Advance Directives: Power of Attorney for Health Care and Living Will

Archdiocese of San Francisco

August 31, 2021

Legal Background - Patient Self-Determination Act (1991)

This federal law affirms your right to …

1. make decisions about your health care
2. accept or refuse medical interventions
3. complete an advance directive for health care

The law requires health care personnel to …

1. inform you of your legal right to make medical decisions for yourself
2. inquire whether you have an advance directive(s) for health care
3. ask if you would like to create an advance directive (if you do not have one)
4. not discriminate against providing treatment to patients based on whether they have, or do not have, an advance directive

Advance Directives

1. Advance Directives are legal documents that allow you to communicate your preferences for future health care interventions (treatments) – most often related to end-of-life care.
    a. Advance directives allow you to remain in charge of your care even after you lose decision-making capacity (the ability to make decisions for yourself).
    b. Advance directives allow you to design a treatment plan or strategy (1) when you are diagnosed with a serious illness, or (2) if you were to experience a sudden devastating injury or trauma.
    c. Clarifications:
        1) Advance directives only take effect when the patient loses decision-making capacity.
        2) As long as you possess decision making capacity, you continue to direct the care you receive.
2. The two most common advance directive documents are (a) the (Durable) Power of Attorney for Heath Care and (b) the Living Will (also known as a "Directive" or "Health Care Declaration")
3. Reasons for completing an advance directive …
    a. Advance directives are a means for you to communicate end-of-life treatment choices that are consistent with your values, beliefs, and goals. They prompt you to respond to the question, "What does 'living well' mean to you?"
    b. Advance directives allow you to designate another person to make health care decisions for you if/when you are not able to make them for yourself.
    c. Advance directives ensure your right to accept or refuse specific medical care. Your loved ones and the health care team will know what medical interventions you want, and don't want.
    d. Advance directives can spare your loved ones (1) from having to make difficult decisions for you, especially when they do not know your wishes; and (2) from conflict, particularly when family members disagree on a particular treatment (or non-

treatment). By sparing others from having to make difficult decisions for you, Advance Directives are a gift to your loved ones.

4. Requirements for completing an Advance Directive
    a. You must be 18 or older
    b. You must freely express a desire to both request and complete an advance directive. You cannot be coerced or unduly pressured by others into completing an advance directive
    c. You must demonstrate decision-making capacity. This includes …
        1) Comprehension, or a full understanding of the situation
        2) Ability to exercise critical reasoning/evaluation – "Why should I complete an advance directive?"
        3) Ability to clearly communicate your choices to others
    d. Advance directive documents must be signed by (1) you (the individual/patient), and (2) a notary public AND/OR two witnesses (confirm state law)
        1) You do not need a lawyer to complete an advance directive
        2) Depending on your state, you may not need a notary to complete an advance directive
5. Clarifications …
    a. Advance directives are legal documents. Health care professionals have a duty to comply with them and they cannot be (easily) changed without your consent.
    b. Completing an advance directive does not mean "Do not treat." You will continue to receive any treatments(s) that you indicate, and you will always receive comfort care.
    c. At any time, you can change what is indicated in your advance directive(s)—or you can revoke it—to meet changing medical or individual circumstances.
    d. Which takes precedence in cases of conflict, the Power of Attorney for Health Care or the living will? (confirm state law).
6. Important!
    a. Make sure you communicate to your loved ones that you have an advance directive.
    b. Make sure family members, loved ones, etc. know where your advance directive(s) are located (where you keep them) so they can be easily accessed when needed.

Again, the two most common Advance Directive documents are (1) the (Durable) Power of Attorney for Health Care and (2) the Living Will

Power of Attorney for Health Care

1. The Power of Attorney for Health Care (POA-HC) is a legal document that names and authorizes another person to make medical decisions for you in situations where you are unable to make them for yourself.
    a. Decision-maker
        1) Primary – the person authorized to make health care decisions for you
        2) Secondary – the person(s) who makes decisions when the primary decision-maker is not available
    b. The designated decision-maker is called the proxy, surrogate, or health care agent.
2. The POA-HC takes effect with the loss of decision-making capacity, when the individual loses the ability to make health care decisions for him/herself. The factor causing the loss of decision-making capacity can be either temporary or permanent.

3. The POA-HC is "durable" ("Durable Power of Attorney for Health Care") in that the designated decision-maker's power of attorney continues indefinitely, even after the patient loses decision-making capacity. The POA remains until it is changed by patient or the patient dies.
4. The designated decision-maker is authorized to: (not complete list, confirm state law)
    a. Give or refuse consent to any medical intervention (medication, procedure, treatment)
    b. Authorize admission or transfer to/discharge from any health care facility.
    c. Consent to comfort care only
    d. Consent to Do Not Resuscitate (DNR) order => Administer no resuscitative measures (CPR, defibrillation)
    e. Transfer the patient to a facility where the patient's wishes will be honored (if the present facility cannot honor these wishes)
    f. Limitations: The patient and can limit the proxy/surrogate's decision-making authority as patient desires (confirm state law)
5. POA-HC can authorize the designated decision-maker to have immediate access to the patient's medical records (confirm state law).
6. Important points regarding the person you choose as your designated decision-maker or proxy:
    a. Assure that the proxy …
        1) knows your beliefs, values, and goals
        2) is aware of your end-of-life wishes
        3) is willing and able to carry out your health care decisions and instructions, even if he/she disagrees
        4) possesses the ability to make decisions in difficult situations
        5) understands Catholic teaching on end-of-life decision-making, or knows where to get accurate information (NCBC)
    b. Clarification: The proxy does not consent to (or implement) interventions that the proxy personally prefers. The proxy consents to interventions in accord with what <u>you</u> (the patient) have indicated.
7. Important: The POA-HC is limited to health care decisions, it is NOT a financial (or other) power of attorney. The person designated as the proxy or surrogate only makes decisions concerning health care.
8. The NCBC recommends that <u>everyone</u> designate a proxy decision-maker, POA-HC

<u>Living Will or "Health Care Declaration"</u>

1. The living will is a legal document that allows you to communicate what medical interventions (including life-sustaining treatments) you want, and don't want.
    • Important: Not all states have living wills.
2. The living will takes effect when you are determined to be (a) terminally ill and unable to make health care decisions for yourself, <u>OR</u> (b) permanently unconscious with no reasonable expectation of regaining decision-making capacity.
3. The living will can authorize the physician to … (not complete list, confirm state statute)
    a. Take appropriate measures, or do what the patient indicates, to maintain life
    b. Decline aggressive medical interventions (treating the underlying medical condition) and provide comfort care only.

c. Administer no life-sustaining interventions such as a ventilator, dialysis, etc.
d. Issue a Do Not Resuscitate (DNR) order => Administer no resuscitative measures (CPR, defibrillation)
e. Withhold or withdraw medically assisted nutrition & hydration (MANH)
    1) Depending on the state, one may need to specifically authorize on the Living Will form the withholding or withdrawing of medically assisted nutrition & hydration (confirm state law)
    2) Important: Withholding/withdrawing medically assisted nutrition & hydration may conflict with Catholic teaching (get guidance from the NCBC or other trusted source)

4. Depending on state statute, a living will (or "Declaration") is suspended (not in effect) when a woman is pregnant
5. The living will may contain an optional Anatomical Gift designation (confirm state statute)
    a. One can authorize the donation of one's entire body, or specific parts of one's body, after death.
    b. Donation can be designated for transplantation, therapy, research, education, or for all purposes.
6. Important: A living will is <u>not</u> a Last Will and Testament, the document that appoints an executor of your estate and designates who will receive your property after you die. The Living Will only addresses health care-related issues at end-of-life.
7. Unless the patient is terminally ill (less than six months to live), the NCBC does not recommend completing the living will:
    a. Generally speaking, living wills are biased against receiving interventions. The language used emphasizes what interventions one can refuse rather than what one can accept.
    b. The living will allows people to refuse treatments that are ordinary and thus morally obligatory (refusing nutrition & hydration, antibiotics). This is contrary to Catholic teaching.
    c. The living will can undermine informed consent. The forms allow (necessitate?) one to make decisions about future interventions/treatments when one does not have full knowledge of the medical condition (diagnosis, prognosis, treatment options, etc.). Life and death medical decisions are being made without adequate informed consent.

<u>Catholic Teaching on Advance Directives</u>

Catechism of the Catholic Church

> #2278: The decision [discontinuing extraordinary medical care] should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.

Ethical and Religious Directives for Catholic Health Care Services, 6th ed. (US Catholic Bishops)

- Directive 24: In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

- Examples of "contrary to Catholic teaching"
    1) (Physician) Assisted suicide
    2) Euthanasia
    3) Withholding/withdrawing medically assisted nutrition and hydration when the patient's condition indicates that it should be provided
    4) Voluntary stopping of eating and drinking (VSED)

- Directive 25: Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.
- Directive 28: Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

<u>NCBC resources</u> (not complete)

1. "A Catholic Guide to End-of-Life Decisions" (available in Spanish) – NCBC online store
    - Includes NCBC Health Care Proxy and Advance Medical Directive forms
2. "Advance Directives: Durable Power of Attorney and Living Will," in *Catholic Health Care Ethics: A Manual for Practitioners*, 3rd edition (Philadelphia, PA: NCBC, 2020), 24.1–24.11.
3. *The Art of Dying: A New Annotated Translation,* Br. Columba Thomas, OP (Philadelphia, NCBC, 2021)
4. *Bioethics on Air* podcasts:
    - Episode 6: End of Life Decision Making (ordinary v. extraordinary)
    - Episode 15: Legal Aspects of Advance Care Planning
    - Episode 19: Deactivating a Pacemaker
    - Episode 72: Reclaiming the *Ars moriendi* ("Art of dying")