

Your Right to Choose

A Personal Guide to Taking Responsibility for Your Health Care Decisions



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The law requires that patients are given enough information to make an informed choice about giving or refusing permission (consent) for medical care and treatment. By law, an adult has the right to agree to or refuse treatment, and has a right to be informed of the possible medical outcomes of refusing care or treatment.

Permission is not required to provide emergency care to an adult who is unconscious or unable to communicate and is suffering from an injury or illness that could result in immediate death. Problems sometimes happen when an adult needs medical treatment in a non-emergency situation but is unable to give permission or tell the doctor his or her desire for medical care.

When adults are unable to decide or communicate their wishes about their medical care, their rights, values and beliefs may be at risk. For this reason, a growing number of people are using advance directives to explain their medical care wishes in writing.

What Is an Advance Directive?

An advance directive is a form that explains your choices for treatment and to name people who are authorized to make treatment choices for you if you are unable to make decisions for yourself. A signed advance directive will take effect only if you become too ill, mentally or physically, and are unable to make medical or mental health care decisions or express your wishes. Advance directives do not cover financial matters. **The five kinds of advance directives legally recognized in Texas are:**

- Medical Power of Attorney (formerly known as a Durable Power of Attorney for Health Care)
- Directive to Physicians and Family or Surrogates (commonly referred to as a Living Will)
- Out-of-Hospital Do-Not-Resuscitate Order
- In-Hospital Do-Not-Resuscitate Order
- Declaration for Mental Health Treatment.

Each of these advance directives is discussed in more detail in this booklet.

You are not required to complete these documents should you choose not to. They are not required for buying health insurance or receiving medical care at a facility.

If, after reviewing this booklet, you would like to talk about your feelings or ask questions about these matters, you may contact your doctor, your lawyer, nurse, Ethics Department/committee, patient advocate, chaplain or a Social Services representative from the facility.

If you would like copies of advance directive forms, you may photocopy the forms in this booklet. You are not required to complete these forms as part of patient registration in a facility or at any time in the future.



This information is provided to comply with the state Advance Directives Act and the federal Patient Self-Determination Act. Complaints concerning the facility's failure to follow federal and state advance directive requirements may be filed with:

*Texas Department of State Health Services
Health Care Quality Section
Health Facility Compliance
P.O. Box 149347, MC-1913
Austin, TX 78714-9347
888-963-7111
dshs.texas.gov/consumerprotection*

Medical Power of Attorney

(formerly Durable Power of Attorney for Health Care)

A Medical Power of Attorney is a form that lets you choose someone to be your agent to make health care decisions for you. These decisions can include:

- Agreeing to or refusing medical treatment;
- Deciding not to continue medical treatment; or
- Making decisions to stop or not start treatment that will keep you alive.

Points to Remember

- The person who you choose to make your decisions (agent) makes decisions for you only when you cannot make decisions for yourself.
- Your agent cannot make decisions about:
 - » Voluntary inpatient mental health services;
 - » Shock (convulsive) treatment;
 - » Psychosurgery;
 - » Abortion; or
 - » Withholding comfort care.
- Talk with your doctor, agent, close family/friend, clergy or lawyer before you sign your Medical Power of Attorney. Also, give these people copies of your signed form and keep track of who has these copies.
- You can change or cancel your Medical Power of Attorney at any time and for any reason.
- The Medical Power of Attorney applies to health care decisions. It does not cover financial matters.

The Medical Power of Attorney form is included in this booklet for your use.

Notice to Patients Regarding Do-Not-Resuscitate Orders

Texas Health facilities have a policy regarding Do-Not-Resuscitate Orders (DNRs) and other limited resuscitation orders (i.e., chest compressions, breathing machines). The policy describes how you or your decision-maker, if you are not able to make your own treatment decisions, may consent to those orders. This policy sets out the requirements for:

- Written DNRs;
- Oral DNRs;
- Who may consent to a DNR order for you; and
- When and by whom a DNR can be revoked.

If you would like more information, please ask any member of your care team.

Directive to Physicians and Family or Surrogates

(commonly referred to as a Living Will)

A Directive to Physicians and Family or Surrogates is a form that lets you tell doctors to give, take away or withhold treatment that will keep you alive when your doctor has determined that you have a terminal condition and you are not able to communicate.

Treatment or care that will keep you alive includes life-saving medicines and artificial life support, such as breathing machines (ventilators), kidney dialysis, feeding tubes (artificial nutrition) and IVs (artificial hydration). These treatments or procedures to keep you alive are not expected to cure your condition or to make you better. They only prolong how long you may live.

Points to Remember

- This advance directive lets you tell doctors and those close to you what treatments or care you want or do not want to keep you alive. It only goes into effect when you have an irreversible or terminal condition and are unable to make or communicate your own health care decisions.
- Talk with your doctor, agent, close family/friend, clergy or lawyer before you sign your Directive to Physicians and Family or Surrogates (Living Will). Also, give these people copies of your signed form and keep track of who has these copies, because:
 - » You can change or cancel your Directive to Physicians and Family or Surrogates (Living Will) at any time and for any reason. (Make sure to collect all copies given to others.)
- The Directive to Physicians and Family or Surrogates (Living Will) applies only to health care decisions. It does not cover financial matters.

A Directive to Physicians and Family or Surrogates (Living Will) form is included in this booklet for your use.

Out-of-Hospital Do-Not-Resuscitate (DNR) Order

An Out-of-Hospital DNR Order is a form completed by you and your doctor that lets you refuse specific treatments to keep you alive outside of a hospital inpatient setting.

An Out-of-Hospital DNR Order form or ID necklace and/or bracelet will tell health care workers, including emergency medical service people, not to use cardiopulmonary resuscitation (CPR) and other care or treatments to keep you alive.

Points to Remember

- Any adult person who is capable of making and communicating informed health care decisions can complete an Out-of-Hospital DNR Order.
- To show that you have an Out-of-Hospital DNR Order, you must have the original copy of your form with you or wear an approved ID necklace and/or bracelet.
- You must get your Out-of-Hospital DNR Order form and necklace/bracelet from your doctor.
- You may cancel the Out-of-Hospital DNR Order at any time.
- Talk with your doctor, agent, close family/friend, clergy or lawyer before you sign your Out-of-Hospital DNR. Also, give these people copies of your signed form and track who has these copies.

Declaration for Mental Health Treatment

The Declaration for Mental Health Treatment is a form that lets you tell a facility providing mental health services what kinds of mental health treatment you do or do not want if you are not able to make or communicate your wishes.

It includes specific kinds of mental health care and treatment, including psychoactive medicines, shock (convulsive) treatment and wishes for emergency treatment, such as restraint, seclusion or medicine.

Points to Remember

- You should talk to a lawyer if you have questions about how the Declaration for Mental Health Treatment works and in which situations your decisions can be overruled.
- For the Declaration for Mental Health Treatment to go into effect, a judge must find that you are incapacitated because you do not have:
 - » The ability to understand the nature and consequences of a proposed treatment, and the benefits, risks and/or treatment; and
 - » The ability to make health care decisions because of impairment. The law and the court understand “incapacitated” in only two ways: (1) in a guardianship proceeding, or (2) in a hearing to consider if you must take psychoactive medicines if you are refusing them.
- The Declaration for Mental Health Treatment is generally good for only three years from the date it is signed.
- You may change or cancel your Declaration for Mental Health Treatment at any time as long as you are mentally competent.
- You may get the Declaration for Mental Health Treatment forms from a psychiatrist, psychologist, licensed social worker, other mental health care provider, or a lawyer.
- Talk with your doctor, agent, close family/friend, clergy or lawyer before you sign your Declaration for Mental Health Treatment. Also, give these people copies of your signed form and keep a record of who has these copies.

Note: Most Texas Health Resources facilities do not routinely provide mental health services. However, in accordance with federal law, it is the policy of Texas Health Resources facilities to provide written information to all adult inpatients on admission regarding their right to a Declaration for Mental Health Treatment, and the written policies and procedures of the facility about such rights.

People who need inpatient mental health services and present to a facility that does not provide mental health services will be examined to determine whether an emergency medical condition exists. If an emergency medical condition exists, appropriate stabilizing treatment will be provided and then the patient will be transferred to a facility that provides inpatient mental health services.

Medical Power of Attorney

Designation of Health Care Agent

Advance Directives Act (see §166.164, Health and Safety Code)

I, _____ (insert your name) appoint:

Name: _____

Address: _____ Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations on the decision-making authority of my agent are as follows:

Designation of an Alternate Agent

You are not required to designate an alternate agent, but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled or declared void unless this document provides otherwise.

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____ Phone: _____

The original of this document is kept at: _____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____.

Prior Designations Revoked

I revoke any prior medical power of attorney.

Disclosure Statement

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

- (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
- (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

Signature Acknowledged Before Notary

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Printed Name)

State of Texas, County of _____

This instrument was acknowledged before me on _____ (date)

by _____ (name of person acknowledging).

NOTARY PUBLIC, State of Texas

Notary's printed name:

My commission expires:

OR

Signature In Presence of Two Competent Adult Witnesses

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

(City and State)

(Signature)

(Printed Name)

Statement of First Witness

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

Signature of Second Witness

Signature: _____

Print Name: _____ Date: _____

Address: _____

Directive to Physicians and Family or Surrogates

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual facility, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, facility representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

Directive

I, _____ recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and
INITIALS my physician allows me to die as gently as possible; OR

_____ I request that I be kept alive in this **terminal condition** using available life-sustaining treatment.
INITIALS (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and
INITIALS my physician allows me to die as gently as possible; OR

_____ I request that I be kept alive in this **irreversible condition** using available life-sustaining treatment.
INITIALS (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests

After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do not have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values:

1. _____
2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed _____ Date _____

City, County, State of Residence _____

Witnesses

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____

Witness 2 _____

Definitions

“Artificially administered nutrition and hydration” means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues or in the gastrointestinal tract.

“Irreversible condition” means a condition, injury or illness:

1. That may be treated, but is never cured or eliminated;
2. That leaves a person unable to care for or make decisions for the person’s own self; and
3. That, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer’s dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family or other important people in your life.

“Life-sustaining treatment” means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient’s pain.

“Terminal condition” means an incurable condition caused by injury, disease or illness that, according to reasonable medical judgment, will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family or other important people in your life.



Our Core Beliefs

Texas Health Mission

To improve the health of the people in the communities we serve.

Texas Health Vision

Partnering with you for a lifetime of health and well-being.

Texas Health Values

Respect

We are committed to respecting the dignity of all persons and to fostering a system culture characterized by teamwork, diversity and empowerment.

Integrity

In building present and future partnerships, we are committed to and accountable for conducting our system and personal lives with integrity. We seek to build relationships based on loyalty, fairness, truthfulness and trustworthiness.

Compassion

We are committed to providing health care with a sensitivity to the whole person, reflective of God's compassion and love, with particular concern for the poor.

Excellence

We are committed to excellence by continuously improving the quality of our service delivery. This is done through the commitment to education and responsible stewardship of assets and resources.

Texas Health Diversity Value Statement

We will provide and maintain a fair and equitable environment for all by valuing and respecting individual differences for our enrichment and that of the communities we serve.

Texas Health Nondiscrimination Statement

Texas Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

To find a Texas Health facility near you, visit [TexasHealth.org/Locations](https://www.texashealth.org/locations).