ADVANCE HEALTH CARE DIRECTIVE

GUIDE AND FORM

Designating Your Agent For Medical Decisions, Agent's General Authority And Specific Instructions at End of Life

May 2023

Dear Friend of Beebe Healthcare,

Thank you for taking the important step of completing this Advance Health Care Directive. The directive will tell your family and healthcare providers who you want to make decisions when you are unable. The directive gives your decision maker the authority to make decisions based on your intentions, protecting your right to have a voice in your care, and it provides specific instructions for the care you want when your doctor determines that you are at the end of life.

The state of 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 Advance directives in Delaware: Power of Attorney for Health Care and the End of Life Decisions.

We encourage you to learn as much about advance directives as possible. A helpful guide is included in this information packet. If you have a question or would like assistance completing your advance directive, contact the Beebe Patient Advocate at 302-645-3547. You can contact the Division of Aging at 800-223-9074, 302-391-3505 (TDD) or DelawareADRC@state.de.us, or you may consult your personal attorney. Beebe Healthcare has formal policies on advance directives available for review. When you have completed this document, 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 create an advance directive. At Beebe Healthcare we believe that our best patient is an informed and prepared patient.

Sincerely,

Jeannie Briley-Wallo, BSN, RN
Director, Patient Experience

Katie Johnson, DO Chair,
Bioethics Committee

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ADVANCE HEALTH CARE DIRECTIVE GUIDE

INFORMATION ABOUT YOUR RIGHT TO DECIDE YOUR HEALTH CARE

Who decides what health care I get?
As a competent adult with decision-making capacity, you have the legal right to make your own health care decisions. Your doctor, Advance Practice Provider, 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 directive will tell your doctors or Advance Practice Providers 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. A Power of Attorney for Health Care
2. Instruction for Health Care Decisions

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 the agent is related to you.

An **Instruction for Health Care Decisions** is a written statement of your intentions about health care treatment. It includes your instructions for treatment when you are terminally ill, permanently unconscious or suffer from serious illness or frailty.

To initiate an Advance Health Care Directive, you must do so while you are still capable and competent to make health care decisions. Two adult witnesses must watch you sign the Advance Health Care Directive, then add their signatures. You must choose witnesses who are not members of your family, will not inherit anything from you, 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, Advance Practice Provider, 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 clergy.

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 who are with you at the same time that you no longer wish your Advance Health Care Directive to be effective. You should also inform your doctor, Advance Practice Provider or any other health care provider and any health agent you have named of your decision to revoke the directive in writing.

Will my Advance Health Care Directive be valid in another state?
State laws vary considerably on Advance Health Care Directives. While the advance directive you make in one state may be good in another state, there is no guarantee. If you move to another state, you should make a new advance directive in that state. If you have a valid advance 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
2. the patient has filed a petition or complaints alleging abuse;
3. An adult child;
4. A parent;
5. An adult brother or sister;
6. An adult grandchild;
7. An adult niece or nephew;
8. An adult aunt or uncle.

If none of these family members are available, a close friend may make medical decisions on your behalf. The friend must be willing to become involved, has maintained regular contact with you and be familiar with your activities, health, personal values, and morals. The friend will need to give your medical provider a notarized affidavit attesting to the facts described in this paragraph.

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

COMPLETING THE FORM

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 through 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. Please write legibly.

Retain the original copy of your Advance Health Care Directive, and give other copies to your doctor or Advance Practice Provider, agent, spouse, family members, and close friends if you desire. You should explain why you made the choices you made to each person who receives a copy. 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 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 seems to conflict with your religious beliefs, you should contact your clergy.

PART I: 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 II) You are strongly encouraged to 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.

Unless you indicate otherwise, your agent will be authorized as follows:

1. To consent to, refuse, or withdraw consent to 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 you are in a qualifying condition. (See Part II),
2. To have access to medical records and information to the same extent that you are entitled, including the right to disclose the contents to others,
3. To authorize your 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 your behalf, without your agent incurring personal financial liability for such contracts,

5. To hire and fire medical, social service, and other support personnel responsible for your 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) your death.

Your agent will make health care decisions for you in accordance with this power of attorney for health care, any instructions you give in Part II of this form, and any other wishes to the extent known to your agent. To the extent your wishes are unknown, health care decisions by your agent will conform as closely as possible to what you would do or intend under the circumstances. If your agent is unable to determine what you would have done or intended under the circumstances, your agent will make health care decisions in accordance with what your agent determines to be your best interest. In determining your best interest, your agent should consider your personal values to the extent known to your agent. To the extent that the agent knows or determines your intentions, the agent should take into account these and other factors if applicable:

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

PART II. INSTRUCTIONS FOR END-OF-LIFE HEALTH CARE DECISIONS

If you are an adult who is mentally competent and has decision-making capacity, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. By completing this form, you are giving advance instructions for medical or surgical treatment that you want or do not want at the end of life. These instructions will only become effective if you lose the capacity to accept or refuse medical or surgical treatment.

If you decide to not give detailed instructions for your choices among life sustaining treatments when you are in a qualifying condition, please use Beebe's General Authority form or initial **Section A** under Part II, Instructions for Health Care Decisions.

Sections B, C, and D specify three common qualifying conditions and list four life-sustaining treatments. Use a check or your initials to indicate any qualifying condition for which you would **not** want your life prolonged. Next, check or initial any treatment you do not want to receive for each qualifying condition. Any treatment left blank is assumed to be an acceptable treatment when medically appropriate. There is a blank line for you to add other

directions regarding therapies like dialysis or amputation. Here are explanations of the end-of-life conditions listed in the directive.

> **Terminal Condition** is an incurable condition from which there is no reasonable medical expectation of recovery, and which will cause death, regardless of the use of life-sustaining treatment.
>
> **Permanent Unconsciousness** is a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards. The physician determines that there is a reasonable medical certainty for 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.
>
> **Serious Illness or Frailty** is a medical condition in which a health care practitioner would not be surprised if you died within the next year because of overall poor health.

Section E allows you to include instructions for any other medical conditions or treatments.

Section F provides space for you to share any guiding values or goals of care that would be helpful to your providers. For example, you could say that you want to be kept comfortable or that you would like to be transferred home if possible.

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.

ADVANCE HEALTH CARE DIRECTIVE
OF

Name _______________________________ Date of Birth _______________

PART I. POWER OF ATTORNEY FOR HEALTH CARE

A. DESIGNATION OF AGENT: I designate _______________________________ as my agent to make health care decisions for me. If this person 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 instructions as stated in this document or otherwise known to my agent.

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.

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

PART II. INSTRUCTIONS FOR HEALTH CARE DECISIONS AT THE END OF LIFE

(Place your initials or a check mark next to each of your instructions.)

A. My Agent Makes All Medical Decisions

_____ I authorize my agent to make all decisions about my end-of-life care.
(Cross out sections B, C and the specific instructions listed below)

B. Instruction to Prolong Life

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. See **Specific Instructions** for any exceptions.

C. Instructions to Not Prolong Life

_____ I do not want my life to be prolonged when my physician determines that I am at the end of my life. See **Specific Instructions** below.

I give these specific instructions to be followed when I am diagnosed with the following end-of-life medical conditions (Please initial or check all that apply):

_____ If I have a terminal condition, I do not want to receive these treatments:
(check any that apply)

_____ CPR (CardioPulmonary Resuscitation, chest compressions and a breathing tube)
_____ Artificial Respiration (BiPAP, CPAP, or breathing tube)
_____ Artificial nutrition through a tube (Nasal or oral tube, abdominal tubes)
_____ Hydration through a tube (Nasal or oral tube, abdominal tubes)
Other (explain) ____

_____ If I become permanently unconscious, I do not want to receive these treatments:
(check any that apply)

_____ CPR (CardioPulmonary Resuscitation, chest compressions and a breathing tube)
_____ Artificial Respiration (BiPAP, CPAP, or breathing tube)
_____ Artificial nutrition through a tube (Nasal or oral tube, abdominal tubes)
_____ Hydration through a tube (Nasal or oral tube, abdominal tubes)
Other (explain) ____

_____ I have a serious illness or frailty, I do not want to receive these treatments:
(check any that apply)

_____ CPR (CardioPulmonary Resuscitation, chest compressions and a breathing tube)
_____ Artificial Respiration (BiPAP, CPAP, or breathing tube)
_____ Artificial nutrition through a tube (Nasal or oral tube, abdominal tubes)
_____ Hydration through a tube (Nasal or oral tube, abdominal tubes)
Other (explain) ____

D. Relief From Pain: I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

E. Other Medical Instructions: If you wish to add to the instructions you have given above, you may do so here.

____
____
____
____
____
____

E. Goals of Care: When I am at the end of my life, I ask that these personal values and medical goals of care be used to guide my plan of care:

____
____
____
____
____
____

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 this person's written declaration under 16 Del.C. §§ 2502, 2503, in our presence, who in this person's presence, at this person's 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:
   3. Is related to the declarant by blood, marriage or adoption;
   4. 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;
   5. 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;
   6. Has a direct financial responsibility for the declarant's medical care;
   7. 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
   8. 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, Notary may not be an employee of Beebe Healthcare.)

Sworn and subscribed to me this ______ day of ______________________________

My term expires: ______________ ______________________________

(Notary)