or a close friend. Be sure to talk with your agent about your wishes in detail and be sure that he or she agrees to act on your behalf.

4. Do I need an attorney to make a Durable Power of Attorney for Health Care Choices and a Health Care Choices Directive?

No. However, if this document fails to meet your needs, you may wish to talk with an attorney.

5. How do I give notice that I have made an advance directive?

It is your responsibility to notify and provide copies of your advance directive to the agent(s) named in your Durable Power of Attorney for Health Care Choices and other appropriate persons (for example, physicians, family, friends, and clergy). Discuss the details of your advance directive with these persons and ask your physician to make it a part of your permanent medical record.

6. How long will my advance directive be effective? May I change or cancel it?

Your advance directive is good until the time of your death unless you cancel it. It is recommended that you periodically review your advance directive. Each time you do this, put your initials and the new date in the margins of the document. This will serve as a powerful indicator that your directions have been well thought out.

7. Will my Durable Power of Attorney for Health Care Choices and Health Care Choices Directive be honored if I am in another state?

The U.S. Supreme Court stated that all adults have the right to refuse health care treatment. The document in this booklet is designed to be good in any state.

8. Can my Health Care Choices Directive or decisions made by my agent be overridden by my family members?

If you have named an agent, only he/she has the legal authority to make health care decisions for you. However, your agent may wish to get information from your family to assist him/her in making decisions. It is a good idea to tell your family members whom you have named as an agent and what your wishes are. In this way, your family will know what to expect.

9. Must my physician, agent and health institution carry out my wishes expressed in my Health Care Choices Directive?

Yes. Health care providers and your agent must honor your wishes as expressed in your advance directive, so long as directions you have made agree with state law. Any provider who will not honor your Health Care Choices Directive or decisions made by your agent must assist in arranging your transfer to a provider who will honor your advance directive.

10. When and how will my Advance Directive be honored?

When you cannot speak for yourself and a physician has determined that you lack the capacity to make your own health care decisions.

THE BENEFIT OF COMMUNICATION

The greatest benefit of your advance directive is its power as a communication tool. Ask your doctor to discuss your advance directive with you; also, make your wishes about health care known to family, friends and clergy.

11. Will my Health Care Choices Directive be honored during surgery or in an emergency situation?

During surgery or in an emergency, it may be impossible for health providers to make a quick judgment of medical treatment versus quality of life. You should assume that treatment would be tried until it proves to be useless. If treatment does not lead to a significant recovery, you should expect that your advance directive will be honored, and treatment which has proven to be useless will be stopped.

12. What if I do not want to be revived when I die (that is, when my heart and breathing stop)?

Some people want to refuse CPR (cardiopulmonary resuscitation) because they fear being "trapped" on life support. This concern is partly addressed in The Health Care Choices Directive. The Health Care Choices Directive clearly says that if it is uncertain whether or not a treatment will "lead to a significant recovery," it should only be tried for a reasonable period of time. If, however, you do not want CPR at all, you need to talk to your physician about a medical order directing emergency workers to not use CPR.

13. How can I describe what an "acceptable quality of life" means to me?

When making a Health Care Choices Directive (Section II of the document in this booklet), it is important to describe what you personally mean by "acceptable quality of life." There is no single "right" answer to this question. However, here are some questions you might consider:

- Are your religious beliefs or values important to your treatment decisions? (if so, how?)
- How important is it for you to be able to care for yourself?
- Do you have strong feelings about where you would want to live or be cared for if you couldn't care for yourself?
- How important is it to you to be able to recognize family and friends?

In your description of an "acceptable quality of life" tell the personal goals and values on which you base your description. To do this, you may need more space than is provided in the Advance Directive.

Write down your thoughts! Even simple and brief statements like, "I do not want life support if I can no longer communicate, recognize people, and make decisions for myself," can be very helpful to your agent and health care providers.

14. May I request that artificially administered food and water (tube feedings) be stopped?

Yes. The constitutional right of liberty supports refusal of any medical treatment-including artificial feeding. Therefore, your wishes will be honored if they are clearly expressed in your Health Care Choices Directive.

15. May I make a provision for donating organs or tissues in my advance directive?

Yes. You can make a statement about organ or tissue donation in your Health Care Choices Directive. You may also wish to sign the Uniform Anatomical Donation Statement on the back of your driver's license.

16. Will my advance directive affect my life or health insurance?

No. Your signature on the advance directive will not cancel or alter insurance policies. It will not affect your ability to get life or health insurance. Your benefits are unaffected.

17. Will my advance directive affect my ability to obtain health care treatment?

No. Your signature on the advance directive will not affect your ability to obtain health care treatment.

Advance Directives

Worksheet

This is a worksheet to help you think about your wishes. It is not part of your legal document. It is not necessary to fill out this section in order to complete the legal document (which follows Page 10). This section may help the person you appoint as your agent tell your caregivers about you and what is important to you.

Who I am and what is important to me:

If I become unable to speak for myself I want my agent to let those caring for me know the following things about my family: [For example, who my family is and their importance to me…]

_____
_____
_____
_____

If I become unable to speak for myself I want my agent to let those caring for me know the following things about my accomplishments: [For example, the things I take pride in…]

_____
_____
_____
_____

If I become unable to speak for myself I want my agent to let those caring for me know the following things about my religious faith: [For example, the faith I belong to, its importance to me, my beliefs about death and life after death, what I hope for from members of my faith family…]

_____
_____
_____
_____

WORKSHEET

WORKSHEET

If I become unable to speak for myself I want my agent to let those caring for me know the kind of person I have tried to be: [For example, "I have always tried to…"]

_____
_____
_____
_____

If I become unable to speak for myself I want my agent to let those caring for me know the following cultural/ethnic beliefs and practices that are important to me: [For example, drumming ceremony celebration of life and I prefer to be spoken to in my native language of...]

_____
_____
_____
_____

If I become unable to speak for myself I want my agent to let those caring for me know that I have some fears about the process of dying: [For example, being alone, being in pain…]

_____
_____
_____
_____

If I become unable to speak for myself and am dying, I want my agent to let those I love know…: [For example, I love them, I am sorry for any offense I have given, I forgive them for…]

_____
_____
_____
_____
_____

Please initial the statements that are important to you.

Direction About My Comfort

___ I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep a lot.

___ If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my caregivers to do whatever they can to help me

___ I want my lips and mouth kept moist to stop dryness.

___ I wish to be kept fresh and clean at all times.

___ I wish to be massaged with lotion as often as I can be.

___ I wish to have my favorite music played when possible until my time of death.

___ I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.

___ I wish to have well-loved readings and poems read aloud when I am near death.

About My Treatment

___ I wish to have people with me when possible.

___ I want someone to be with me when it seems that death may come at any time.

___ I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.

___ I wish to have others by my side praying for me when possible.

___ I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.

___ I wish to be cared for with kindness and cheerfulness.

___ I want to be cared for with respect.

___ I wish to have pictures of my loved ones in my room, near my bed.

___ If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.

___ I want to die in my home, if that can be done.

What I Want My Loved Ones To Know

___ I wish to have my family members and loved ones know that I love them.

___ I wish to be forgiven for the times I have hurt my family, friends, and others.

___ I wish for my family members and loved ones to know that because of the faith I have, I do not fear death itself. I think it is not the end, but a new beginning for me.

___ I wish for all of my family members to make peace with each other before my death, if they can.

___ I wish for my family and friends to think about what I was like before I became ill. I want them to remember me in this way after my death.

___ I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.

___ I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.

Please use the space below to make any additional statements.

Legal Documents

Durable Power of Attorney for Health Care Choices and Health Care Choices Directive

Section I
Durable Power of Attorney for Health Care Choices

It is important to choose someone to make health care decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the right to make decisions for you and to make sure your wishes are honored when you are unable to speak for yourself.

I _____ SS#_____,

appoint _____,
(NAME OF PERSON)

_____,
(TELEPHONE)

_____,
(ADDRESS)

to be my agent to make health care decisions for me when I cannot make decisions or communicate what I want done.

If the person I named above is unable to serve, I appoint:

_____,
(NAME OF PERSON)

_____,
(TELEPHONE)

_____,
(ADDRESS)

to be my agent to make health care decisions for me when I cannot make decisions or communicate what I want done.

This Durable Power of Attorney for Health Care Choices and Health Care Choices Directive belongs to: _____

This is a *Durable Power of Attorney for Health Care Choices,* and my agent has authority *only* if I become unable to speak for myself or make my own decisions, as determined by a physician. This cancels any *Durable Power of Attorney for Health Care Choices* I may have made at an earlier time. My agent may not appoint anyone else to make decisions for me. My agent acting under this *Durable Power of Attorney for Health Care Choices* will not become financially responsible for me. I give my agent full power to make all decisions for me about my health care, including the power to direct that life-prolonging treatment not be used or be stopped (that is, withheld or withdrawn). When speaking for me, I expect my agent to be guided by my directions as stated in my *Health Care Choices Directive.* I also give my agent the power to:

- Consent, refuse or withdraw consent to treatment, service or procedure (including tube feedings; that is, artificially supplied nutrition and/or hydration) used to maintain, diagnose or treat a physical or mental condition;
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other health care organization; hire or fire health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall decide necessary for my physical, mental, or emotional well being;
- Request, receive, and review any information about my physical or mental health, or my personal affairs, including medical and hospital records; sign any releases of other documents that may be needed to get such information;
- Move me into or out of any State or health care facility for the purpose of honoring my wishes as expressed in my *Health Care Choices Directive* or the decisions of my agent;
- Take legal action, if needed, to do what I have here directed;
- To carry out my decisions about autopsy and organ donation, and what is to be done with my body

Affirmation of Trust in My Agent

I encourage my agent to follow my wishes as expressed to him/her and as conveyed by other means. I have confidence in my agent's ability to make decisions for me, as I would make them. Therefore, I authorize my agent to make the decision which he/she believes is right even if that decision may appear to conflict with my wishes.

Section II
Health Care Choices Directive

I _____
SS#_____,
want everyone who cares for me to know what health care I want when I cannot speak for myself and am unable to decide about my health care. I am making this Directive to give clear and convincing proof of my wishes about my health care and treatment.

> *Quality of Life Definition:* **If it is reasonable to expect that medical treatment will get me back to an acceptable quality of life, I want my doctor to try those treat**ments. My definition of acceptable quality of life is: [For example, the ability to recognize family and friends, make decisions, communicate, feed myself, take care of myself…]
>
> _____
> _____
> _____
> _____
> _____
> _____

I always expect to be given care and treatment for pain or discomfort even when such care might shorten my life, make me feel like not eating, slow down my breathing, or be habit-forming.

When I have,

- **a condition that will cause me to die soon, or**
- **a condition so bad (including serious brain damage or brain disease) that there is no reasonable hope that I will regain a quality of life acceptable to me as described.**

I DO NOT want any of the treatments I have initialed.

____ surgery or other invasive medical treatments
____ Cardiopulmonary Resuscitation (CPR) to restart my heart or my breathing
____ medicine to treat infections (antibiotics)
____ artificial kidney machine (dialysis)
____ breathing machine (respirator, ventilator)
____ artificially supplied nutrition and hydration (tube feeding or water given through a tube in the vein, nose, or stomach)
____ chemotherapy (cancer treatment with drugs)
____ radiation therapy
____ all other "life prolonging" medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially after my death on a breathing machine until my organs can be removed.

☐ Yes ☐ No ☐ I do not want to address this question now.

My other directions include:

_____
_____
_____
_____
_____
_____

Talk about this document and your ideas about your health care with your agent (the person you have chosen to make decisions for you), and with your doctor(s), family, friends, and clergy, and give each of them a completed copy. Keep the original of this document with your important papers. Take a copy of this document with you when you go to a hospital or other health facility for medical or residential care.

If you have questions about this document, ask your physician, nurse or other knowledgeable health care worker. Or, contact the Community Alliance for Compassionate Care at the End of Life at 417-865-4501.

This Durable Power of Attorney for Health Care Choices and
Health Care Choices Directive belongs to:_____

This form should be signed and witnessed in the presence of a notary.

SIGN HERE for *Durable Power of Attorney for Health Care Choices* and *Health Care Choices Directive*. **Please ask two (2) persons to witness your signature who are not related to you nor financially connected to you or your estate.**

Your Name (please print) _____
Signature _____
Address _____
Date_____ Time_____

First Witness (please print)_____
Signature _____
Address _____
Date_____ Time_____

Second Witness (please print)_____
Signature _____
Address _____
Date_____ Time_____

Notarization

On this _____day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the
County of _____, State of _____, on the date written above.

_____
Signature of Notary Public

_____
Name of Notary, printed, typed or stamped

_____
My Commission Expires

Official Seal

This Durable Power of Attorney for Health Care Choices and
Health Care Choices Directive belongs to:_____

FOR YOUR CONVENIENCE: Fill out, cut on the outside lines, fold, and place this card in your wallet with other medical information.

I, _____, have a *Durable Power of Attorney for Health Care Choices*.

I have appointed:

Name _____

Address _____

Phone _____

to be my personal agent to make care decisions on my behalf in the event that I lose my ability to speak for myself. Date_____

I, _____, have a *Durable Power of Attorney for Health Care Choices*.

I have appointed:

Name _____

Address _____

Phone _____

to be my personal agent to make care decisions on my behalf in the event that I lose my ability to speak for myself. Date_____