

# UNDERSTANDING ADVANCE DIRECTIVES

If you have questions, call 377-3439 or pager 790-7284.

Watch the Advance Directives film  
on Channel 4 at 9:00 a.m. and 5:30 p.m.



## NORTH MISSISSIPPI MEDICAL CENTER

North Mississippi Medical Center-Eupora  
North Mississippi Medical Center-Hamilton (AL)  
North Mississippi Medical Center-Iuka  
North Mississippi Medical Center-Pontotoc  
North Mississippi Medical Center-Tupelo  
North Mississippi Medical Center-West Point  
North Mississippi Medical Center-Baldwyn Nursing Facility

## ***INTRODUCTION***

You have the right to make health care decisions, including decisions about nursing home care, for yourself. Under the law, a patient must consent to any treatment or care received. Generally, if you are a competent adult, you can give this consent for yourself. For you to give this consent, you should be told what the recommended procedure is, why it is recommended, what risks are involved with the procedure, and what the alternatives are.

If you are not able to make your own health care decisions, your advance directives can be used. An “advance directive” can be an Individual Instruction or a Power of Attorney for Health Care.

An “Individual Instruction” is a directive concerning a health care decision. An Individual Instruction can be written or oral. No specific format is required for Individual Instructions.

A “Power of Attorney for Health Care” (“PAHC”) is a document through which you designate someone as your agent to make health care decisions for you if you are unable to make such decisions. The PAHC comes into play when you cannot make a health care decision, either because of a permanent or temporary illness or injury. The PAHC must specifically authorize your agent to make health care decisions for you and must contain the standard language set out in the law. This language is included in the form of the PAHC contained in the Form section at the back of this booklet. Otherwise, the PAHC can contain any instructions which you wish.

If you are unable to make a decision and have not given or prepared Individual Instruction or a PAHC, you may designate an adult of your choice, call a surrogate, to make health care decisions for you. If you do not appoint a surrogate, the members of your family may make decisions for you.

The law on making health care decisions and advance directives is discussed in this booklet in detail. **Please read the entire booklet.**

## ***YOUR RIGHT UNDER MISSISSIPPI LAW TO MAKE DECISIONS CONCERNING HEALTH CARE***

The Patient Self Determination Act of 1990 (The “PSDA”) is a federal law which imposes on the state and providers of health care - such as hospitals, nursing homes, hospices, home health agencies, and prepaid health care organizations - certain requirements concerning advance directives and an individual’s rights under state law to make decisions concerning medical care. This booklet will discuss your rights under state law to make health care decisions and set out a description of the Mississippi law on advance directives.

### **◆ WHAT ARE MY RIGHTS TO ACCEPT OR REFUSE TREATMENT OR CARE?**

In general, you have the right to make health care decisions, including decisions about nursing home care, for yourself if you are 18 or older and are competent.

◆ **WHAT INFORMATION MUST I BE TOLD TO GIVE MY CONSENT?**

The physician should explain to you the pertinent facts about your illness and the nature of the treatment in nontechnical terms which are understandable to you. The physician should inform you of all reasonable risks and material consequences or “side effects” associated with the proposed treatment.

Finally, the physician must tell you about any other types of treatment which you could undergo instead. The nature, purpose, and reasonable risks and consequences of these treatments should be explained to you.

With this information, you can then make your health care decision.

◆ **WHAT IF I AM UNABLE TO MAKE THESE DECISIONS?**

If you cannot make a health care decision because of incapacity, your advance directive, such as an Individual Instruction or Power of Attorney for Health Care, can be used. If you have not signed an advance directive, you may designate an adult of your choice, call a surrogate, to make the decision. If you do not have an advance directive and you have not designated a surrogate, a family member may make the decision for you. If you do not have an advance directive, have not designated a surrogate, and do not have a family member available to make a health care decision for you, then an adult who shows care and concern and who is familiar with your values may make health care decisions for you. If you do not have advance directives and do not have anyone to make health care decisions for you, then a court might have to make the decision for you.

◆ **WHAT IS AN ADVANCED DIRECTIVE?**

The PSDA defines an “advance directive” as a written instruction, such as an Individual Instruction or Power of Attorney for Health Care, recognized under State law and relating to the provision of health care when the individual is incapacitated. Two types of advance directives are statutorily recognized in Mississippi: Individual Instruction and Power of Attorney for Health Care.

**INDIVIDUAL INSTRUCTION**

◆ **WHAT IS AN INDIVIDUAL INSTRUCTION?**

An Individual Instruction means an individual’s direction concerning a health care decision for the individual. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

◆ **WHAT MUST THE INDIVIDUAL INSTRUCTION SAY?**

Mississippi law does not prescribe any particular format for individual instructions. However, the law does specify an acceptable format for those instructions which deal with End-of-Life

Decisions, Artificial Nutrition and Hydration, and Relief from Pain. This form is Part 2 of the form at the back of this booklet.

◆ **WHERE SHOULD I KEEP MY INDIVIDUAL INSTRUCTION?**

You should provide a copy of your Individual Instruction to anyone you designate to make health care decisions for you and to your health care provider. Your Individual Instruction should not be filed with the Mississippi State Department of Health.

◆ **HOW CAN MY INDIVIDUAL INSTRUCTION BE REVOKED?**

The Individual Instruction is valid until revoked. You may revoke an Individual Instruction in any manner that indicates an intent to revoke.

◆ **WILL MY INDIVIDUAL INSTRUCTION BE FOLLOWED?**

Your Individual Instruction must be honored by your agent, family, surrogate or health care provider.

For reasons of conscience, a physician, hospital, nursing home or other provider has the right to refuse to follow your Individual Instruction. A provider not honoring your Individual Instruction must cooperate in your transfer to another provider who will follow your Individual Instruction.

Upon admission, you receive a copy of this facility's policy concerning advance directives. You should review this policy and determine whether the facility will follow your Individual Instruction.

◆ **SHOULD I GIVE MY PHYSICIAN A COPY OF MY INDIVIDUAL INSTRUCTION?**

Yes. If you have a written Individual Instruction, you should give a copy to the physician who has primary responsibility for your health care. A copy also should be given to any other provider, such as a hospital, home health agency, or nursing home, from which you are receiving care.

**POWER OF ATTORNEY FOR HEALTH CARE**

◆ **WHAT IS A POWER OF ATTORNEY FOR HEALTH CARE?**

You may designate an individual or agent to make health care decisions for you if you are unable to make such a decision because of a permanent or temporary illness or injury. The document authorizing this action is the Power of Attorney for Health Care (PAHC).

◆ **WHAT MUST THE PAHC CONTAIN?**

The PAHC must be properly witnessed, must specifically authorize your agent to make health care decisions for you, and must contain the standard language set out in the law.

This language is included in the form of PAHC contained in the Form section at the back of this booklet. Otherwise, the PAHC can contain any instructions which you wish.

◆ **WHAT SHOULD I DO WITH THE PAHC?**

The PAHC does not need to be filed with the Mississippi State Department of Health or any court. You should keep the PAHC for yourself and give a copy to the agent you named in the PAHC. A copy should also be given to your physician to make a part of your medical records. You should also give a copy to any other provider from which you are receiving care, such as a nursing home, hospital, or a home health agency. You might also want to provide a copy to your clergy, family members, and friends who are not named in the documents.

◆ **WHO WILL DECIDE IF I CANNOT ACT AND MY AGENT SHOULD ACT FOR ME?**

Unless otherwise specified in the PAHC, the physician designated by you or your agent to have primary responsibility for your health care will make this determination. In making this determination, your physician will act in accordance with “generally accepted health care standards.”

◆ **WHOM CAN ACT AS MY AGENT?**

Unless related to you by blood, marriage, or adoption, your agent may not be an owner, operator, or employee of a residential long term care institution at which you are receiving care. Otherwise, any person, such as a family member or a friend, may act as the agent. The agent does not need to be a lawyer.

◆ **WHAT ARE THE POWERS OF MY AGENT?**

Your agent has whatever power you give in the PAHC to make health care decisions for you. “Making health care decisions” means a decision regarding your health care, including the selection and discharge of health care providers and institutions; approval and disapproval of diagnostic tests, surgical procedures, medications, and orders not to resuscitate; and direction to provide, withhold, or withdraw artificial nutrition and hydration.

◆ **ARE THERE LIMITATIONS ON THE POWER OF MY AGENT?**

Your agent has a duty to act according to what you put in the PAHC or as you otherwise have made known to him or her. If your desires are unknown, he or she must act in your best interest. Your agent cannot make a particular health care decision for you if you are able to make that decision.

◆ **WHAT IF SOMEONE OTHER THAN THE AGENT WANTS TO MAKE HEALTH CARE DECISIONS FOR ME?**

Unless the PAHC says otherwise, your agent has priority over any other person to act for you.

◆ **WILL A HEALTH CARE PROVIDER RECOGNIZE MY AGENT'S AUTHORITY?**

In general, yes.

Upon admission, you receive a copy of the facility's policy on advance directives. You should review this policy and determine whether the facility will follow your PAHC.

◆ **CAN MY PAHC BE CHANGED?**

You can change your agent by a signed writing, or you can revoke the authority for your agent to make decisions by personally informing your primary physician or the health-care provider who has undertaken responsibility for your health care.

**GENERAL**

◆ **WHAT IF I HAVE AN INDIVIDUAL INSTRUCTION OR PAHC I SIGNED WHEN LIVING IN ANOTHER STATE?**

To be binding, these documents must meet Mississippi law. Many out-of-state documents will not meet these requirements. The safest route is to execute new documents following the Mississippi statute.

◆ **DO I NEED BOTH AN INDIVIDUAL INSTRUCTION AND PAHC?**

No. You may include Individual Instructions in your PAHC.

◆ **WHAT OTHER DOCUMENTS SHOULD BE CONSIDERED?**

Prior to July 1, 1998, Mississippi recognized Living Wills and Durable Powers of Attorney for Health Care (DPAHC) as the only statutory documents for Health Care decisions. As of July 1, 1998, Mississippi combined Living Wills and DPAHC into the PAHC. Individual Instructions, PAHC and Living Wills executed prior to July 1, 1998 are the only documents recognized in Mississippi by statute. However, depending upon particular circumstances, the state may recognize other health care directives or indications of your desires concerning health care, such as the Durable Power of Attorney for Health Care.

◆ **CAN I LET MY FAMILY MAKE THESE DECISIONS?**

Members of your family may make decisions for you if you are unable to do so and have not left Individual Instructions or PAHC. Family members, however, might disagree among themselves or with the physician. In such instances, Individual Instructions or PAHC can help to clarify the decisions and who can make them.

◆ **WHEN WILL A COURT MAKE THIS DECISION?**

As a last resort, if someone authorized to consent for you has refused or declined to do so and no other person known to be available is authorized to consent, a court may order treatment for you if you are not able to do so.

## **ADVANCE HEALTH CARE DIRECTIVE**

### **Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

**Part 1** of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now, even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long term health care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- Select or discharge health care providers and institutions;
- Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

**Part 2** of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part 3** of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form and have it witnessed by two adult witnesses or notarized. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at anytime.

**PART 1 - POWER OF ATTORNEY FOR HEALTH CARE**

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me.

\_\_\_\_\_  
(Name of individual you choose as agent) (Date)

\_\_\_\_\_  
(Address, City, State, Zip Code)

\_\_\_\_\_  
(Home Phone #) (Work Phone #)

**OPTIONAL:** If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

\_\_\_\_\_  
(Name of first alternate) (Date)

\_\_\_\_\_  
(Address, City, State, Zip Code)

\_\_\_\_\_  
(Home Phone #) (Work Phone #)

**OPTIONAL:** If I revoke the authority of my agent and first alternative or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

\_\_\_\_\_  
(Name of second alternate) (Date)

\_\_\_\_\_  
(Address, City, State, Zip Code)

\_\_\_\_\_  
(Home Phone #) (Work Phone #)

(2) AGENTS AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Add additional sheets if needed)



3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

**If I mark this box [ ] my agent's authority to make health care decisions for me, takes effect immediately.**

(4) AGENT'S OBLIGATION: My agent will make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent will make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent will consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

## **PART 2 - INSTRUCTIONS FOR HEALTH CARE**

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

- (6) **END-OF-LIFE DECISIONS:** I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

**(a) Choice Not to Prolong Life**

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

**(b) Choice to Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

- (7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I made in paragraph (6) unless I mark the following box.

**If I mark this box  artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).**

- (8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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- (9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.): I direct that:

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(Add any additional sheets if needed.)

**PART 3 - PRIMARY PHYSICIAN (OPTIONAL):**

(10) I designate the following physician as my primary physician:

\_\_\_\_\_  
(Name of physician) (Date)

\_\_\_\_\_  
(Address, City, State, Zip Code)

\_\_\_\_\_  
(Office Phone #)

**OPTIONAL:** If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

\_\_\_\_\_  
(Name of physician) (Date)

\_\_\_\_\_  
(Address, City, State, Zip Code)

\_\_\_\_\_  
(Office Phone #)

(11) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

**PART 4 - PATIENT SIGNATURE (REQUIRED):**

(12) SIGNATURE: (Sign and date the form here):

\_\_\_\_\_  
(Sign Your Name) (Date)

\_\_\_\_\_  
(Print Your Name)

\_\_\_\_\_  
(Address, City, State, Zip Code)

(13) **WITNESSES:** This Power Of Attorney For Healthcare will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign your signature; or (b) acknowledge before a Notary Public in the state.

**Alternative No. 1**

*Witness:*

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this

Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Address, City, State, Zip Code)

*Witness:*

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Address, City, State, Zip Code)

**Alternative No. 2**

State of \_\_\_\_\_

County of \_\_\_\_\_

On this the \_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me appeared \_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires:  
\_\_\_\_\_