

Important Decisions

Information about issues you may need to consider with your family and physician

Decisions about medical treatment at the end of life frequently occur in the hospital. The skillful application of advanced medical technology can often contribute to remarkable cures. Sometimes, however, significant improvement is unrealistic and all efforts seem only to prolong the inevitability of death, not life. At times such as these, difficult decisions must be considered by you as a patient, by your family, and by your physician. This brochure provides you with the information you need to consider and understand these decisions — how they're made, as well as how you can ensure your wishes are honored.

Background information

Burden-Benefit Principle

An important guiding principle recognized in medical ethics, religion and United States law is the *Burden-Benefit Principle*. This principle recognizes that medical procedures may be withheld when the burden or risk incurred exceeds the expected or actual benefit. This judgement may be made either by a patient, the family, or a recognized surrogate. A surrogate is appointed to act in place of another to carry out an incompetent patient's wishes.

Factors to be considered when assessing burdens and benefits include the effects of the procedure on the quality and/or length of life, and the effects on the patient's and family's physical, mental, emotional and spiritual well-being. Throughout this careful and thorough consideration, however, the primary emphasis and objective is to determine and implement the wishes of the patient, or when such wishes are unknown, to act in the patient's best interest. The best way for a patient to maintain autonomy regarding decisions about medical care is to execute an *Advance Directive*, commonly known as a living will. Additional information about *Advance Directive* can be found in this brochure.

Questions you may have

Asking questions

There are many questions surrounding the concepts of withholding resuscitation procedures and other life-prolonging treatments, and these may be questions that you did not expect to face. Consequently, you may not know how to make decisions about these issues. Discussing the issues with your family, clergy or close friends may be an important first step in the process. You may also want to ask questions of the people responsible for your medical care. We encourage you to obtain as much information as you need from all those around you in order to make an informed, considered decision. The attending physician should be the primary source of information regarding the medical aspects of your care. Nurses, hospital chaplains and others may also be important resources for information and guidance. As with most situations, open communication is the best way to avoid misunderstandings.

What are life-prolonging treatments?

Life-prolonging treatments may include: artificially administered nutrition and hydration (intravenous or other feeding tubes, either through the nose or by an incision in the stomach), respirators or mechanical ventilation, surgery, blood transfusion, hemodialysis, cancer chemotherapy treatments and medications, e.g., antibiotics.

What is a “Do Not Resuscitate” (DNR) order?

A *Do Not Resuscitate* order is an agreement stating that no attempts will be made by any method to revive heart or lung function if a person stops breathing or his or her heart stops beating. Ordinarily, when heart or lung function stops, the response is to do everything possible to restore and maintain those functions, including the use of cardiopulmonary resuscitation and, if necessary, mechanical or other measures. A *Do Not Resuscitate* order means that none of these procedures will be employed to attempt to revive the patient. This order will be given only after the physician has discussed the clinical status with the patient or surrogate decision-maker and both are in agreement.

How can you forgo these treatments and procedures?

If a mentally competent patient decides he or she does not want resuscitation or further life-prolonging treatment, then this should be discussed with the attending physician. If a person is mentally incompetent, then a prior statement of intention set forth in an *Advance Directive* (living will), or the unified decision of the patient's family or a recognized surrogate, ordinarily will be respected. Such a decision should be discussed with the patient's attending physician. It is often helpful to obtain a second, independent medical opinion before making this decision.

Will this decision affect the care provided?

An order to withhold or withdraw treatment does not mean that other care of the patient will be discontinued. Supportive care and comfort will always be given.

Can an order be cancelled?

A *Do Not Resuscitate* order, or life-prolonging treatment decision, may be revoked at any time by requesting a cancellation of the attending physician's written order.

How to ensure your wishes are carried out

Face up to the responsibility

Although no one expects to have to make these decisions, everyone may one day have to face making them. It is difficult to make sound decisions in the midst of an unexpected crisis. It is better to discuss your thoughts and healthcare wishes with loved ones, clergy members and caregivers before you become ill. This is also the best time to make your wishes known through an *Advance Directive*, a document that describes the kind of medical care you want in the event you become unable to make these decisions for yourself.

Consider an Advance Directive

There are three kinds of *Advance Directives*. An *Instruction Directive* (also called a living will) describes the kind of treatment you would accept or reject in certain situations. Because it is difficult to consider all the possibilities, you may elect to use a *Proxy Directive* (also called a Durable Power of Attorney for Health Care), which lets you name a healthcare representative — such as a family member or close friend — to make healthcare decisions on your behalf. Finally, you may wish to execute a *Combined Directive*, which lets you both give instructions for many possible scenarios *and* name a healthcare representative.

Remember, the purpose of an *Advance Directive* is to allow you to control decisions about your health care when you are no longer able to communicate. It only takes effect when you are in that situation, and only after your doctor is able to offer a diagnosis and prognosis. A clearly written Directive will help prevent disagreements among loved ones, alleviating some of the burden of decision-making often experienced by family members and healthcare providers. It will also avoid the need to obtain a court-appointed guardian for those who have no family and have not named a proxy.

How do I obtain an Advance Directive?

Advance Directives are available at The Valley Hospital on all the patient care units, as well as in the Department of Pastoral Care and the Medical Staff Administration offices. An *Advance Directive* is provided as part of this brochure. They may also be obtained through your physician or attorney, as well as from the Medical Society of New Jersey. Please note: Before completing any Living Will, Medical Directive or Power of Attorney forms, you may want to obtain appropriate professional advice.

Conflict Resolution

When confronting difficult issues and decisions about the care of a loved one, families may encounter conflicts and disagreements that can usually be resolved through open communication. To facilitate this process of open communication, The Valley Hospital Biomedical Ethics Committee is available to advise you and your family. They can be reached through your nurse, the nursing supervisor, or the office of the Vice President of Medical Affairs.

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ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____, hereby declare and make known my instruction and wishes for my future health care. This advance directive for health care shall take effect in the event I become unable to make my own healthcare decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

DESIGNATION OF A HEALTHCARE REPRESENTATIVE

I hereby designate: Name _____
Address _____
Phone _____

as my healthcare representative to make any and all healthcare decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining measures. I understand my healthcare representative may have access to my protected health information under the Health Insurance Portability and Accountability Act.

If the person I have designated above is unable, unwilling or unavailable to act as my healthcare representative, I hereby designate the following person(s) to act as my healthcare representative, in the order of priority stated:

1. Name _____	2. Name _____
Address _____	Address _____
Phone _____	Phone _____

INSTRUCTION DIRECTIVE

I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, injury, disease or condition which may or may not be terminal. Also, a time may come when I become permanently unconscious, that is, I have totally and irreversibly lost my capacity for interaction with other people and my surroundings. In either of these circumstances, I hereby direct that the life sustaining measures checked below be withheld or discontinued. I also direct that I be given medication to assure my comfort at the end of my life and that any treatments that would serve to prolong my dying be withheld or discontinued.

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Artificially provided fluids and nutrition | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Respiratory support | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Cardiopulmonary resuscitation (CPR) | <input type="checkbox"/> Dialysis |

(The above list is not all inclusive and you may add other measures to it.)

ADDITIONAL INSTRUCTIONS

You should provide any additional information about your healthcare preferences which is important to you and which may help those concerned with your care to implement your wishes. If you wish aggressive treatment continued in any of the circumstances described above, you should state this. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.

Continued on reverse side

ADVANCE DIRECTIVE FOR HEALTH CARE (continued)

BRAIN DEATH

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. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death. If so, please indicate in the space provided.

AFTER DEATH – ANATOMICAL GIFTS

It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. I wish to have my healthcare representative consider organ donation upon my death.

Yes No

SIGNATURE

By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision-making which this responsibility may impose. I have discussed the terms of this designation with my healthcare representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I hereby release and discharge from any and all liability whatsoever any person or entity who takes any action to carry out my wishes in reliance on this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____, 20 _____ Signature _____

Address _____

WITNESSES*

I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's healthcare representative, nor as an alternate healthcare representative.

1. Witness _____	2. Witness _____
Signature _____	Signature _____
Date _____	Date _____

*In lieu of witnesses, this document may be notarized.

Sworn to before me on this _____ day of _____, 20 _____

Notary Public