ADVANCE DIRECTIVE

Your Right to Make Health Care Decisions

Saint Peter's University Hospital provides you with this booklet which explains your rights to decide about your health care under New Jersey law. It tells you how to plan ahead for your health care if you become unable to make decisions for yourself.

You have the right to:

- ask questions about your care.
- completely understand your medical condition.
- accept or refuse any treatments.
- make future decisions by completing an Advance Directive.

An Advance Directive lets you decide who will make the decisions for you and states your decisions about your health care.

- Your Advance Directive will not go into effect unless you are no longer able to make your own decisions for your care.

- You may change your mind about any of your decisions at any time.

You can state your decision in several ways:

A Proxy Directive lets you choose a relative or friend to make health care decisions for you.

An Instruction Directive lets you state what kinds of medical treatment you would accept or reject in certain situations.

A Combined Directive allows you to give both written instructions and also choose a health care representative.

Taking a few moments to read through this booklet and fill out an Advance Directive will help your loved ones and physicians do what you feel is right for you.

CHOOSE ONE.

Enclosed are two types of Advance Directive forms. Either form is an acceptable way to record your decisions or you may complete other available forms.

1. An Advance Directive prepared by the Catholic Bishops of New Jersey (page 3).
2. An Advance Directive developed by the Medical Society of New Jersey (page 11).

If you would like more information, or have questions about Advance Directives, please contact:

- Your Social Worker or the Social Work Discharge Planning Office at 745-8522.
- Your Chaplain or the Pastoral Care Office at 745-8565.
- Your nurse.

Advance Directive for Health Care

A Catholic Perspective

Approved by the Catholic Bishops of New Jersey - 12/98

ADVANCE DIRECTIVE FOR HEALTH CARE: A CATHOLIC PERSPECTIVE

EXPLANATION

The Catholic Bishops of New Jersey have prepared the following Advance Directive for Health Care. The naming of a health care representative (proxy) and instruction directive are combined into one form. The New Jersey Advance Directives for Health Care Act went into effect January 7, 1992. This act allows adults to complete an advance directive. You can either choose a health care representative (proxy) or give directions about your health choices and wishes, or both. It is not a law that you must have an advance directive. You can not be refused admission to a health care facility because you do not have an advance directive.

Before completing an advance directive, it is important to think about the following:

- You should talk about your choices with your entire family. Your family may include your spouse, adult children, parents, brothers, and sisters.
- You should talk to your doctor about your health care choices.
- Your health care representative (proxy) should know you and your wishes about medical treatment. Your health care representative has the legal right to make health care decisions based on your advance directive when you cannot make decisions.
- You do not need a lawyer to complete an advance directive. You may talk to one if you wish.
- You need to review your advance directive from time to time to make sure that your wishes are still the same.
- You can decide to change your advance directive at any time.
- If you want to cancel your advance directive, put it in writing or talk to your health care representative, doctor, or family.
- You have the right to make decisions about your medical treatment.
- Medical care will not be withheld just because you become unable to make your own treatment decisions.

STEPS FOR COMPLETING YOUR ADVANCE DIRECTIVE

PART ONE:

- Choose a person whom you trust to act as your health care representative (proxy).
- Direct your health care representative (proxy) to make your health care choices in accordance with your health care instructions or wishes when you cannot make these choices for yourself.

PART TWO:

- Give directions about your health care choices and wishes to those who will be responsible for your care.
- Tell your health care representative (proxy), family member or friend to bring a copy of this form to the hospital when you are admitted.

PART THREE:

- Sign the advance directive form in the presence of two witnesses 18 years of age or older (but your health care representative, alternate health care representative or doctor cannot serve as witnesses).
- Have those two witnesses sign and date the form.
- Give copies of the advance directive to your health care representative (proxy), your doctor, and appropriate family members or friend.
- Keep the original copy of this form for yourself.
- Bring a copy of this form to the hospital when seeking medical treatment.

COMBINED ADVANCE DIRECTIVE FOR HEALTH CARE
(Combined Proxy and Instruction Directive)

STATEMENT OF BELIEF

Catholics believe that life is a gift of a loving God. Life is a holy gift for which we are responsible, but do not own. We believe that assisted death and suicide destroy human life and are never allowed.

As an adult, I have the right to make decisions about my health care. As a Catholic, I may never choose my own death as an end or a means. There may come a time when I am unable to express my own health care decisions. By writing an advance directive, I give instructions and wishes for my future health care decisions. This advance directive for health care shall take effect when I am not able to express my health care decisions, as determined by my attending doctor. I direct that those responsible for my care make health care decisions according to my stated wishes. I direct that this advance directive be included in my permanent medical record.

PART ONE: NAMING MY HEALTH CARE REPRESENTATIVE

A) I have chosen the following person to be my Health Care Representative.

Name ____________________

Address ____________________

City ____________________ State __________ Zip __________

Telephone Number ____________________

He or she will be my health care representative to make my health care decisions when I am not able to speak for myself. If my wishes are not clear or events take place that I have not talked about, I ask that my health care representative make the decisions based upon what he or she knows of my wishes.

I have talked with my health care representative about this responsibility. He or she has willingly agreed to accept this role.

B) I have chosen the following person(s) as my Alternate Health Care Representative, if the person I have chosen above is not able, not willing or not available to act as my health care representative:

1. Name ____________________

   Address ____________________ City __________ State __________

   Zip __________ Telephone Number ____________________

OR

2. Name ____________________

   Address ____________________ City __________ State __________

   Zip __________ Telephone Number ____________________

He or she will be my health care representative to make my health care decisions when I am not able to speak for myself. If my wishes are not clear or events take place that I have not talked about, I ask that my health care representative make the decisions based upon what he or she knows of my wishes.

I have talked with my alternate health care representative about this responsibility. He or she has willingly agreed to accept this role.

PART TWO: TREATMENT CHOICE INSTRUCTIONS

In Part Two, you are asked to give directions about your future health care. This will mean making important and difficult choices. You need to think about and write down different situations when different types of medical treatments, including life-sustaining actions, should be given or should not be given. Before finishing this part, you should talk this over with your health care representative, doctor, priest, deacon, spouse, family members or those who may be responsible for your care. It is suggested that from time to time you look over these instructions with these same people to make sure that your wishes are still the same.

Please take time to look over all of Part Two before completing the form.

GENERAL INSTRUCTIONS: I direct the people who are responsible for my care to carry out the following:

- **Initial one of the following statements - either A or B.**

________ **A.** I direct that all medically indicated treatments and food and water (through tubes if necessary) be given to maintain my life, no matter what my physical or mental condition. **(Skip B & C)**

OR

________ **B.** If a serious health condition occurs and my primary doctor and at least one other doctor who has personally examined me, decide that the irreversible process of dying has begun and death is very near, I direct **not** to have treatments that would only prolong my dying. If these treatments have been started, they should be stopped. I also want to be given all necessary medical care appropriate to stop pain and to make me comfortable. **(Go to C)**

C. If I have been diagnosed as being in a permanent coma or in a persistent vegetative state after being examined by my primary doctor and at least one other doctor who is qualified to make this decision, **choose either 1 or 2.**

________ 1. I direct that **extraordinary*** medical care, as understood in the teachings of the Catholic Church, including food and water (through tubes if needed) shall be used no matter what my physical or mental health.

OR

________ 2. I direct that **extraordinary*** medical care, as understood in the teachings of the Catholic Church, shall not be used. I direct that food and water (through tubes if needed) be continued unless or until the benefits of this food and water are clearly outweighed by a definite danger or burden, or are useless.

***extraordinary** medical care is understood as those medicines, treatments or operations which may be very expensive, may cause excessive pain or other extreme difficulties or which may offer no reasonable hope of benefit.

Examples of extraordinary measures that I would want are as follows:

____

____

____

____

D. If I am **pregnant** and I am diagnosed as being in a permanent coma, in a persistent vegetative state or that the process of dying has begun and death is near, I direct that all medically indicated measures and food and water (through tubes if necessary) be given to maintain my life, regardless of my physical or mental condition, if this could maintain the life of my unborn child until birth.

E. The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. Generally, physicians will follow this standard. However, if you cannot accept this standard because of your personal religious beliefs, you may request that it not be applied in determining your death by initialing the following statement:

_______ To declare my death on the basis of the irreversible cessation of all functions of the entire brain, including the brain stem, would violate my personal religious beliefs. I therefore direct that my death be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

F. Please initial one:

_____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

_____ Upon my death, I am **not** willing to donate any parts of my body that may be beneficial to others.

PART THREE: SIGNATURE, WITNESSES AND COPIES

A. Signature: By writing this advance directive, I ask that my wishes, as stated, be put into effect by those people indicated to make health care decisions for me when I can no longer make them for myself. I have talked about the terms of this agreement with my health care representative. He or she has willingly agreed to accept the responsibility for making decisions for me according to this advance directive. I understand the purpose and effect of this document. I am signing it willfully, voluntarily and after careful consideration.

Signed today on (month, day, year) ______________________________

Signature ______________________________

Name (print name)______________________________

Address ____________________**City** __________ State ________ Zip ________

B. **Witnesses:** I state that the person who signed this document above did so in my presence, and appears to be of sound mind and free of duress or undue influence to complete this advance directive. I am 18 years of age or older, and am not designated by this or any other document as this person's health care representative.

1. Witness signature____ Date ______________

   Print witness name____

   Address ______________________ City ________________ State _____ Zip _____

2. Witness signature____ Date ______________

   Print witness name____

   Address ______________________ City ________________ State _____ Zip _____

C. COPIES: A copy of this advance directive has been given to the following people: **(It is important to provide your doctor, your health care representative, and appropriate family members or friends with a copy of this document. You keep the original.)**

1. Name ____

   Address ______________________ City ________________ State _____ Zip ______

   Telephone number ____

2. Name ____

   Address ______________________ City ________________ State _____ Zip ______

   Telephone number ____

COPY OF THIS DIRECTIVE SHOULD BE GIVEN TO YOUR HEALTH CARE REPRESENTATIVE, YOUR DOCTOR, AND APPROPRIATE FAMILY MEMBERS OR FRIENDS.

Developed by the Health Literacy Committee of Saint Peter's University Hospital.

Advance Directive for Health Care

Developed & Approved by the Medical Society of New Jersey

ADVANCE DIRECTIVE FOR HEALTH CARE

INSTRUCTION DIRECTIVE

An **Instruction Directive for Health Care**, sometimes called a **Living Will**, is a written document, signed by you, in which you decide the kind of care you would want, if for any reason you are unable to make health care decisions for yourself.

You do not need to have a Living Will, but having one will avoid many problems. It will let your physician, family, and friends know ahead of time what kind of decisions should be made for you if you become disabled, physically or mentally, and are unable to decide for yourself. You will receive appropriate medical care whether or not you have an Advance Directive.

PROXY DIRECTIVE-DURABLE POWER OF ATTORNEY FOR HEALTH CARE

In addition to your Instruction Directive, we encourage you to fill out a **Proxy Directive** in which you designate a health care representative, for example, a family member, friend, or other person who understands your feelings and is willing to make decisions for you about accepting, refusing, or withdrawing treatment if you become unable to do so for yourself.

* * *

This four-page document includes a list of definitions and the above two types of Advance Directives (together called a **Combined Directive**). Some people choose to fill out only one of these forms. We recommend that you fill out both.

Before filling out these forms, you are encouraged to speak with your doctor, family, health care representative, or others who may become responsible for following your wishes. Once you sign and date these forms and have them witnessed by two individuals, your requests must be followed by anyone involved in your care, but only at a time when you are not capable of making decisions for yourself.

After you fill out your Advance Directive, we recommend that you keep the original and give copies to your appointed health care representative, your physician, and any other family member, close friend, or advisor who is interested in your health and well-being.

Written and approved by the Medical Society of New Jersey 7/95.

TERMS YOU SHOULD UNDERSTAND

A. Life-Sustaining Treatment

1. *Cardiopulmonary Resuscitation (CPR).* CPR describes procedures that are done to restart the heart when it stops beating ("cardiac arrest"), and/or to provide artificial respiration when breathing stops ("respiratory arrest"). CPR can involve manual pressure to the chest and mouth-to-mouth breathing or pumping of air into the lungs using a rubber bag. In some instances, a tube may be inserted into the windpipe ("intubation") for mechanical ventilation.

2. *Mechanical Ventilation or Respiration. A* machine called a respirator or ventilator can take over breathing if the lungs cannot adequately breathe. It provides oxygen through a tube inserted into the windpipe.

3. *Surgery.* A surgical procedure involves cutting into the body to treat a problem.

4. *Chemotherapy.* Chemotherapy is drug treatment for cancer. It is used to cure cancer or reduce the discomfort of cancer even if it does not cure it.

5. *Radiation Therapy (RT).* RT involves the use of high levels of radiation to shrink or destroy a tumor.

6. *Dialysis.* Dialysis requires the use of a machine that cleanses the blood when the kidneys cannot function adequately. This can be done through tubes placed into blood vessels (hemodialysis) or through tubes into the abdomen (peritoneal dialysis).

7. *Transfusion.* The term transfusion refers to the giving of any type of blood product into a vein intravenously.

8. *Artificially Provided Nutrition and Fluids.* This group of terms refers to feeding patients who are unable to swallow food and fluid. This can be done through a tube into a vein or into the stomach. The feeding tube to the stomach can be placed through the nose (nasogastric tube) or through the abdomen (gastrostomy tube).

9. *Antibiotics.* Antibiotics are medications used to fight infections. They can be administered by mouth, by vein, by injection into a muscle, or through a feeding tube.

B. Comfort and Supportive Care (Palliative Care)

Comfort care is any kind of treatment that increases a person's physical or emotional comfort. Comfort care includes adequate pain control. It may also include oxygen, food and fluids by mouth, moistening of the lips, cleaning, turning, touching a person, or simply sitting with someone who is bedridden.

C. Medical Conditions

1. *Terminal Condition:* the end stage of an irreversibly fatal illness, disease, or condition.

2. *Permanent Unconsciousness:* a medical condition that is total and irreversible in which a person cannot interact with his/her surroundings or with others in any way and in which a person does not experience pleasure or pain.

Written and approved by the Medical Society of New Jersey 7/95.

INSTRUCTION DIRECTIVE – (LIVING WILL)

To My Family, Doctors, and All Those Concerned with My Care:

I, ____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care. *(Initial* any that apply.)

A.______ 1. I direct that life-sustaining procedures be *withheld* or *withdrawn:* a) if I become permanently unconscious; b) if I have a terminal illness; c) if I experience extreme mental deterioration; or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

______ 2. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

______ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are **un**acceptable to me. (Initial only those that describe a way of living that you could not tolerate):

______ a) Permanently unconscious with a ventilator breathing for me.

______ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.

______ c) On a ventilator when there is little or no chance of recovery.

______ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IV's to keep me alive.

______ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

______ 2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If you choose A. 1., above, the life-sustaining procedures that would be withheld or withdrawn include, but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you (see "Terms You Should Understand").

______ In the circumstances described in A. 1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. ______ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions:

____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed ____

Witnesses (cannot be health care representative or alternative representative if any are named on the other side of this page). I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness ____ **Date** ____________

Witness ____ **Date** ____________

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Written and approved by the Medical Society of New Jersey 7/95.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(PROXY DIRECTIVE)

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so. Your Living Will declaration will be in effect even if you have not designated a proxy.

I, ____, designate the following person as my health care representative to make any and all health care decisions for me, acting in my best interest, in the event that I become incapable of making decisions for myself.

Name ______________________________________ Relationship ______________________

Street ____

City __________________________ State ______ Zip ________ Telephone ____________

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. Name ______________________________________ Relationship ______________________

   Street ____

   City ____________________________ State __________ Zip _____ Telephone ________

2. Name ______________________________________ Relationship ______________________

   Street ____

   City ____________________________ State __________ Zip _____ Telephone ________

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes.

______ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or IV infusion, be withheld or withdrawn.

______ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

Signed ____ **Date** ________________

Witness (cannot be health care representative or alternative representative listed above).
I declare that the person who signed this document or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness ____ **Date** ________________

Witness ____ **Date** ________________

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Written and approved by the Medical Society of New Jersey 7/95.

254 Easton Avenue
New Brunswick, N.J. 08901

Designed and Printed by Saint Peter's University Hospital Print Shop Rev. 3/00