



**Your Right
To Make Your Own
Health Care Decisions**



Sinai Hospital of Baltimore
2401 West Belvedere Avenue
Baltimore, Maryland 21215-5271

WHAT YOU NEED TO KNOW ABOUT ADVANCE DIRECTIVES

Sinai Hospital is committed to providing quality health care for all patients. When you are a patient here, you have the right to a high standard of care and service throughout your stay. It is our practice to make sure that patients' wishes about their medical care and treatment are respected in accordance with accepted principles of medical practice, ethics and law.

As a patient you have the right to be told in understandable terms:

- the nature of your illness
- the general nature of your proposed treatment
- the risks of not undergoing this treatment
- any alternative treatments that may be available to you

You then have the right to decide what type of treatment to accept, refuse or discontinue.

Sometimes, because of illness or injury, you may be unable to make decisions about your medical care. Through an advance directive you can designate someone to make health care decisions for you, if necessary and/or let others know what kind of health care you wish to receive by the written instructions (advance directive) you complete.

Sinai Hospital has prepared this brochure to provide you with information about advance directives so you can make and communicate decisions about your wishes to accept and/or withhold medical treatment. These very important decisions can be difficult to make. The staff at Sinai is available to discuss the information in this booklet and answer your questions.

What are Advance Directives?

Advance Directives are legal documents which state your choices about medical treatment or name someone to make decisions about your medical treatment if you are unable to make those decisions yourself. They are called "advance directives" because they are made in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

Maryland law recognizes the following types of advance directives:

- written appointment of a health care agent (also known as Durable Power of Attorney for Health Care) and health care instructions
- oral statement to your physician (documented and witnessed in your medical record) leaving instructions or appointing an agent

What is the Appointment of Health Care Agent/Health Care Instructions?

(formerly known as Durable Power of Attorney for Health Care)

The Appointment of Health Agent form provides a place for you to write the name of the person (Health Care Agent) you want to make medical decisions for you if you become permanently or temporarily unable to make these decisions yourself. The person you choose as your Health Care Agent does not have to be an attorney. If you name a Health Care Agent to make medical decisions for you, you may, but do not have to, complete the Health Care Instructions form. However, if you do not complete the Health Care Instructions form, your Health Care Agent will make the medical decisions for you based only on what they think is in your best interest.

The Health Care Instructions form provides a place for you to outline your wishes concerning treatment options if you: 1) have an end-stage condition; 2) are dying from a terminal illness; or 3) are in a permanent vegetative state. You can also write in any other health care instructions on this form.

If you have named a Health Care Agent, your agent can use your health care instructions to help them make decisions for you. If you do not wish to name a Health Care Agent, your physicians and other care providers will follow your written health care instructions to guide them in determining your treatment.

After you have completed and signed the Appointment of Health Care Agent and/or Health Care Instructions form, please give a copy to your physician and provide a copy for the hospital so the form can be put on your chart.

What are Oral Advance Directives?

Oral advance directives are verbal instructions from you to your physician describing the kind of care you wish to receive. Your physician will document your instructions regarding your care in your medical record and have a witness sign the documentation. This makes your instructions part of your permanent medical record. Your wishes (instructions) can be communicated to your physician at any time prior to or during your hospitalization.

What If I Wish To Change My Advance Directive?

You can withdraw or change your written or oral advance directive at any given time after you have communicated them by letting your physician or other hospital care providers know of your decision. At your request, any advance directives can be canceled or changed.

OTHER FREQUENTLY ASKED QUESTIONS:

What is a Terminal Condition?

A terminal condition is an incurable condition for which medical treatment will only prolong the dying process. Without the administration of medical treatment or procedures, death will occur in a relatively short period of time.

What is a Persistent Vegetative State?

A persistent vegetative state means that a person is in a permanent coma or state of unconsciousness, caused by illness, injury or disease. The person is totally unaware of himself, his surroundings and environment. To a reasonable degree of medical certainty, there can be no recovery.

What is End-Stage Disease?

End-stage disease is when a person has suffered permanent deterioration indicated by the inability to make decisions for oneself and complete physical dependency. This can be caused by injury, disease or illness. To a reasonable degree of medical certainty, treatment of end-stage disease would not be medically effective.

How to Get More Information

This booklet does not cover every issue regarding your right to make your own health care decisions. If you have more questions, request to speak with your physician, a hospital Social Worker, Chaplain or an attorney. Also talk with your doctor about the medical issues involved in your care. Please tell your family about your decisions and give them a copy of any advance directive that you complete.

The Advance Directive forms in this booklet were developed after the Health Care Decision Act of 1993 was enacted by the Maryland Attorney General's Office.

For additional copies, call LifeBridge OnCall at 410-601-9355, the Attorney General's Office at 410-576-7000, or the Maryland Office on Aging at 1-800-243-3425.

What is the Purpose of the Ethics Committee at Sinai Hospital

Sinai Hospital has an Ethics Committee whose members will help patients and their families with resolving specific clinical situations which have ethical implications. Patients and families who wish to meet with the committee should call the hospital Social Work Department at 410-601-5578 or let another health care provider know of their wish.

Important Telephone Numbers

Main Hospital	410-601-9000
Emergency Department	410-601-8800
LifeBridge OnCall	410-601-9355
Chaplain Office	410-601-9680
Social Work Office / Ethics Committee Consults	410-601-5578
TTY	410-601-4900

Advance Directive

Appointment of Health Care Agent

(If you use this form to appoint an agent, cross through any items in the form that you do not want to apply.)

1. I, _____
residing at _____

appoint the following individual as my agent to make health care decisions for me:

(Full Name, Address and Telephone Number of Agent)

Optional: if this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

(Full Name, Address and Telephone Number of Back-Up Agent)

2. My agent has full power and authority to make health care decisions for me, including the power to:

- A. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;
- B. Employ and discharge my health care providers;
- C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult group home, or other medical or custodial care facility; and
- D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

3. The authority of my agent is subject to the following provisions and limitations:

4. If I am pregnant, my agent shall follow these specific instructions:

5. My agent's authority becomes operative (*initial only the one option that applies*):

When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; or

When this document is signed.

6. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

7. My agent shall not be liable for the costs of care based solely on this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

(Date) (Signature of Declarant)

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual.

(Witness) (Witness)

(Signatures and Addresses of Two Witnesses)

Please share your instructions with your family members and provide a copy of this document to your family doctor and any hospital you are admitted to.

Advance Directive

Health Care Instructions

To be used if you have not designated a Health Care Agent OR to provide additional instructions for your Health Care Agent.

*(If you do want to complete this portion of the form, **initial** those statements you want to be included in the document and **cross through** those statements that do not apply.)*

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. *(Initial all those that apply.)*

1. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

2. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

4. _____ I direct that, no matter what my condition, medication to relieve pain and suffering not be given to me if the medication would shorten my remaining life.

5. _____ I direct that, no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.

6. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

7. I direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care):

By signing below, I indicate that I am emotionally and mentally competent to make this Advance Directive and that I understand the purpose and effect of this document.

(Date)

(Signature of Declarant)

The declarant signed or acknowledged signing these health care instructions in my presence and, based upon my personal observation, appears to be a competent individual.

(Witness)

(Witness)

(Signatures and Addresses of Two Witnesses)

Please share your instructions with your family members and provide a copy of this document to your family doctor and any hospital you are admitted to.