



ADVANCE DIRECTIVES

UNDERSTANDING YOUR RIGHTS AS A PATIENT TO REFUSE TREATMENT AND APPOINT AN AGENT TO ACT ON YOUR BEHALF

What are Advance Directives?

Advance directives are written instructions given by you to your doctor or any other person who has primary responsibility for your health care (throughout this pamphlet, this person will be referred to as a "Health Care Provider"). Advance directives instruct your Health Care Provider on whether to withhold life-sustaining treatment (such as life support or artificially provided food, water, or other nourishment) under certain specified circumstances. Advance directives only spring into effect if you lack decision-making capacity at the time care is needed. A sample Advance Care Plan is provided at the back of this pamphlet.

Documents called "Living Wills" and "Durable Powers of Attorney for Healthcare" have traditionally been used to convey advance directives. However, advance directives may be contained in any document that complies with the legal requirements discussed below.

Use of advance directives comes from a patient's right under state law to make decisions about medical care, including the right to accept or refuse medical or surgical treatment and those related to withdrawing life-sustaining treatment.

Appointment of an Agent.

Advance directives may also designate an agent (also called "attorney in fact") to make any health care decision that you could have made while having decision-

making capacity, including refusal of treatment. However, the agent is bound to follow any specific instructions that you give. Generally, any competent adult may serve as your agent, but trusted family members or other care givers are typically designated as agents. Even if you have appointed an agent, your Health Care Provider must listen to you if you are able to communicate in some manner.

What is “Decision-Making Capacity”?

Decision-Making Capacity generally refers to your ability to do all of the following:

- understand your physical or mental condition;
- understand the benefits and risks of the main treatment options, including non-treatment;
- judge the relationship between the treatment options and their consequences;
- reason and deliberate about your options; and
- communicate your decisions in a meaningful manner (vocally, by hand gestures, etc.).

You are generally presumed to have decision-making capacity absent a determination to the contrary.

Who Makes the Determination of Whether you have Decision-making Capacity?



The threshold clinical decision is made by your Health Care Provider. However, the decision is often not clear-cut. Historically, the Health Care Provider will consult with your family to make this determination.

If you have decision-making capacity, the Health Care Provider will seek permission or informed consent from you before he or she performs certain medical procedures.

Why Have Advance Directives?

Advance directives:

- ensure that your wishes are met with respect to the provision of life-sustaining medical treatment in times when you cannot make the decision for yourself;
- provide your Health Care Provider and family members with clear guidance if a decision ever has to be made with respect to the withholding of life-sustaining treatment; and
- eliminate the potential for conflicts or confusion among family members or other caregivers who may be called upon to make health care decisions for you.

What are the Legal Requirements for Advance Directives?

Advance directives must:

- be given by an adult or emancipated minor;
- be in writing and signed by the patient; and
- Be either notarized or signed by two witnesses.



Who can Serve as a Witness?

- A witness must be a competent adult.
- An agent cannot be a witness.
- At least one witness must also be:
 - unrelated to you by blood, marriage or adoption; and
 - not entitled to any portion of your estate upon your death.

For the advance directives to be valid, there must be statement confirming that the witnesses comply with the requirements listed above.

What Happens if you do not have Advance Directives and have not Appointed an Agent?

For critical decisions regarding medical treatment, consultation by the Health Care Provider with a patient's family has been a long-standing custom, however, under patient privacy laws referred to as HIPAA, family members are to be consulted only to the extent the patient has directed it and only to the extent of their need to know for payment or treatment purposes.

Now, under state law, a surrogate (similar to an agent) may be designated by you or identified by a care giver. You may designate anyone to act as your surrogate by personally informing your Health Care Provider. A surrogate may be designated orally or in writing.

A surrogate may make a health care decision for you only if: (i) you have been determined to lack decision-making capacity; (ii) either no agent or guardian has been appointed for you; or (iii) the agent or guardian who has been appointed is not available. If you have decision-making capacity, you may not defer to a surrogate.

Surrogates must comply with your wishes, to the extent known, or otherwise act in your best interest.

Can a Health Care Provider Designate a Surrogate?

A Health Care Provider may identify a surrogate for you if: (i) you as the patient lack decision-making capacity; (ii) you have not appointed an agent; (iii) you have not designated a surrogate; (iv) you do not have a guardian; or (v) the agent, surrogate, or guardian who has been appointed is not available.

The surrogate chosen under these circumstances must be an adult who:

- has exhibited special care and concern for you;
- is familiar with your personal values;
- is reasonably available; and
- is willing to serve.

The Health Care Provider currently involved in your care (including his or her employees) may not serve as a surrogate unless he or she is related to you.

Consideration is generally first given to the following people:

- your spouse (unless legally separated);
- your adult child;
- your parent;
- your adult sibling; or
- any other adult relative of yours.

If a Surrogate cannot be found, can the Health Care Provider Make Decisions for you?

If you as the patient lack capacity, have not appointed an agent, have not designated a surrogate, do not have a guardian or agent, or the appointed surrogate or guardian is not reasonably available and no other surrogate is reasonably available, then the Health Care Provider may then make health care decisions for you after he or she either consults with and obtains the recommendations of the hospital's or institution's ethics policies or obtains concurrence with another doctor who: (i) is not directly involved in the patient's care; (ii) does not serve in a capacity of decision making influence, or have responsibility over the first doctor; and (iii) is not under the first doctor's decision-making influence or responsibility.

Disclosure of Healthcare Information to the Agent or Surrogate.

Under the current law, both agents and surrogates may request, receive, examine, copy and consent to the disclosure of health care information except where otherwise excepted in the patient's advance directives.

WHO SHOULD I CONTACT WITH QUESTIONS?

Memphis Area Legal Services, Inc.
Memphis Service Office
109 N. Main Street, Suite 200
Memphis, TN 38103
(901) 523-8822

Rural Service Office
899-A Highway 51 South
Covington, TN 38019
(901) 476-1808

Website: <http://www.malsi.org>

ADVANCE CARE PLAN
(Tennessee)

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me, including any health care decision I could have made for myself if able:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me, including any health care decision I could have made for myself if able:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond any more to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows: **Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.**

<input type="checkbox"/>	<input type="checkbox"/>	<u>CPR (Cardiopulmonary Resuscitation):</u> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Life Support / Other Artificial Support:</u> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Treatment of New Conditions:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Tube feeding / IV fluids:</u> Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Yes	No	

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

Any organ/tissue My entire body Only the following organs/tissues: _____

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____
(Patient)

DATE: _____

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent