

MY CHOICES

Information on:

Advance Care Directive

Living Will

POLST Orders



My Choices

Adults have the right to accept or refuse medical care. As long as you can make health care decisions for yourself, health care providers must talk with you about what you want. But if you are injured or have a serious illness, you may become unable to make decisions.

An **Advanced Directive/Living Will** is a document that lets health care providers, family and others know what health care you want and do not want. Montana law does not allow you to direct your care if you are diagnosed to be in a permanent coma or persistent vegetative state, however, you can ask that the wishes outlined in an advanced directive/living will be followed by the individuals making decisions for you. This is your right under the U.S. Constitution. The Montana Rights of the Terminally Ill Act protects your rights at the end of your life. This act allows your wishes for providing, withholding or withdrawing any life prolonging procedures as outlined in your Advance Care Planning Directives to be carried out. You have the right to change or revoke an advance care directive at any time.

A **Health Care Agent** is a person named by you to make decisions regarding health care for you when you are not able to make your own decisions. Your health care agent should be someone you trust, who will have your best interest in mind when making decision for you and make those decisions according to your intended wishes. Be sure to discuss your wishes with your Health Care Agent! Your agent may make all health care decisions for you unless you limit the authority of your agent. Your agent must be at least 18 years of age and may not be:

- An operator or employee of a community care facility or residential care facility where you are receiving care.
- Your supervising health care provider (doctor, nurse practitioner)
- An employee of health care institution where you are receiving care, unless your agent is related to you or is a coworker.

A **POLST** (Provider Orders for Life-Sustaining Treatments) helps assure your wishes at the end of your life are followed by health care providers. A POLST form is an official documentation of medical orders on a standardized form coupled with a promise by health care professionals to honor those wishes. A POLST is intended for people with serious illness. This form does not replace your other directives. Instead, it serves as

doctor ordered instructions (not unlike a prescription) to ensure that, in case of an emergency, you receive the treatment you prefer. Like Advance Directive/Living Will a POLST can be canceled or updated at any time.

DNR/DNI (Do Not Resuscitate or Do Not Intubate): You do not need an Advance Directive/Living Will to have a DNR or DNI order. However it is helpful for your loved ones to know your preferences. You need to make your preferences known to your health care provider upon admission so that he/she can write these orders in your chart. A DNR and DNI means that if your heart has stopped beating or you are no longer breathing and you have died, health care workers do not start CPR to try and “bring you back”. A DNI order will be honored unless you request a breathing machine (ventilator) to help you breathe while you recover from a severe respiratory disease.

Definitions

- **Health Care Provider:** any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.
- **Artificially administered food or water** (tube feeding): food or water given either through a tube inserted in a vein (IV), under the skin (Sub Q), or into the stomach (Stomach tube or Feeding Tube).
- **Vegetative State:** “A vegetative state is when a person is awake but showing no signs of awareness...A person in a vegetative state may open their eyes, wake up and fall asleep at regular intervals and have basic reflexes, such as blinking when they're startled by a loud noise, or withdrawing their hand when it's squeezed hard. They're also able to regulate their heartbeat and breathing without assistance. However, a person in a vegetative state doesn't show any meaningful responses, such as following an object with their eyes or responding to voices. They also show no signs of experiencing emotions nor of cognitive function.” (Taken from: <http://brainfoundation.org.au/disorders/vegetative-state>).
- **Green Burial:** “Green, or natural burial is a way of caring for the dead with minimal environmental impact that aids in the conservation of natural resources, reduction of carbon emissions, protection of worker health, and the restoration and/or preservation of habitat. Green burial necessitates the use of non-toxic and biodegradable materials, such as caskets, shrouds, and urns.” (Taken from: <https://greenburialcouncil.org/home/what-is-green-burial/>).

- **Palliative Care:** Palliative care is specialized medical care aimed at improving the quality of life of patients and their families facing serious illness. Care can be provided in conjunction with curative or life prolonging treatment.
- **Hospice:** Hospice care is provided to a patient who has a chronic and usually terminal illness with a usual life expectancy of 6 months or less. Hospice care is provided by an interdisciplinary team (physician, nursing, social work) to give patients and families an extra layer of support and help manage distressing and painful symptoms. Patients on hospice are not seeking curative treatment and the focus is on comfort and quality of life at the end of life.
- **Comfort Care:** treatment, including prescription medications, given to the patient to alleviate pain.
- **Irreversible Coma:** a permanent state of unconsciousness cause by disease, injury, poison, or other means and for which it has been determined that there is no reasonable expectation of regaining consciousness.
- **Life Prolonging Procedure:** any medical procedure, treatment, or intervention that keeps a person alive. This may include artificial respiration (breathing tube or ventilator), cardiopulmonary resuscitation (perform CPR if the heart stops and the person is dead), artificially administered food or water, or dialysis.
- **Terminal Condition:** a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

Frequently Asked Questions

What are the benefits of having an Advanced Care Planning Directive?

- As long as you can make health care decisions for yourself, health care practitioners must talk with you about what you want. But, if you are injured or have a serious illness, you may become unable to make decisions. Advance Care Planning Directives are documents that lets your health care practitioner, family and others know what you want and do not want. Planning Directives. All health care facilities are required by law to inform you of these rights.
- No one knows what the future holds. At some point, nearly everyone may need assistance with making medical decisions for them. It is important to think ahead about your values, goals, and wishes. You are not required to have advance directive/living will but it is important to talk with the people (Health Care Agent, family, friends) who will be making decisions about your care if you are unable to do so for yourself so that your wishes can be followed.

What happens if I do not have an advanced directive/living will?

- Montana law defines who can make decisions for you if you do not have an advance directive/living will, health care agent, or court appointed guardian. The order of who can make decisions is: spouse (if divorce is not filed), adult child or children, parents, adult sibling or siblings, or nearest other adult relative. If no listed person is available to decide for you a judge might decide what treatment is best.

What are some of the decisions I should consider?

- Members of your health care team (usually your primary care doctor or nurse practitioner or a member of a Palliative Care team) can talk with you about your medical condition and treatment choices. Use of life prolonging procedures is the most common decision to be made. These procedures include: cardiopulmonary resuscitation (CPR) to try to restart breathing and/or heart beat; hydration (water) and nutrition by tube; use of respirators (machines that breathe for you); IV antibiotics, and dialysis for kidney failure. Thinking about how long you would want these treatments to continue if you were not getting better is also important. How long do you think it's reasonable to continue? It is very helpful to

family and health care workers if you put these thoughts in your advance directive/living will.

- Another decision to think about is what treatments you would want for pain and other symptoms. Palliative care at any time and hospice care at the end of life are two methods of focusing on comfort. You may request these in your advance directive/living will if you want that kind of care.
- You may also think about other options after your death. Some options include eye, tissue, and organ donation for transplant or autopsy to help your doctor and family understand what happened to you.

Will having an advance directive/living will affect my insurance? What about emergency care?

- Health and life insurance will not be affected by advance directives/living wills. Refusing life-prolonging treatment will not void life insurance policies. If your advance directives/living will is followed, death is not considered suicide. Emergency medical personnel (ambulance, firemen, and police officers) are required to provide emergency efforts to save your life. An advance directive/living will cannot change this. If you do not want to receive emergency efforts to save your life talk to your health care provider about a POLST. This is a special order that says you will not get CPR if your heart or breathing stops but you may get other treatments that are not aimed at restarting your heart.

What if I change my mind?

- You may cancel, revoke or change your advance directives/living will at any time. You should let everyone know your new wishes and destroy any old forms.

How will a doctor know I have an advance directive/living will?

- Hospital staff must ask you if you have one when you are admitted to the hospital. If you give your advance directive/living will to hospital staff a copy of it will be placed on your medical record. If you complete an advance directive/living will you should give a copy to your health care agent, family and health care provider. You can complete the Consumer Registration Agreement from the Montana End of Life Registry form and mail it, along with a copy of your advanced directives/living will, to the registry to have a copy of file with the state of Montana. The registry will send you a wallet card.

What else should I know?

- Filling out an advanced directive/living will is part of advance care planning. This process helps you:
 - Get information to understand your medical condition and choices for care.
 - Think about your beliefs, values, and goals for treatment.
 - Discuss these thoughts with family, friends, clergy, health care providers, and agents.
 - Write down your wishes
 - Remember to review your plan every year to be sure it still reflects your wishes.