

HOSPICE OF THE WESTERN RESERVE



# Courage in Conversation: A Personal Guide

Advance Care Planning for Health Care Decision Making



# Advance Care Planning for Health Care Decision Making

Advance care planning for healthcare decision making does not happen overnight. It takes thought, emotional readiness and time to sort out the options and ready oneself for this serious undertaking. Sharing your choices through conversation is an important first step. In the long run, the conversations will be the greatest gift to those you love, giving them the confidence to act knowingly on your behalf and the comfort of knowing that your wishes will be honored.

# Foreword



According to several scientific opinion polls, most Americans know what they want to avoid at the end of life. When asked to envision how they see their dying, they are very clear about certain things. People report that they do not want to be:

- *Alone*
- *In Pain*
- *Ventilated*
- *Afraid*
- *Intubated*
- *Resuscitated*

Moreover, they want to die at home and not in an institution. These wishes are reflected in over 90% of our population. The unfortunate reality is in stark contrast to this aspiration. More than 75% of us currently die in institutional settings, including more than 50% in hospitals and about 24% in nursing homes.

Furthermore, polls indicate that people believe their loved ones will make sure that their wishes will be met, although fewer than 15% have ever discussed their requests with anyone.

Although we strongly support the development of advance directives in the form of living wills and durable powers of attorney for health care, it has become evident that these alone are not sufficient to assure that one's requests will be realized. We believe that in addition to the *advance directives*, the availability of an *advocate* is the best assurance that one's wishes will not be ignored.

Advocates may be family members, friends or professionals such as attorneys or health care providers. Advocates should be identified in

and authorized through the *advance directives*. However, the most important aspect in assuring effective advocacy is for the advocate to know your health care choices. This provides for confident, informed and competent representation for you when you may not be able to express your own wishes.

We are convinced that taking control of your future will be best achieved through conversations based on the concepts in this guide.

It takes *courage* to have these *conversations*. Death may be an uncomfortable topic, but there is a good time to bring it up – that is well before its reality is upon us. Talking about how we want to live as we approach death and communicating our wishes for end-of-life care will ease the strain for loved ones when the time comes.

This booklet is about having an open dialogue with your loved ones. While it is intended to guide you in creating documents that will clarify your health care decisions, do not construe this document as legal advice. While not required, you might consider consulting with an attorney as part of the process. All of this information can be found at [hospicewr.org/planning](http://hospicewr.org/planning).

We hope that you find it useful and that it assists you in arming yourself with the most effective assurance in these matters. We hope that it leads you to successful courageous conversations.



## Getting Started

There are a few points to consider as you begin this process. The most important thing is that you are well on your way.

**Planning** Have a plan as to how you will share your wishes. Will you have things written down? With whom will you be talking?

**Environment** Creating an environment that is conducive to listening is very important. It is usually helpful to sit down with your loved ones and try to be at the same eye level.

**Information** It may be necessary to give the information in small segments. Avoid apologizing for the information you are sharing; these are your wishes.

**Time** Allow time for your loved ones to process information and respond. This is one of the most important things you can do. They may have questions or feelings to share with you.

**Next Steps** Begin to plan your next steps. These may include discussing resources to help support your loved ones, funeral arrangements, financial arrangements or simply stating where your documents will be stored.

Sharing your choices through conversation may be challenging. It is, however, important to be sure your loved ones understand your wishes and are willing and able to speak on your behalf at a most difficult time. The more information you provide, the more guidance they receive.

## About Advance Directives

Many people assume that their financial power of attorney can make health care decisions for them. However, it is necessary to appoint a **Health Care Power of Attorney** who may or may not be the same individual. If you are not able to communicate due to serious injury or illness your loved ones will need to rely on your instructions, which will be contained in documents known as your *advance directives*.

Written *advance directives* help others accurately remember your wishes and may consist of:

- **Health Care Power of Attorney:** you appoint someone else to make health care decisions for you if you are unable to do so. This *does not* apply to finances.
- **A Living Will:** provides a narrow set of instructions about care at the end of life.

But remember, as long as you are capable of making your own decisions, you remain in control of your own medical care. In the event that you are unable to speak on your own behalf, the *advance directive* would guide decision making.

The following questions and answers may assist you.

**Q: If I have a Health Care Power of Attorney, do I need a Living Will too?**

**A:** Many people want to have both documents because they can address different aspects of your medical care. In a Living Will you are able to state your wishes in regards to life-sustaining medical treatments if you are at the end of life and unable to communicate. A Health Care Power of Attorney gives you the opportunity to appoint someone you trust to make medical treatment decisions for you in the event you are unable to make or communicate them yourself.

**Q: Who should I choose as my agent?**

**A:** Choose someone you trust. They may be a family member or close friend. It is important that he or she understands your wishes and is willing to act on your behalf.

**Q: Is it possible to request that food and water administered by IVs (intravenous tubes) be withheld or withdrawn?**

**A:** Yes. In your *advance directive* you can state a specific request to have artificially administered food withheld or withdrawn.

**Q: How can I address organ donation in my advance directive?**

**A:** You may state your wishes in the document. You also need to complete an organ donor card. Be sure to share this request with your loved ones.

**Q: What other documents might I need?**

**A:** Financial planners and estate planning attorneys recommend completing health care *advance directives* along with your **financial documents such as trusts, last will and testament, and financial power of attorney.**

**Q: When can I change my *advance directive*? How long is it effective?**

**A:** You may change or revoke your documents at any time. It is recommended that you review the directive when you have a change in your health status. Documents are effective for your lifetime unless you change or revoke them.

**Q: Where should I keep my *advance directive*?**

**A:** You should keep your *advance directive* documents in a safe place, making certain your loved ones know of this location. Make copies for the agent named in your Health Care Power of Attorney and other key individuals in your life (i.e., physician, clergy, attorney, loved ones). Have your physician make it a part of your permanent medical record. Some people, if they are able, choose to bring a copy with them when they are hospitalized.

**Q: What if I choose not to have an *advance directive*?**

**A:** You put others in the uncomfortable position of making decisions for you, without the knowledge of knowing what you would have wanted.

## Achieving Courage in Conversation

Just imagine. You have made choices to assist your loved ones in caring for you, and in doing so, have most likely gained a sense of control that you were not expecting. Your conversations with those you trust may not feel courageous but they are indeed. Why? Because by talking about your wishes you are confronting one of life's most difficult moments and that is achieving *courage in conversation*.

Hospice of the Western Reserve has a team of professionals that can assist you and your loved ones when time is limited due to a life-limiting illness. We can walk with you every step of the way, providing assistance in making your decisions regarding *advance directives* for care at end of life.

## What is Hospice

Hospice is a concept of compassionate care and support for seriously ill people. Working closely with our patients, their loved ones, and their doctors, the hospice team develops a care plan that focuses on pain and symptoms, emotional support, and spiritual care needs.

Care should be sought soon rather than later in the course of a serious or terminal illness—not just the last days or weeks of life—to benefit from the full realm of services including:

- 24-hour telephone access to services and support
- Medical equipment, tests, procedures, medications and treatments necessary to make our patients comfortable
- Nursing care and instruction for caregiver and loved ones
- Pain management and symptom control
- Counseling and social work services
- Expressive therapies, including art and music therapy for patients and family members
- Massage therapy for patients and family members
- State-tested nursing assistants to help with personal care
- Volunteer supportive visits
- Spiritual care
- Palliative care for those not ready for hospice care
- Bereavement services for more than a year following the loss of a loved one

## Why Choose Hospice of the Western Reserve

As a nationally recognized non-profit hospice, Hospice of the Western Reserve serves patients of all ages, including children, wherever they are. We offer first-class services, unmatched by other hospice providers, with more offices close to you and your loved ones.

We believe the only way to enhance your quality of life is by starting with superior quality of care. Our staff represents the most experienced and well-trained professionals in end-of-life care, with over 3,000 collective years of hospice experience. We employ more nurses who have obtained the distinctive credential as a Certified Hospice and Palliative Care Nurse (CHPN) and our physician team is either board certified in hospice and palliative or preparing for the exam.

Choosing the right hospice provider for you or your loved one is one of the most important decisions you will ever have to make. We know you have choices but if excellence, comfort and commitment are important to you, then we are your hospice of choice.

## How to Choose Hospice of the Western Reserve

Family members, neighbors and patients themselves can call Hospice of the Western Reserve to start services or simply inquire about services available. Physicians, social workers and nurses often assist family members by initiating the call. Early referrals are encouraged so that patients and their families can receive all the benefits of our care.

To begin the referral process, call **800.707.8921** or fill out our online referral form.



## PREPARING FOR THE CONVERSATION

Defining your wishes for end-of-life care

It is important to give careful consideration for your choices in care. Although not a legal document, use this worksheet to help you define those choices in preparation for your “*Courage in Conversation.*”

### 1. My Quality of Life

*I would like my doctor to try treatments that may restore an acceptable quality of life so that I may do what I feel is important and necessary. On a scale of 1 to 5, with 1 being very important and 5 not important to me, I rate these issues, which define my quality of life:*

(Please check one)

- Being able to recognize my family and friends.....  1  2  3  4  5
- Being able to communicate with them and knowing I am understood.....  1  2  3  4  5
- Having the ability to think clearly .....  1  2  3  4  5
- Being free from pain .....  1  2  3  4  5
- Being free from symptoms most of the time (nausea, diarrhea, shortness of breath) .....  1  2  3  4  5
- Being able to eat and drink .....  1  2  3  4  5
- Being able to control my bladder and bowels.....  1  2  3  4  5
- Being able to live in my own home.....  1  2  3  4  5

### 2. My Prognosis

*If I was very ill and told there was little chance that I would live much longer, it is important that I be able to:*

(Please circle one)

Continue with all possible treatments in the hope that a miracle might happen to restore my health ..... Yes No Unsure

Be allowed to die with dignity and given medications to alleviate any pain or discomfort I might have ..... Yes No Unsure

*If I were in a coma and my doctors thought there was little hope for regaining consciousness, I would like to:*

(Please circle one)

Be kept alive indefinitely in the hope that future medical advancements would restore my health..... Yes No Unsure

Have all treatment discontinued, and no new treatment started... Yes No Unsure



### 3. Treatments

*These are my choices on possible treatments that can be administered if I should have a terminal illness, dementia or serious stroke or in a coma:*

(Please circle one)

- Surgery..... Yes No Unsure
- CPR to start my heart or breathing if either should stop ..... Yes No Unsure
- Medicine for infections (antibiotics) ..... Yes No Unsure
- Kidney dialysis..... Yes No Unsure
- A respirator or ventilator to breath for me ..... Yes No Unsure
- Food or water through a tube in my vein, nose or stomach..... Yes No Unsure
- Blood transfusions..... Yes No Unsure

### 4. The End of the Journey

*My last days are an important time to say, “I love you” “Thank you” and “Goodbye.” On a scale of 1 to 5, with 1 being very important and 5 not important to me, I rate these issues, which define how I would like to spend those days:*

(Please check one)

- At home ..... (1) (2) (3) (4) (5)
- In a hospital..... (1) (2) (3) (4) (5)
- Surrounded by family and friends ..... (1) (2) (3) (4) (5)
- Free from pain and discomfort ..... (1) (2) (3) (4) (5)
- Being alert, even if I might be in pain ..... (1) (2) (3) (4) (5)
- Having time with my pastor, rabbi, priest or other spiritual advisor ..... (1) (2) (3) (4) (5)
- Having time to address forgiveness, gratitude and love ..... (1) (2) (3) (4) (5)

*Now that you have completed this worksheet, which helps to define your health care decisions, share your wishes with the person you’ve chosen to be your health care advocate as identified in your health care power of attorney document, as well as other loved ones and your trusted advisors (medical, legal and financial professionals).*

**I realize that this is not a legal document, but a tool to help clarify my wishes.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



HOSPICE  
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RESERVE

# Legal Advance Directive Documents for Ohio

Each state has its own advance directive documents. You must use the documents for the state in which you live. State documents can be found at [www.caringinfo.org/stateaddownload](http://www.caringinfo.org/stateaddownload).

# State of Ohio Living Will Declaration Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable only to individuals in a terminal condition or a permanently unconscious state. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration controls over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes, or if you later decide to complete a Health Care Power of Attorney. If you have both documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.



# State of Ohio Living Will Declaration Of

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(Print Full Name)

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(Birth Date)

I state that this is my Ohio Living Will Declaration. I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my wish that my dying not be artificially prolonged.

If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

**Definitions.** Several legal and medical terms are used in this document. For convenience they are explained below.

**Anatomical gift** means a donation of all or part of a human body to take effect upon or after death.

**Artificially or technologically supplied nutrition or hydration** means the providing of food and fluids through intravenous or tube “feedings.”

**Declarant** means the person signing this document.

**Donor Registry Enrollment Form** means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

**Do Not Resuscitate** or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

**Health care** means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

**Health Care Power of Attorney** means another document that allows me to name an adult person to act as my agent to make health care decision for me if I become unable to do so.

**Life-sustaining treatment** means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

**Living Will Declaration** or **Living Will** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

**Permanently unconscious state** means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

**Terminal condition** or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not received life-sustaining treatment.

*[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]*

**Health Care if I Am in a Terminal Condition.** If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Health Care if I Am in a Permanently Unconscious State.** If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Special Instructions.** By placing my initials at number 3 below, I want to specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:

1. I am in a permanently unconscious state; and
2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
3. I have placed my initials on this line: \_\_\_\_\_

**Notifications.** [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority:

[Note: If you do not name two contacts, you may wish to cross out the unused lines.]

First Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Second Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

### **Anatomical Gift (optional)**

Upon my death, directions regarding donation of all or part of my body are indicated on a DONOR REGISTRY ENROLLMENT FORM.

If I do not indicate a desire to donate all or part of my body by filling out a DONOR REGISTRY ENROLLMENT FORM, no presumption is created about my desire to make or refuse to make an anatomical gift.

I wish to make an anatomical gift.

**NOTE:** If you modify or revoke your decision regarding anatomical gifts, please remember to make those changes in your Living Will, Health Care Power of Attorney, and Donor Registry Enrollment Form.

**No Expiration Date.** This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

**Copies the Same as Original.** Any person may rely on a copy of this document.

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law.

**Health Care Power of Attorney.** I have completed a Health Care Power of Attorney.

\_\_\_\_\_ Yes \_\_\_\_\_ No

**SIGNATURE**

*[See below for witness or notary requirements.]*

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on \_\_\_\_\_, 20\_\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
DECLARANT

*[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (if you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]*

*[You may choose to file a copy of this Living Will Declaration with your county recorder for safekeeping.]*

**WITNESS OR NOTARY ACKNOWLEDGMENT**

*[Choose one.]*

*[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, **or** it is acknowledged before a Notary Public.]*

*[The following persons **cannot** serve as a witness to this Living Will Declaration: the agent or any successor agent named in your Health Care Power of Attorney ;your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*





Notes

## DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

\_\_\_\_\_  
(name of donor)

### INSTRUCTIONS:

If you have not already registered as a donor with the Ohio Bureau of Motor Vehicles when renewing a license or State ID, the "Ohio Donor Registry Enrollment Form" must be filed with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organs and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions. The form can also be used to amend or revoke your wishes for donation.

To register for the Ohio Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles  
ATTN: Record Clearance Unit  
P.O. Box 16583  
Columbus, Ohio 43216-6583

Make a copy of this form and retain it with other important documents such as a Living Will Declaration or Healthcare Power of Attorney. Keep these forms accessible in case of emergencies.

*[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]*

Print or Type Full Name of Donor \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License or ID Card Number \_\_\_\_\_

Social Security Number (optional) \_\_\_\_\_



Please select one of the following three options.

**Option 1:**

Upon my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

**Option 2:**

Upon my death, I make an anatomical gift of the following specified organ, tissues, or eyes:

ALL ORGANS, TISSUES AND EYES

**ORGANS:**

HEART

LUNGS

LIVER

KIDNEYS

PANCREAS

INTESTINE/SMALL BOWEL

**TISSUES:**

EYES/CORNEAS

HEART VALVES

BONE

TENDONS

LIGAMENTS

VESSELS

FASCIA

SKIN

For the following purposes authorized by law:

ALL PURPOSES

TRANSPLANTATION

THERAPY

RESEARCH

EDUCATION

**Option 3:**

**Please take me out of the Organ Donor Registry**

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Signature of Donor Registrant

Date Signed

# State of Ohio Health Care Power of Attorney of

\_\_\_\_\_  
(Print Full Name)

\_\_\_\_\_  
(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

**Definitions.** Several legal and medical terms are used in this document. For convenience they are explained below.

**Agent or attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

**Anatomical gift** means a donation of all or part of a human body to take effect upon or after death.

**Artificially or technologically supplied nutrition or hydration** means the providing of food and fluids through intravenous or tube “feedings.”

**Cardiopulmonary resuscitation or CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.



**Comfort care** means any measure taken to diminish pain or discomfort, but not to postpone death.

**Donor Registry Enrollment Form** means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

**Do Not Resuscitate or DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

**Health care** means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

**Health Care Power of Attorney** means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

**Life-sustaining treatment** means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

**Living Will Declaration or Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

**Permanently unconscious state** means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

**Principal** means the person signing this document.

**Terminal condition or terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

*[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]*

**Naming of My Agent.** The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: \_\_\_\_\_

Agent's Current Address: \_\_\_\_\_

Agent's Current Telephone Number: \_\_\_\_\_

**Naming of Alternate Agents.** [Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Second Alternate Agent:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

**Guidance to Agent.** My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

**Authority of Agent.** My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do **not** want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.
2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.
3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.
4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ, and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

- (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and
- (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and
- (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

***Special Instructions.*** By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:

- 1. I am in a permanently unconscious state; and**
- 2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and**
- 3. I have placed my initials on this line: \_\_\_\_\_**

***Limitations of Agent's Authority.*** I understand that under Ohio law, there are five limitations to the authority of my agent:

- 1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and
- 2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and
- 3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and



**No Expiration Date.** This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

**Guardian.** I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

**Enforcement by Agent.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

**Release of Agent's Personal Liability.** My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

**Copies the Same as Original.** Any person may rely on a copy of this document.

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law.

**Living Will.** I have completed a Living Will: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Anatomical Gift(s).** I have made my wishes to be an organ and tissue donor known in my Living Will: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Donor Registry Enrollment Form.** I have completed the Donor Registry Enrollment Form: \_\_\_\_\_ Yes \_\_\_\_\_ No

**SIGNATURE**

*[See next page for witness or notary requirements.]*

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on \_\_\_\_\_, 20 \_\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
PRINCIPAL

*[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]*

*[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]*

**WITNESSES OR NOTARY ACKNOWLEDGMENT**

[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]

[The following persons **cannot** serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

**Witnesses.** I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature  
\_\_\_\_\_  
Print Name  
Dated: \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature  
\_\_\_\_\_  
Print Name  
Dated: \_\_\_\_\_, 20\_\_\_\_\_

**OR**

**Notary Acknowledgment.**

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned Notary Public, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

## **NOTICE TO ADULT EXECUTING THIS DOCUMENT**

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

- (1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:
  - a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

- b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);
  
- (2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**
  
- (3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);
  
- (4) **Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:**
  - (a) **You are in a terminal condition or in a permanently unconscious state.**

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

**(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**

**(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**

**(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**

**(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**

**(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.**

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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For more information about organ, eye and tissue donation, please contact [www.donatelifehio.org](http://www.donatelifehio.org) or your local organ procurement organization:

**Lifeline of Ohio**

770 Kinnear Rd., Suite 200  
Columbus, OH 43212  
800.525.5667  
614.291.5667

**Life Center Organ Donor Network**

615 Elsinore Place, Suite 400  
Cincinnati, OH 45202  
800.981.5433  
513.558.5555

**LifeBanc**

4775 Richmond Rd.  
Cleveland, OH 44128-5919  
216.752.5433  
800.558.5433

**Life Connection of Toledo**

3661 Briarfield Blvd., Suite 105  
Maumee, OH 43537  
800.262.3443  
419.893.1618

**Life Connection of Dayton**

40 Wyoming St.  
Dayton, OH 45409  
800.535.9206  
937.226.8223

**Caring Connections**

A program of the National Hospice and Palliative Care Organization  
[www.caringinfo.org](http://www.caringinfo.org)  
800.658.8898

**Midwest Care Alliance**

formerly Ohio Hospice and Palliative Care Organization  
[www.midwestcarealliance.org](http://www.midwestcarealliance.org)  
800.776.9513

**American Bar Association**

Consumer's Tool Kit  
[www.abanet.org/aging/toolkit](http://www.abanet.org/aging/toolkit)  
202.662.1000

It is important to let your loved ones know that you have Advance Directives. This card is provided for your use. Please complete the card and place it in your wallet or purse so your wishes will be known to medical professionals.

Forms located: \_\_\_\_\_

My Healthcare Power of Attorney(s)/Agent(s):  
*Primary* Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Secondary* Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I have a Living Will.  
 I have a Healthcare Power of Attorney Form.  
 I am an Anatomical Gifts Donor and have registered with the Bureau of Motor Vehicles.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Health Care Information**

*Advance Directives Wallet Card*

# Coming to Terms: A Glossary

**Advance Directive** – A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow you to give instructions about future medical care and appoint a person to make health care decisions if you are unable to make them yourself. Each state regulates the use of advance directives differently.

**Capacity** – In the health care context, this denotes the ability of the patient to understand and appreciate the nature and consequences of health care decisions and to make an informed decision. The term “competent” is also used to indicate ability to make informed decisions.

**CPR (Cardiopulmonary Resuscitation)** – A group of treatments, any or all of which are given to support or restore breathing and circulation if the heart or lungs stop working.

**DNR (Do-Not-Resuscitate) Order** – A physician’s written order instructing health care providers not to attempt CPR if the patient stops breathing or the heart stops beating. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of the patient or the person speaking on behalf of the patient, it must be signed by a physician to be valid.

**DNR Comfort Care (DNRCC)** – is a legally-sanctioned program that is implemented according to a standardized protocol. The DNRCC Order is implemented at different points, depending upon the patient’s wishes and must be consistent with reasonable medical standards.

The two options within the DNR Comfort Care Protocol are the DNR Comfort Care (DNRCC) Order and the DNR Comfort Care-Arrest (DNRCC-Arrest) Order. With a DNRCC Order, a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life from the moment the order is signed by the physician. With a DNRCC-Arrest Order, a person receives standard medical care that may

include some components of resuscitation until he or she experiences a cardiac or respiratory arrest.

**Health Care Power of Attorney** – A document that allows individuals to appoint someone else to make decisions about their medical care if they are unable to communicate. It may also be called a “health care proxy,” “durable power of attorney for health care,” or “appointment of a health care agent or surrogate.” The person appointed may be called a health care agent, surrogate, attorney-in-fact, or proxy.

**Hospice/Palliative Care** – A comprehensive approach to caring for individuals with a life-limiting illness that focuses on the physical, psychological, spiritual, and social needs of the patient. Its goal is to achieve the best quality of life possible by relieving suffering, controlling pain and symptoms, and enabling maximum functional capacity. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient’s family while the patient is dying, and bereavement support after their loss.

**Life-sustaining Treatment** – Treatments (medical procedures) that replace or support an essential bodily function (may also be called life-support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

**Living Will** – A type of advance directive in which people document their wishes about future medical treatment if they are at the end of life and unable to communicate. It may also be called a “directive to physicians,” “healthcare declaration,” or “medical directive.” The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments.

**Withholding or Withdrawing Treatment** – Choosing not to have life-sustaining measures or discontinuing them after they have been used for a certain period of time.



Notes



## OUR MISSION

Hospice of the Western Reserve provides palliative and end-of-life care, caregiver support, and bereavement services throughout Northern Ohio.

In celebration of the individual worth of each life, we strive to relieve suffering, enhance comfort, promote quality of life, foster choice in end-of-life care, and support effective grieving.



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