



## **HOUSE BILL 1119: Fact Sheet**

***This bill makes changes to the Indiana Code in two areas relevant to healthcare. Changes will affect the Indiana POST (Physician Orders for Scope of Treatment) Act and the Healthcare Consent Act. The Healthcare Consent Act will impact who is able to make decisions when a patient loses capacity.***

**TO GO INTO EFFECT JULY 1, 2018**

### **Healthcare Consent Hierarchy:**

If an adult, incapable of consenting has not appointed a health care representative/power of attorney for healthcare or the health care representative/POA is not available or declines to act, **consent to health care may be given in the following order of priority:**

1. Court appointed guardian
2. A spouse
3. An adult child (or majority of adult children\*)
4. A parent
5. An adult sibling (or majority of adult siblings\*)
6. A grandparent (or majority of grandparents\*)
7. An adult grandchild (or majority of adult grandchildren\*)
8. The nearest other adult relative in the next degree of kinship who is not listed above
9. An adult friend who has maintained regular contact with the individual and is familiar with the individual's activities, health and religious or moral beliefs
10. The individual's religious superior if the individual is a member of a religious order

\*If there are multiple members at the same priority level, then the majority of available individuals controls.

### **The following individuals may NOT provide health care consent:**

- A spouse who is **legally separated** or has a petition for dissolution, legal separation or annulment of marriage that is pending in court
- An individual who is **subject to a protective order** or other court order to avoid contact with the individual that is unable to make their own decisions
- An individual who is **subject to a pending criminal charge** in which the ill individual was the alleged victim

### **What happens if healthcare providers need to locate someone who can consent?**

Healthcare providers **shall make a reasonable inquiry** as to the availability of individuals who are able to provide healthcare consent. **Reasonable inquiry includes** examining the medical records and personal effects. The healthcare provider **shall attempt to contact individuals** who are high in the priority level and able to provide consent by telephone or other means.

### **Indiana POST (Physician Orders for Scope of Treatment) Form:**

Treating physician, **advanced practice nurse, or physician assistant** may execute a POST form.

**Document must be in English;** translated versions can be used for interpretation only

Patient who is physically **unable to sign** may direct a person to sign on their behalf

**May honor other state's version of POST** if similar to Indiana POST

The above **hierarchy DOES NOT apply** to the POST form. Only a **legally appointed representative** can sign for an individual.

## **HOUSE BILL 1119: AN OVERVIEW**

### **What is in House Bill 1119?**

This bill proposes changes to two areas of the Indiana Code concerning health care. One set of changes are relevant to the Indiana POST (Physician Order for Scope of Treatment) Act (IC-16-36-6). The other set of changes are relevant to the Health Care Consent Act (IC-16-36-1) and who is able to make decisions when a patient loses decisional capacity.

### **Why are changes necessary to the Indiana POST Act?**

The Indiana POST is used to document a patient's treatment preferences as actionable medical orders that are valid throughout the healthcare system. It is for patients with very advanced, chronic progressive disease, frailty, or terminal conditions. The proposed changes reflect areas for improvement identified by Indiana health care providers and attorneys since the Indiana POST act passed in 2013.

### **What changes are proposed to the Indiana POST Act?**

- 1) Adding licensed dentists, home health aides, and licensed physician assistants to the definition of "health care providers" who are required to honor POST (p. 3).
- 2) Allowing licensed advance practice nurses (nurse practitioners, clinical nurse specialists, nurse anesthetists) and physician assistants to sign POST form orders (starts on p. 7).
- 3) Clarifying that the statute does not create a duty to perform cardiopulmonary resuscitation if there is a POST form indicating do not resuscitate in anyone not specifically mentioned in the statute (p. 8).
- 4) Permitting a patient who is physically unable to sign to direct another person to sign the form on his or her behalf (p. 9).
- 5) Clarifying that a representative may revoke POST form orders signed by a patient if they are acting in good faith and in accordance with the patient's known or implied intentions in the patient's best interest, if preferences are unknown (p. 11).
- 6) Allowing health care providers to other state's version of POST if similar to the Indiana POST (p. 15).

### **Why are changes being proposed to the Health Care Consent Act?**

If a person loses capacity and has no legally appointed representative, IC-16-36-1 authorizes relatives to make health care decisions on his or her behalf. This group includes the patient's spouse, adult children, adult siblings, parents, grandparents, and grandchildren. Currently, all of these people have equal decision-making authority, which can result in significant conflict and delay important decisions. HB1119 adds a hierarchy to this list to help clarify who takes priority (e.g., starting with the patient's spouse) and how to resolve disagreements. The list also includes the nearest adult relative or an adult friend for patients without first-degree relatives.

### **What changes are proposed to the Health Care Consent Act?**

- 1) Adding a hierarchy to the list of people authorized to make decisions on behalf of patients who lose decisional capacity (pp. 4-5).
- 2) Clarifying how disagreements between individuals at the same priority level in the hierarchy should be resolved (p. 6) and when someone is disqualified from making decisions (pp. 6-7).
- 3) Clarifying what a reasonable effort is to identify someone who can make decisions for a patient without capacity (p. 7).



- ☐ Community Cancer Center North   ☐ Community Cancer Center South   ☐ Community Heart and Vascular Hospital  
☐ Community Hospital East   ☐ Community Hospital North   ☐ Community Hospital South   ☐ Community Howard Regional Health

## APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

I, \_\_\_\_\_ voluntarily appoint \_\_\_\_\_ whose telephone number and address are:

\_\_\_\_\_  
respectively, as my health care representative who is authorized to act for me in all matters of health care in accordance with I.C. 16-8-12 and I.C. 30-5 *et. seq.*, except as otherwise specified below.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death my result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others; to the extent, they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions (if any):

This appointment becomes effective and remains effective if I am incapable of consenting to my health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above named individual making the appointment, I witnessed the signing of this document by the Appointor on the date noted above.

Signature of Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Witness Address/Telephone Number: \_\_\_\_\_

**INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT**

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.
2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.
3. An individual is not required to complete a health care representative appointment form. An individual may always choose to not appoint a health care representative. If there were no appointed representative, state medical consent laws would determine who may consent to your healthcare.
4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.
5. The patient/ appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.
6. The authority granted becomes effective according to the terms of the appointment.
7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.
8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.
9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.
10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
  - a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
  - b. In good faith.
11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
  - a. The patient / appointor.
  - b. The patient's / appointor's legal representative if one is known.
  - c. The health care provider if the representative knows there is one.
12. An individual who is capable of consenting to health care may revoke:
  - a. The appointment at any time by notifying the representative orally or in writing; or
  - b. The authority granted to the representative by notifying the health care provider orally or in writing.



## DESIGNACIÓN DEL REPRESENTANTE DE ATENCIÓN DE LA SALUD EN INDIANA

Formulario del Estado 56241 (1-17)

Departamento de Salud del Estado de Indiana – IC 16-36-1; IC 16-36-6

**INSTRUCCIONES:** Consulte las instrucciones al dorso.

Información del paciente / poderdante		
Apellido del paciente	Primer nombre del paciente	Inicial del segundo nombre del paciente
Fecha de nacimiento del paciente (mm/dd/aaaa)	Número de historia médica de la instalación o proveedor de atención de la salud (opcional)	Instalación o proveedor de atención de la salud (opcional)
Designación de representante de atención de la salud		
<p>Yo, con al menos dieciocho (18) años de edad, en pleno uso de mis facultades mentales y capaz de otorgar el consentimiento para mi atención de la salud, por el presente designo a la(s) persona(s) indicadas más adelante como mi(s) representante(s) legal(es) de atención de la salud en todos los asuntos relacionados con mi atención de la salud, incluyendo, entre otros, otorgar o rehusar el consentimiento para la atención de la salud, cirugía u hospitalización en instalaciones de atención de la salud, incluyendo instituciones de tratamiento prolongado, a menos que se establezca de otro modo en esta designación. Esta designación entrará en vigencia a partir del momento en el que el médico que me brinda sus servicios determine que soy incapaz de otorgar el consentimiento para mi atención de la salud u ocasionalmente. Comprendo que si he nombrado anteriormente a un representante de atención de la salud, la designación indicada más adelante sustituye (reemplaza) a cualquier o cualesquiera representante(s) que haya(n) sido designado(s) anteriormente.</p> <p>Autorizo a mi representante de atención de la salud a que tome decisiones en mi mejor interés en relación con el retiro o suspensión de la atención de la salud. Si en cualquier momento, y en función de las preferencias expresadas y del diagnóstico o la prognosis, mi representante de atención de la salud está conforme con que cierta atención médica no es o no sería beneficiosa, o que tal atención de la salud es o sería excesivamente gravosa, mi representante de atención de la salud puede expresar mi voluntad de que se retire o suspenda tal atención de la salud y puede otorgar el consentimiento en mi nombre para que se descontinúe toda la atención de la salud o no se inicie, incluso si esto pudiese ocasionar la muerte. Mi representante de atención de la salud debe tratar de discutir esta decisión conmigo. Sin embargo, si no tengo la capacidad de comunicarme, mi representante de atención de la salud puede tomar esa decisión en mi nombre, después de consultar con mi médico o médicos y otros proveedores de atención de la salud que sean relevantes. Hasta el límite que sea adecuado, mi representante de atención de la salud también puede discutir esta decisión con mi familia y otros en la medida en que ellos estén disponibles.</p> <p>Especifico los siguientes términos y condiciones (si los hubiera):</p>		
Nombre del representante designado	Dirección del representante designado (número y calle, ciudad, estado, y código postal)	Número de teléfono del representante designado
Firma del paciente / poderdante o representante designado (debe firmarse en presencia del poderdante)	Nombre del paciente / poderdante o representante designado en letra de imprenta	Fecha de la designación (mm/dd/aaaa)
Firma del testigo	Nombre del testigo en letra de imprenta	Fecha (mm/dd/aaaa)

## **INSTRUCCIONES PARA FORMULARIO DEL ESTADO 56241, DESIGNACIÓN DEL REPRESENTANTE DE ATENCIÓN DE LA SALUD EN INDIANA**

1. Existen numerosos tipos de voluntades anticipadas. El Departamento de Salud del Estado de Indiana anima a las personas a que consulten con su abogado, planificador y proveedores de atención de la salud para rellenar cualquier formulario de voluntades anticipadas.
2. No se requiere de este formulario estatal para designar a un representante de atención de la salud. Una persona puede utilizar un formulario designado por su abogado u otra entidad para cumplir con las necesidades específicas de la persona. Para que sea válido, cualquier formulario debe cumplir con los requisitos legales.
3. No se exige que una persona rellene un Formulario de designación del representante de atención de la salud. Una persona puede siempre elegir no designar a un representante de atención de la salud. Si no se ha designado un representante, la legislación de autorización médica del estado determinará quién puede autorizar su atención de la salud.
4. No se exige el número de historia médica ni el nombre de una institución o proveedor de atención de la salud para que la designación se haga efectiva. Esta información se puede incluir como un medio para asistir al proveedor de atención de la salud en la identificación correcta del paciente y archivar el documento de designación en la historia médica correcta.
5. El paciente/poderdante puede especificar en la designación los términos y condiciones adecuados, incluyendo una autorización para que el representante delegue la autoridad del permiso a otra persona.
6. La autoridad otorgada toma vigencia de acuerdo con los términos de la designación.
7. La designación no comienza hasta que el poderdante quede incapacitado para otorgar el consentimiento. La autoridad otorgada en la designación no entra en vigencia si el paciente/poderdante recupera la capacidad de otorgar el consentimiento.
8. A menos que la designación establezca lo contrario, un representante designado según esta sección quien esté razonablemente disponible y dispuesto a actuar tiene prioridad de actuar en todos los asuntos de atención de la salud del paciente/poderdante, salvo cuando el paciente/poderdante sea capaz de otorgar la autorización.
9. La designación de un representante de atención de la salud debe ser presenciada por un adulto distinto del representante de atención de la salud.
10. Para tomar todas las decisiones relativas a la atención de la salud del paciente/poderdante, el representante de atención de la salud debe actuar:
  - a. En el mejor interés del paciente/poderdante de acuerdo con la finalidad expresada en la designación.
  - b. De buena fe.
11. Un representante de atención de la salud que renuncie o no esté dispuesto a cumplir con la designación escrita no puede ejercer funciones según la designación y lo informará a:
  - a. El paciente/poderdante.
  - b. El representante legal del paciente/poderdante si este tuviese uno conocido.
  - c. El proveedor de atención de la salud si el representante conoce que existe tal persona.
12. Una persona que sea capaz de autorizar la atención de la salud puede revocar:
  - a. La designación en cualquier momento notificándolo al representante de forma oral o escrita; o
  - b. La autoridad otorgada al representante notificándolo al proveedor de atención de la salud de forma oral o escrita.



## LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I, \_\_\_\_\_, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition. I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, and the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

Other instructions:

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request honor this declaration.

I understand the full import of this declaration. Signed:

\_\_\_\_\_

\_\_\_\_\_, City,  
County, and State of Residence

I have personally known the declarant, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly and/or financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

Witness \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



## DECLARACIÓN DE PROCEDIMIENTOS PARA PROLONGACIÓN DE VIDA

Código de Indiana 16-8-11

Declaración hecha el día \_\_\_\_\_ de \_\_\_\_\_ (mes, año).

Yo, \_\_\_\_\_, siendo mayor de dieciocho (18) años de edad y en pleno uso de mis facultades, deliberada y voluntariamente hago conocimiento de mi deseo de que si en algún momento tengo una enfermedad o lesión incurable determinada a ser una condición terminal, pido la utilización de procedimientos para prolongación de vida, que pudieran extender mi vida. Esto incluye nutrición e hidratación apropiada, administración de medicamento y la realización de todos los demás procedimientos médicos necesarios para extender mi vida, proporcionar comodidad en mi cuidado o para aliviar dolor.

En la ausencia de mi capacidad para dar indicaciones con respecto al uso de procedimientos para prolongación de vida, es mi intención que esta declaración sea aceptada por mi familia y mi médico como la expresión final de mi derecho legal para pedir tratamiento médico o quirúrgico y aceptar las consecuencias de la petición.

Entiendo la trascendencia total de esta declaración.

Firma \_\_\_\_\_ Fecha \_\_\_\_\_

Ciudad, Condado y Estado de Residencia \_\_\_\_\_

El declarante me ha sido presentado personalmente y lo/le creo en pleno uso de sus facultades. Soy competente y mayor de dieciocho (18) años de edad.

Testigo \_\_\_\_\_ Fecha \_\_\_\_\_

Testigo \_\_\_\_\_ Fecha \_\_\_\_\_



## Living Will Declaration

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, year of \_\_\_\_\_.

I \_\_\_\_\_, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease or illness; (2) my death will occur within a short period of time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or make your mark before signing this Declaration.):

\_\_\_\_ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

\_\_\_\_ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

\_\_\_\_ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under I.C. 16-36-1-7 or my attorney in fact with health care powers under I.C. 30-5-5.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal honor this Declaration. I understand the full import of this declaration.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*County*

\_\_\_\_\_  
*State*

I have personally known the declarant, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

**DECLARACIÓN DE TESTAMENTO VITAL**

Esta declaración entra en vigor a la fecha de su firma y permanecerá vigente hasta que sea revocada o al fallecimiento del/de la declarante. Esta declaración se debe entregar a su médico.

**DECLARACIÓN DE TESTAMENTO VITAL**

Declaración realizada este \_\_\_\_\_ día de \_\_\_\_\_ (mes, año). Yo, \_\_\_\_\_, habiendo cumplido por lo menos dieciocho (18) años de edad y en pleno uso de mis facultades mentales, de forma deliberada y voluntaria, hago conocer mi deseo de que no se prolongue de forma artificial el proceso de mi muerte de acuerdo con las circunstancias establecidas a continuación, y declaro que:

Si en cualquier momento mi médico tratante certifica por escrito que:

- (1) tengo una lesión, padecimiento o enfermedad incurable;
- (2) mi muerte ocurrirá en un corto período de tiempo; y
- (3) el uso de procedimientos para prolongar la vida serviría solo para prolongar artificialmente el proceso de mi muerte,

expreso mi deseo de que tales procedimientos no se lleven a cabo o se retiren y que se me permita morir de forma natural únicamente con el suministro de cualquier procedimiento médico o medicamento necesario para proporcionarme confort o aliviar el dolor y, si así lo hubiese indicado a continuación, que se me proporcione nutrición e hidratación suministrada artificialmente. (Indique lo que desea mediante sus iniciales o una marca antes de firmar esta declaración):

\_\_\_\_\_ Deseo recibir nutrición e hidratación suministrada artificialmente, incluso si el esfuerzo de mantener la vida es ineficaz o excesivamente gravoso para mí.

\_\_\_\_\_ No deseo recibir nutrición e hidratación suministrada artificialmente si el esfuerzo de mantener la vida es ineficaz o excesivamente gravoso para mí.

\_\_\_\_\_ Intencionalmente no tomé ninguna decisión relativa a la nutrición e hidratación suministrada artificialmente y dejo la toma de decisión a mi representante de atención a la salud, designado de acuerdo con IC 16-36-1-7 o a mi apoderado legal con poder relativo a mi atención médica de acuerdo con IC 30-5-5.

Cuando no disponga de la capacidad de dar instrucciones relativas al uso de procedimientos para prolongar la vida, mi intención es que mi familia y mi médico respeten esta declaración como la expresión final de mi derecho legal de rehusar tratamiento médico o quirúrgico y aceptar las consecuencias de tal solicitud.

Comprendo la importancia total de esta declaración.

Firmado \_\_\_\_\_

\_\_\_\_\_  
Ciudad, condado y estado de residencia

**TESTIGOS**

Conozco personalmente al/a la declarante y considero que está en pleno uso de sus facultades mentales. No firmé en nombre del declarante anteriormente indicado ni por instrucciones del declarante. No soy el padre/madre, cónyuge ni hijo del/de la declarante. No tengo derecho a ninguna porción del patrimonio del/de la declarante ni soy responsable directo financieramente de la atención médica del/de la declarante. Estoy en pleno uso de mis facultades y tengo al menos dieciocho (18) años de edad.

Testigo \_\_\_\_\_ Fecha (mes, día, año) \_\_\_\_\_

Testigo \_\_\_\_\_ Fecha (mes, día, año) \_\_\_\_\_

## **ADVANCE DIRECTIVES**

### **You need to know . . .**

You can decide, right now, what medical treatments you want or do not want.

You can tell your doctor or loved ones these decisions, so that if you become too sick to tell them, they will know what you want them to do.

You can choose someone you trust to make these decisions for you if you become unable to make them for yourself.

You can write these decisions down on a paper called an advance directive . . .

*...For more information, keep on reading!*

## **INTRODUCTION**

You can decide -- right now -- what treatment you want or do not want, and you can tell that decision to your doctor and your loved ones so that if you become too sick or unable to tell them, they will know what you want them to do. Federal law now says that you must also be informed of other ways that you can control the medical treatment you receive. That is the purpose of this pamphlet.

## **WHAT HAPPENS IF I BECOME UNABLE TO MAKE MY OWN MEDICAL DECISIONS?**

Unless you do something, someone else if you become unable to consent to or refuse your medical treatments for yourself will make your health care decisions. In Indiana, these decisions may be made by whomever your doctor talks to in your immediate family (meaning your spouse, parent, adult child, brother or sister) or by a person appointed by a court.

However, in Indiana, you can make and write down your own decisions about your future medical treatment if you wish. Alternatively, you can appoint a person you choose to make these decisions for you when you are not able to do so. You can even disqualify someone you do not want to make any health decisions for you.

You can do these things by having what is called an advance directive. Advance directives are documents you can complete to protect your rights to determine your medical treatment and to help your family and doctor understand your wishes about your health care.

Your advance directive will not take away your right to continue to decide for yourself what you want. This is true even under the most serious medical conditions. Your advance directive will speak for you only when you are unable to speak for yourself, or when your doctor determines that you are no longer able to understand enough to make your own treatment decisions.

## **WHAT CAN I DO NOW TO EXPRESS MY WISHES IN CASE I LATER BECOME UNABLE TO TELL MY DOCTOR OR MY FAMILY?**

There are three ways you can make your wishes known now, before you get too sick to tell what treatment you want or do not want:

1. You can speak directly to your doctor and your family.
2. You can appoint someone to speak or decide for you.
3. You can write some specific medical instructions.

## **DO I HAVE TO FILL OUT MORE PAPERS?**

No. You can always talk with your doctor and ask that your wishes be written in your medical chart. You can talk with your family. You do not have to write down what you want, but writing it down makes it clear, and sometimes, writing it down is necessary to make it legal. When you are no longer able to speak for yourself, Indiana law pays special attention to what you have written in your advance directive about your health care wishes and whom you appointed to carry them out.

## **DO I HAVE TO DECIDE ABOUT AN ADVANCE DIRECTIVE NOW?**

No. You have a right to make an advance directive if you want to, and no one can stop you from doing so. Nevertheless, no one can force you to make an advance directive if you do not want to, and no one can discriminate against you if you do not sign one.

## **WHICH ADVANCE DIRECTIVE SHOULD I USE?**

That depends on what you want to do. If you want to put your wishes in writing, there are three Indiana laws that are important -- the Health Care Consent Act, the Living Will Act, and the Powers of Attorney Act. These laws may be used singly or in combination with each other. These laws are complicated, however, and it is always wise to talk to a lawyer if you have specific questions about your legal choices.

## **WHAT IS THE INDIANA HEALTH CARE CONSENT ACT?**

The Indiana Health Care Consent Act is found in the Indiana Code at Ind. Code 16-36-1. This law lets you appoint someone to say yes or no to your medical treatments when you are no longer able to do so. This person is called your health care representative, and he or she may consent to, or refuse, medical treatment for you in certain circumstances that you can spell out. To appoint a health care representative, you must put it in writing, sign it, and have it witnessed by another adult.

Because these are serious decisions, your health care representative must make them in your best interest. In Indiana, courts have already made it clear that decisions made for you by your health care representative should be honored.

These decisions can determine which medical treatments you will or will not receive when you are unable to express your wishes. If you want, in certain circumstances and in consultation with your doctor, your health care representative may even decide whether food and water should be artificially provided as part of your medical treatment.

## **WHAT IS THE INDIANA LIVING WILL ACT?**

The Indiana Living Will Act is found in the Indiana Code at Ind. Code 16-36-4. This law lets you write one of two kinds of legal documents for use when you have a terminal condition and are unable to give medical instructions. The first, the Living Will Declaration, can be used if you want to tell your doctor and family that life prolonging medical treatment should not be used, so that you can be allowed to die naturally from your terminal condition. In a Living Will Declaration, you may choose whether or not food or water should be artificially provided as part of your medical treatment or whether someone else should make that decision for you. The second of these documents, the Life-Prolonging Procedures Declaration can be used if you want all possible life-prolonging medical treatments used to extend your life.

For either of these documents to be effective, there must be two adult witnesses and the document must be in writing and signed by you or someone that you direct to sign in your presence. Either a Living Will Declaration or a Life- Prolonging Procedures Declaration can be cancelled orally, or in writing, or by canceling or destroying the declaration yourself. The cancellation is effective, however, only when your doctor is informed.

## **WHAT IS THE INDIANA POWER OF ATTORNEY ACT?**

The Indiana Powers of Attorney Act is found in the Indiana Code at Ind. Code 30-5. This law spells out how you can give someone the power to act for you in many situations, including health care. You do this by giving this person your power of attorney to do things you want this person to do. This person should be someone that you trust. He or she does not have to be an attorney, even though the legal term for this person is “attorney in fact.” The person you appoint as your attorney in fact is given the power to act for you in only the ways that you specify. Your power of attorney must be in writing and signed in the presence of a notary public. It must spell out whom you want as your attorney in fact and exactly what powers you want to give to the person who will be your attorney in fact, and what powers you do not want to give. Since your attorney in fact is not required to act for you if he or she does not want to, you may wish to consult with this person before making the appointment.

If you wish, your power of attorney document may appoint the person of your choice to consent to or refuse health care for you. This can be done by making this person your health care representative under the Health Care Consent Act, or by referring to the Living Will Act in your power of attorney document. You can also let this person have general power over your health care. This would let him or her sign contracts for you, admit or release you from hospitals or other places, look at or get copies of your medical records, and do a few other things in your name. You can cancel a power of attorney at any time, but only by signing a written cancellation and having this delivered to your attorney in fact.

## **ARE THERE FORMS TO HELP ME WRITE THESE DOCUMENTS?**

Although Indiana law provides limited forms for some of the purposes listed above, these may not be sufficient to accomplish everything you might want. Although these laws do not specifically require an attorney, you may wish to consult with one before you try to write one of the more complicated legal documents described above.

## **CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?**

Yes. As we mentioned above, you can change your mind about any of the types of appointments or about the living will.

However, you need to make various people aware that you have changed your mind - like your doctor, your family or the person you have appointed - and you might have to revoke your decision in writing. Remember, however, that you can always speak directly to your doctor. However, be sure to state your wishes clearly and be sure they are understood.

## **WHAT IF I MAKE AN ADVANCE DIRECTIVE IN INDIANA AND I AM HOSPITALIZED IN A DIFFERENT STATE, OR VICE VERSA?**

The law on honoring an advance directive in or from another State is unclear. Because an advance directive tells your wishes regarding medical care, however, it may be honored wherever you are, if it is made known. However, if you spend a great deal of time in more than one state, you may wish to consider having your advance directive meet the laws of those States, as much as possible.

## **WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?**

Make sure that someone, such as your lawyer or a family member, knows that you have an advance directive and knows where it is located. You should give a copy of your power of attorney document to the person you have appointed to serve as your attorney in fact. You may also decide to ask your doctor or other health care provider to make your advance directive a part of your permanent medical record. Another idea would be to keep a second copy of the directive in a safe place where it can easily be found. You might keep a small card in your purse or wallet, which states that you have an advance directive and where it is located, or who your attorney in fact is, if you have named one.

**FINAL THINGS TO REMEMBER:**

You have the right to control what medical treatment you will receive.

Even without a lawyer or a form, you can always tell your doctor and your family what medical treatments you want or do not want.

No one can discriminate against you for signing, or not signing an advance directive.

Using an advance directive is, however, your way to control your future medical treatment.

The Indiana State Department of Health attorneys cannot provide you with legal advice concerning living wills or advance directives. Therefore, it is recommended that you contact your personal attorney or representative for advice and assistance in this matter.