



Advanced Directive For Health Care

Your Right to Make Your Own Decisions About Medical Care

The best source for more information about
Advanced Directive is your attorney.

Patients of Helen Keller Hospital may ask their
nurse for more information.



LEGAL DOCUMENTS

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YOUR RIGHT TO MAKE YOUR OWN DECISIONS ABOUT MEDICAL CARE

A Summary of the Law in Alabama

1. UNDER CURRENT ALABAMA LAW. DO I HAVE THE RIGHT TO MAKE MY OWN DECISIONS ABOUT MEDICAL CARE?

Yes, if you are nineteen (19) years old or older and are reasonably alert and mentally capable of understanding the consequences of your own decisions. Alabama and Federal laws give you the right to decide whether medical procedures or treatment will be provided to you. This right applies whether such procedure or treatment is lifesaving emergency treatment, life-sustaining treatment, or the provision of food and liquid by artificial means. Examples of lifesaving treatment include CPR, cardiac defibrillation (a procedure where electric current is applied to your chest), mechanical ventilators to assist in breathing, dialysis machines to assist kidneys, administration of medication, food, and liquid which can be administered through intravenous (IV) needles, or through a tube inserted in your nose and down your throat, or through a tube which has been surgically placed directly into your stomach.

If you are unable to make your wishes known and have previously made your wishes known in a written document you signed when you were nineteen (19) years of age or older and were reasonably alert and mentally capable of understanding the consequences of your decisions, then the Supreme Court of Alabama has recognized your right to have your wishes followed. These written documents are called Advanced Directives and include: Living Wills, Durable Powers of Attorney, Health Proxies, and other written expression of your wishes regarding health care. If you are at all uncertain what your wishes are or that your wishes will not be followed, you should discuss your wishes with your physician and with as many of your family members as possible so that there will not be any question. If you are in an accident or suffer from a serious illness, you may become permanently unconscious because you are in a Persistent Vegetative State. If you have not made your wishes known, your family may be called upon to make health care decisions on your behalf.

2. AM I PERMITTED TO DECIDE WHAT TREATMENT I WANT OR DO NOT WANT TO HAVE?

Yes. Every Alabama citizen has the right to refuse unwanted medical treatment. If you are nineteen (19) years of age or older, reasonably alert, and able to understand the consequences of your own decisions, you have the right to refuse any medical treatment, including lifesaving and life-sustaining treatment.

3. HOW CAN I MAKE IT KNOWN THAT I DO NOT WANT CERTAIN MEDICAL TREATMENT?

You should simply tell your physician and other health care providers, such as the hospital or nursing home to which you have been admitted, exactly what treatment you do or do not want. It is clear that your wishes will be honored so long as you remain conscious and reasonably alert. If you are not sure what treatment may be offered to you, you should be sure to ask your physician.

4. CAN I DO ANYTHING NOW SO THAT MY WISHES WILL BE HONORED IF I LATER BECOME UNCONSCIOUS OR UNABLE TO COMMUNICATE?

There are three things you should do to make sure your wishes are honored even if you later become unable to speak for yourself.

First, you may wish to consider creating a Living Will. This document will permit you to express your wishes in advance about certain medical treatment that is commonly offered to patients who have a terminal condition. It will only take effect if you later become unable to express your wishes about medical treatment at the time it is offered. If the document is properly filled out, it should be honored by physicians, nurses, hospitals, nursing homes, and home health agencies. Some health care providers object to withholding artificially provided food and liquid. But even those health care providers may not give you treatment that you specify you do not want in your Living Will. Such a facility, however, may choose to transfer you to another facility where your wishes will be honored without objection.

Second, you may designate another person to make decisions on your behalf. Such a person may be known as a health care proxy or an attorney-in-fact. Don't be confused by the term attorney-in-fact. The person you select to make decisions on your behalf need only be a competent adult, and does not have to be a lawyer. This person will have the power to make decisions and grant consents on your behalf concerning your health care and treatment.

Third, you should in all cases discuss your wishes in advance about various kinds of medical treatment with your close family members so that they won't give conflicting instructions.

5. WILL I BE TREATED ANY DIFFERENTLY IF I DECIDE NOT TO VREATE A LIVING WILL OR HEALTH CARE PROXY?

Absolutely not. It is unlawful for health care providers to discriminate in the treatment and services offered based on a patient's decision about a Living Will or other form that specifies the patient's health care wishes.

6. HOW CAN I CREATE A LIVING WILL OR HEALTH CARE PROXY?

There is a form included in this pamphlet, which has been specially designed by Alabama attorneys representing the State Medicaid Agency, the State Department of Public Health, the State Medical Association, the State Hospital Association, the State Nursing Home Association and the State Bar Association. This form includes both a Living Will and a durable power of attorney for health care, or health care proxy. (Of course, you may also choose not to create a Living Will or health care proxy). The Living Will form contains a number of options where you may choose which medical treatment you want given and which treatment you want withheld. You may also want to contact your own attorney who may have another form that he or she prefers to use.

In any case, you will want to discuss your decisions about creating a Living Will or a health care proxy, and about the treatment you want and do not want with family members, close friends, and perhaps with a clergyman or other counselor.

If you decide to create a Living Will or health care proxy, it is most important that you give a copy to your physician and to any hospital or nursing home to which you are admitted.

7. CAN A HEALTH CARE PROXY APPOINTED UNDER THE FORM INCLUDED IN THIS PAMPHLET HAVE ACCESS TO MY PROPERTY?

No. Your health proxy appointed under the form included in this pamphlet can only make decisions concerning your health care. If you wish for that person to have access to your property to use for your benefit, you should consult an attorney for advice.

8. HOW DO I REVOKE (TAKE BACK) A WRITTEN ADVANCE DIRECTIVE?

You may revoke your Advance Directive by means of: 1) a signed, dated, written document which explicitly revoke the Advance Directive; 2) physically canceling or destroying the Advance Directive (you may do this on your own or have someone else do it for you in your presence); 3) by means of an oral expression of an intent to revoke the Advance Directive to your health care provider; or 4) a new Advance Directive which is materially different from the prior Advance Directive.

Such revocations will not be effective unless communicated to your attending physician and to the provider where you are receiving treatment. No health care provider has responsibility for failure to act upon a revocation, unless he/she has actual knowledge of the revocation.

9. SHOULD I ASK MY PHYSICIAN ABOUT HIS OR HER POSITION IN REGARDS TO MY RIGHT TO REFUSE MEDICAL TREATMENT?

Yes. You should discuss with your physician your wishes in regard to medical treatment you may want or may not want, so that both of you are clear exactly what your wishes are. Also, some physicians may have moral or ethical reasons for being unable to assist patients in such situations. If this is the case with your physician, you need to know this so that you may make other arrangements.

10. DO I NEED TO MEET WITH MY ATTORNEY PRIOR TO SIGNING ANY ADVANCE DIRECTIVE?

You may want to meet with your attorney prior to signing any Advance Directive. Alabama statues currently provide a form for Living Wills. However, the printed language does not provide for all situations. The statues do allow persons to include other specific directions in a Living Will. Alabama also has a statue allowing people to created Durable Powers of Attorney. An attorney can assist you in creating a document whereby you could designate someone as your attorney-in-fact to make health care decisions on your behalf, or you may use the form attached to the pamphlet.

11. DO HOSPITALS, NURSING HOMES, AND HOME HEALTH CARE AGENCIES HAVE TO ASK PATIENTS ABOUT ADVANCE DIRECTIVE?

Yes. Under a Federal law passed in 1990, providers must ask about the existence of Advance Directives; they must inform patients of their written policies and procedures about Advance Directives; and they must inform patients that care provided at the institution cannot be conditioned on completing and Advance Directives. This is why you have been given this document. If the provider cannot honor a request based on religious or moral grounds, the provider is obligated to help arrange transfer so that the patient's wishes can be followed.

NOTE: The attached Declaration is only a suggested form that may be used if you wish to create a Living Will and/or appoint a health care proxy. You cannot be required to do so, and you do not need to sign anything unless you DO want to create a Living Will and/or appoint a health care proxy.

**ADVANCE DIRECTIVE FOR HEALTH CARE
(Living Will and Health care Proxy)**

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. Living Will

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand these directions will only be used if I am not able to speak for myself.

IF I BECOME TERMINALLY ILL OR INJURED:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life-sustaining treatment - Life-sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no"

I want to have life-sustaining treatment if I am terminally ill or injured.

_____Yes _____No

Artificially provided food and hydration (Foods and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initial by either "yes" or "no"

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

_____Yes _____No

IF I BECOME PERMANENTLY UNCONSCIOUS:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life-sustaining treatment – Life-sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either “yes” or “no”

I want to have life-sustaining treatment if I am permanently unconscious

_____Yes _____No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either “yes” or “no”

I want to have food and water provided through a tube or an IV if I am permanently unconscious.

_____Yes _____No

OTHER DIRECTIONS:

Please list any other things you want done or not done.

In addition to the directions I have listed on this form, I also want the following:

If you do not have other directions, place your initials here:

_____No, I do not have any other directions.

Section 2. If I need someone to speak for me

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer.

_____ I do not want to name a health care proxy. (If you check this answer, go to Section 3)

_____ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone number: _____

Night-time phone number: _____

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone number: _____

Night-time phone number: _____

Place your initials by either "yes" or "no"

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.

_____ Yes _____ No

Place your initials by only one of the following:

_____ I want my health care proxy to follow only the directions as listed on the form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital that will follow my directions;
 - If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
 - If the time comes for me to stop receiving life-sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:
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Section 4. My signature

Your name: (Print) _____

The month, day and year of your birth: _____

Your signature: _____

Date signed: _____

Section 5. Witnesses
(need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

Section 6. Signature of Proxy

I, _____, am willing to serve as the health care proxy.

Signature: _____

Date: _____

Signature of Second Choice for Proxy:

I, _____, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: _____

Date: _____