

# COMMUNICATING YOUR CHOICES

Understanding and Completing Advance Directives



Medical Power of Attorney  
& Directive to Physicians and  
Family or Surrogates

# How to Use this Booklet

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Throughout your life, you make important choices. You choose whom you want to marry, where you want to live, when you want to retire, and more. Perhaps one of the most important choices you face is your choice for future medical care.



You've reached a milestone in life. You've thought about your choices, talked with your loved ones, and now it is time to act by formally documenting your decisions. This booklet provides information on advance directives, along with the following forms:

**1 Medical Power of Attorney**  
(formerly called the Durable Power of Attorney for Health Care)

**2 Directive to Physicians and Family or Surrogates**  
(also referred to as a Living Will)

**Texas Talks is here for you every step of the way.**

Texas Talks is a program designed to help ensure your choices are honored for your end-of-life care, and will guide you throughout the whole process.

All patients will be asked about their choices. Texas Talks is here to help you plan for the future and ensure your choices are honored.





## Gifts we can give our loved ones...

**By documenting your decisions, you are giving your loved ones a wonderful gift: peace of mind.**

They will know exactly how you would like to receive medical treatment in the future, and they will feel much more at ease knowing that they are honoring you and carrying out your wishes.

Without an advance directive, your rights may be at risk. A law, which took effect in December 1991, requires healthcare facilities that accept Medicare or Medicaid funding to present patients with information about advance directives on admission to either a hospital or nursing home.

That means if you have to go to the hospital, even for a simple procedure, the staff will ask you if you have filled out an advance directive. They will also provide written information about your right to refuse medical care. Your family, physician, hospital, and in some cases a judge, would need to make decisions regarding your future care should you become unable to make them yourself.

## A Daughter's Story

It occurred to me that my mother gave me a very loving and insightful gift in my life—namely, careful direction about what to do when she became irreversibly ill and unable to make her own decisions.

During the time in our lives when we are able to discuss this issue, it seemed so far off, but within a few years she was the victim of Alzheimer's disease. The issue then became very difficult to discuss because of the impairment in her ability to make judgments, decisions, and understand the complexity of her situation. It was necessary, at this point, to become her advocate and rely on the direction she had given me.

The first experience in decision making occurred when the doctor discussed the "no resuscitation" issue with me.

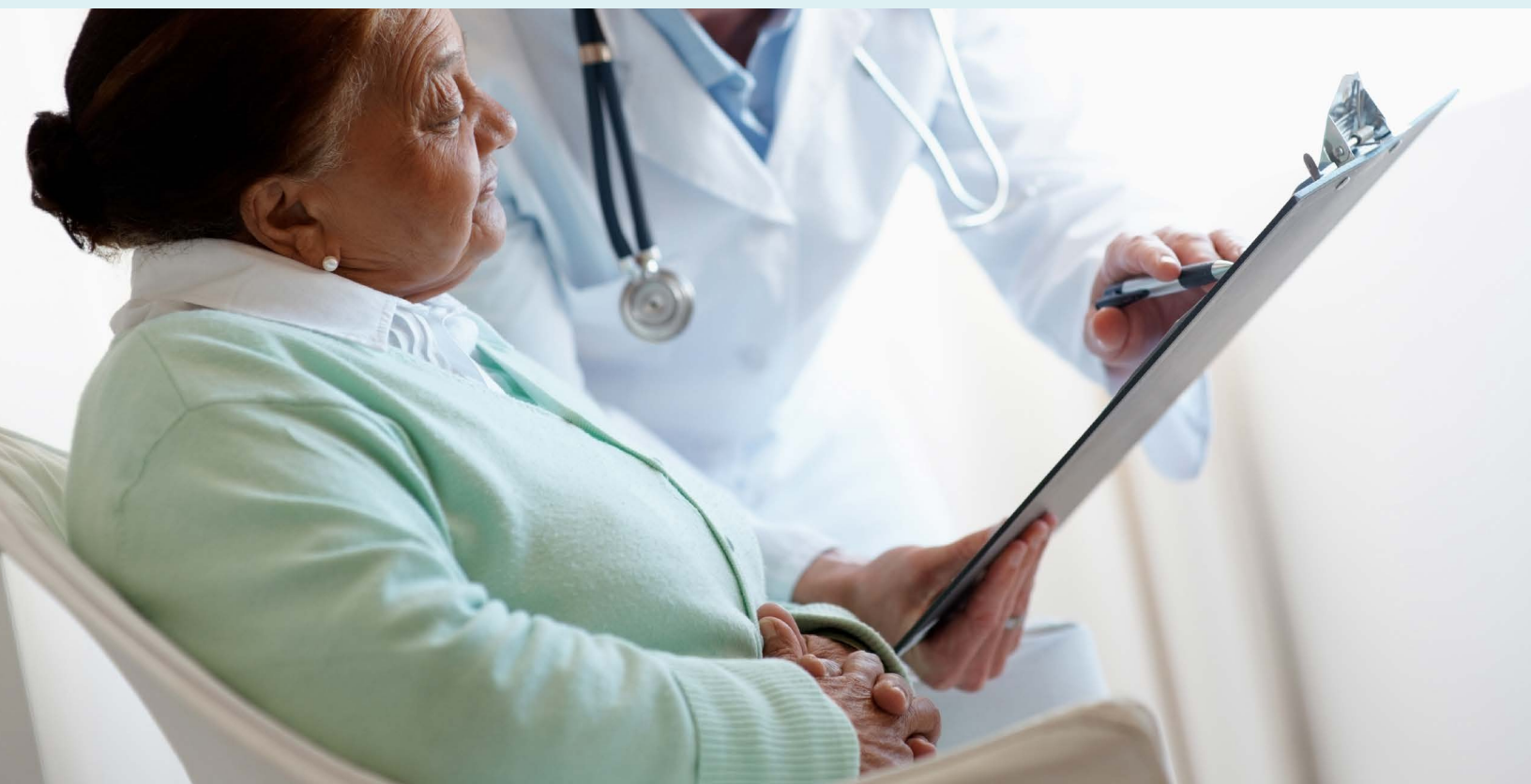
"We need to know what your mother's choice would be if her heart should stop," he stated. She had prepared me for this—the answer was clearly not to initiate resuscitation. There were not many other illnesses along the way that required much decision making, which was fortunate for us. But I do think I would have known what she wanted and acted accordingly.

I lost my mom on April 30—not to Alzheimer's disease, but to heart failure.

Amidst the sadness, there was peace. Peace in knowing that many times she had said to me, "No medical intervention when there's nothing that can be done for me." I am grateful that I didn't have to struggle with decisions during that time.

- Linda Butterworth

Advance directives are the plans you make for your future healthcare decisions in the event you cannot communicate for yourself.



An advance directive could be oral or in writing. Putting your plan in writing helps people accurately remember your plan, makes it easier to communicate to health providers who do not know, and provides the possibility for it to be a legal document.

When completing an advance directive, you will document your healthcare choices in two forms. The **Medical Power of Attorney** form lets you appoint someone, a healthcare agent, to carry out your healthcare choices if you are incapable. The **Directive to Physicians and Family or Surrogates** form lets you provide a set of instructions about the care you would like at the end of your life.



## Answers to commonly asked questions...

### ADVANCE CARE PLANNING

#### **How can I talk about these issues with my family?**

Plan for yourself first and let your family know what you want. Tell them you want to alleviate the burden of making decisions for you. Then ask them to tell you what they want.

**Who do I talk to?** Talk to those who are close to you and most likely to be involved in decision making if you are very ill. Just because you have a close relationship does not necessarily mean you know what your loved one thinks or wants for future medical care.

**What would I talk about?** 1) Who would make decisions for you and how would they make these decisions? Make sure the person you choose to represent you not only knows what you want, but is able to make complex decisions in difficult situations. 2) Consider what your goals for medical treatment would be if you had a serious, permanent injury to your brain. How bad would such an injury be for you to say, "Don't use medical treatments to keep me alive in that state." Many people simply say, "Don't keep me alive if I am a vegetable." If you feel that way, can you describe what it would mean to you to "be a vegetable?"

**Do I need to talk with my physician?** When possible, it is important for you to talk with your physician to make sure your planning is clear, complete, and will be supported by your health care providers.

### ABOUT ADVANCE DIRECTIVES

**When is an advance directive used?** As long as you are capable of making your own decisions, you remain in control of your own medical care. If you're unable to make your decisions, your plans in the advance directive would guide decision making.

**Can my advance directive be changed?** Advance directives can be changed at any time, as long as you are capable of making decisions. If you complete one, a copy can become part of your medical file.

**What if I am injured or become ill when I am away from home?** The best way to ensure that you receive the type of care you want is to discuss your choices with the person who will represent you and make sure he/she has a copy of your advance directive.

**What happens in an emergency?** In the event of an emergency, life-sustaining measures may be started, possibly before your medical record is available. Treatment can be stopped if it is discovered that it's not what you would have wanted.

**Do I have to have a lawyer to complete an advance directive?** No. The law does not require you to have an attorney. The choice is yours.

## A Physician's Story

I had a patient with a serious lung disease. His life consisted of moving from his bed to a nearby chair, and even that would leave him short of breath. We talked about what he would want us to do if his lungs failed. Since it was likely he would be totally dependent on a machine for the rest of his life, he refused to consider it as an option.

**His wife understood his decision and was very supportive, and his decision was recorded in his medical record as an advance directive.**

Six months later he was brought to the hospital very short of breath, without mechanical support he would clearly die. The physician on duty asked him what he wanted them to do. He again said he only wanted to be comfortable; he didn't want assistance from mechanical breathing machines. The physician did not know the patient or his family so she was not sure if a lack of oxygen was affecting his judgment.

The written advance directive in his chart indicated that this decision was carefully considered by him and his family. His choices were respected by the medical staff and he died according to his wishes. Discussing his medical care in advance with both his family and physician made his final hours less traumatic. Talk about your concerns, your fears and your decisions with your own physician. It's critically important.



## Glossary

**Antibiotics:** Drugs used to fight infection (pneumonia, for example).

.....

**Cardiopulmonary Resuscitation:** A medical procedure involving external chest compression, administration of drugs, and electrical shock, used in an effort to restore the heartbeat.

.....

**Dialysis:** A dialysis machine is used to cleanse the blood when the kidneys cannot function normally.

.....

**Intravenous (IV) Line:** A tube placed in a vein that is used to administer fluids, blood or medication.

.....

**Nutritional Support and Hydration:** Using IVs or tubes to supply food (nutrients) or water when a patient is unable to eat or drink.

.....

**Ventilator:** A breathing machine attached to a tube that is placed into the windpipe of persons unable to breathe on their own.



## STEP 1: Appoint Your Health Care Agent.

Name a person to act as an agent to carry out your health care choices if you are not capable of making them for yourself. This person may be a family member or friend that:

- is at least 18 years old
- knows you well
- can be there for you when you need him/her
- you trust to do what is best for you
- can tell the doctors about the decisions you have made for your care

Your Health Care Agent cannot be your doctor or someone who works at your hospital, clinic or residential facility unless he/she is a relative. The reason for this is because that person would have to choose between acting as your agent or your care provider.

▶ See Page 11: *Write your agent's name and contact information*

## STEP 2: Communicate limits you want your agent to follow:

You may write specifics of choices regarding care in the limitations section. For example, you can write down whether or not you want CPR, whether you would prefer to die at home or in a hospital, etc. You may find it simpler to list these choices in the *Texas Directive to Physicians and Family or Surrogates* form.

▶ See Page 11: *Limitations on the decision-making authority of my agent*

## STEP 3: (Optional) You may designate a first or second alternate agent if you choose.

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.

▶ See Page 12: *Designation of alternate agent*

## STEP 4: Sign and date the form.

▶ See page 13: *Acknowledgement of Disclosure Statement*

## STEP 5: Have two witnesses sign and date the form.

Please note that at least **one** of the two witnesses may not:

- be your health care agent
- be related to you by blood or marriage
- be entitled to get any part of your estate following your death
- be your attending physician or an employee of that physician
- be involved in providing direct patient care
- be an officer, director, partner or business office employee of the health care facility

**OR** if you do not have two witnesses, a notary public may sign on page 13

▶ See page 13: *Statement of First Witness, Signature of Second Witness*

## STEP 6: Make copies of this form and give them to your health care agent, your doctor, and other individuals involved in your care.

## STEP 7: Discuss your choices with your health care agent, your doctor, and your loved ones.

**THIS 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 no longer capable of making them 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 begins 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 had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure 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 home, or residential care home, 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 permit a person to do 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 who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so 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, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must complete an entirely new one.

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

**THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED 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 power of attorney is executed, has a claim against any part of your estate after your death.

**MEDICAL POWER OF ATTORNEY**

**DESIGNATION OF HEALTH CARE AGENT**

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 ALTERNATE AGENT

You are not required to designate an alternate agent, but you may choose to 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.

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

### A. First Alternate Agent

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

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

Phone: \_\_\_\_\_

### B. 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.

**ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT**

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

**YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY:**

I sign my name to this medical power of attorney on the \_\_\_\_\_ day of \_\_\_\_\_  
Month, Year

at \_\_\_\_\_  
City, State

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print 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: \_\_\_\_\_

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## STEP 1: Determine your choices if you have six months to live.

If your doctor determines because of your condition that you are likely to pass away in the next six months - regardless of treatment - choose **one** of the following:

Request all treatments be discontinued or withheld except those to keep me comfortable and allow me to die as gently as possible

**OR**

Request that I be kept alive in this terminal condition using available life-sustaining treatment.

▶ See Page 16: Initial next to your choice

## STEP 2: Determine your choices if you have an irreversible condition.

If your doctor determines that you have an irreversible condition so that you cannot care for or make decisions for yourself - choose **one** of the following:

Request all treatments other than those needed to keep me comfortable be discontinued or withheld and allow me to pass away as gently as possible

**OR**

Request that I be kept alive in this irreversible condition using available life-sustaining treatment

▶ See Page 17: Initial next to your choice

## STEP 3: Consider writing down other treatments you do or do not want.

Think about whether you want treatments such as CPR, breathing machines, or artificial nutrition. Talk with your nurses, social workers or doctors about what the likely success, failure or complications of these treatments might be. Think about whether it is important for you to die in the hospital or at home.

▶ See Page 17: Place these under Additional Requests

## STEP 4: Sign and date the form. ▶ See Page 17

## STEP 5: Have two witnesses sign and date the form.

Please note that at least **one** of the two witnesses may not:

- be your health care agent
- be related to you by blood or marriage
- be entitled to get any part of your estate following your death
- be your attending physician or an employee of that physician
- be involved in providing direct patient care
- be an officer, director, partner or business office employee of the health care facility

**OR** if you do not have two witnesses, a notary public may sign on page 16

▶ See page 17

## STEP 6: Make copies of this form and give them to your health care agent, your doctor, and other individuals involved in your care.

## STEP 7: Discuss your choices with your health care agent, your doctor, and your loved ones.

## 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, or 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 at the end of this document 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 hospital, 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, hospital representative, or other advisors. You may also wish to complete a directive related to the donation of organs and tissues.

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## DIRECTIVE

I, \_\_\_\_\_ (insert your name), 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 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  
Initials discontinued or withheld and my physician allow me to die as gently as possible;

**OR**

\_\_\_\_\_ I request that I be kept alive in this terminal condition using available life-sustaining  
Initials treatment (THIS SECTION 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:



## DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

\_\_\_\_\_ I request that all treatments other than those needed to keep me comfortable be  
Initials discontinued or withheld and my physician allow me to die as gently as possible;

**OR**

\_\_\_\_\_ I request that I be kept alive in this irreversible condition using available life-sustaining  
Initials treatment (THIS SECTION DOES NOT APPLY TO HOSPICE CARE).

**ADDITIONAL REQUESTS:** (After discussing 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 artificial nutrition and fluids, 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 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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

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 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 any parent organization of the health care facility.

\_\_\_\_\_  
Witness 1

\_\_\_\_\_  
Witness 2

## DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

### DEFINITIONS:

**“Artificial 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 stomach (gastrointestinal tract).

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

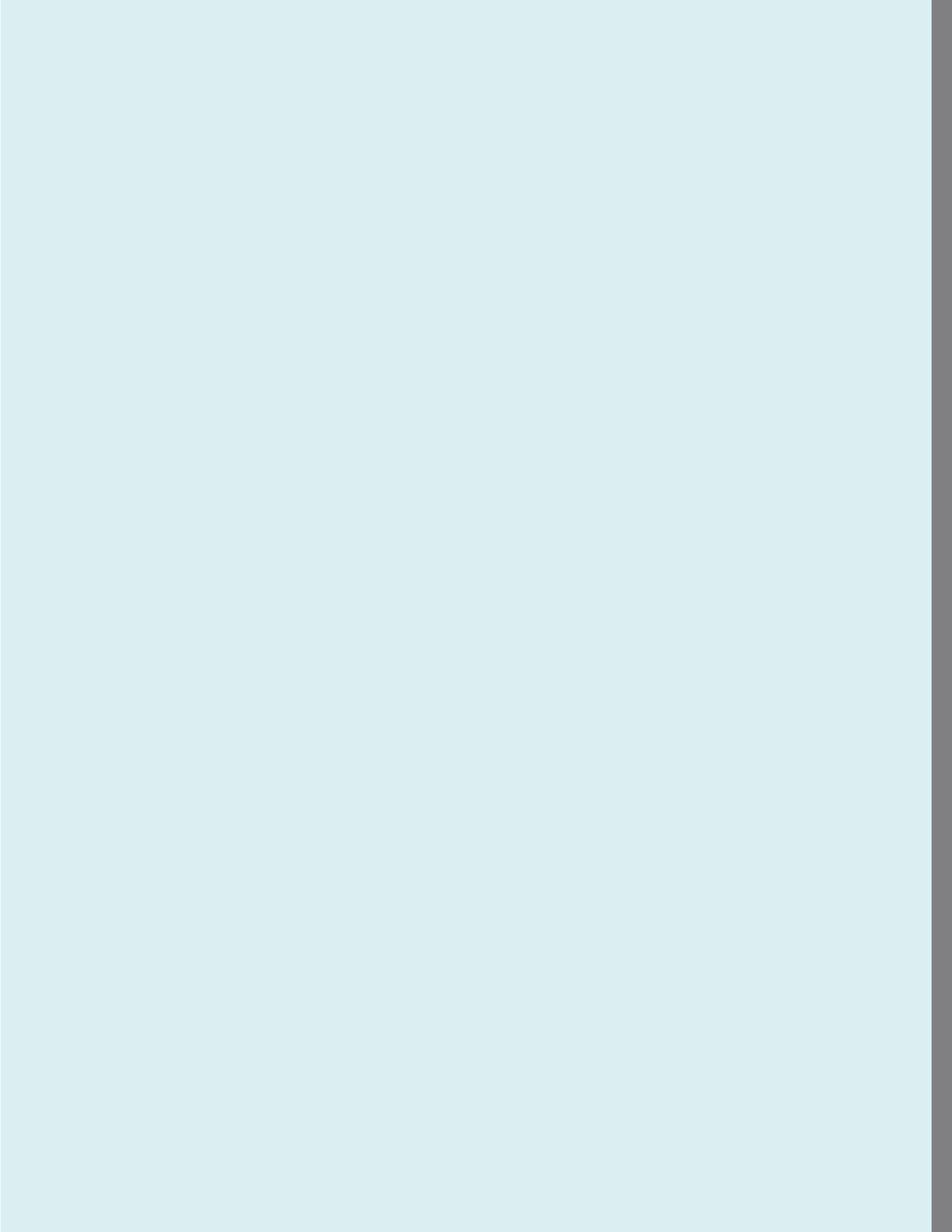
1. That may be treated, but is never cured or eliminated;
2. That leaves a person unable to care for or make decisions for the person’s own self; and
3. That, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

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 artificial hydration and nutrition. 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 persons in your life.





**TEXAS  
TALKS**

Supporting  
Conversations  
That Matter

**For More Information**

Visit: [texastalks.org](http://texastalks.org)

Contact: [texasconversations@gmail.com](mailto:texasconversations@gmail.com)

## Next Steps...

Contact us if you have questions or need assistance. If you have completed both forms in this booklet, be sure to make copies and give them to your healthcare provider and loved ones.

If you decide to change your documented healthcare decisions, simply visit our website to download and complete new forms, or call 1-866-308-5888 to receive them in the mail.