

Declaring Your Wishes

Through an Advance Health-Care Directive

A Guide for Mississippi Families

Advances in medical technology have given us awe-inspiring ability to prolong life despite debilitating diseases and injuries. These life-sustaining mechanisms brought with them some equally awesome responsibilities.

Life can now be prolonged through conditions not imaginable to previous generations. Decisions faced in regard to prolonging life can bring hot debate and family turmoil. There are questions over the quality of a loved one's existence and the toll placed on family caregivers. The issues surrounding heroic medical procedures are personal, difficult, and emotional. They call for family communication if families are to survive with minimal scars and as a cohesive unit. As families deal with these issues, documents called advance health-care directives can help ensure that loved ones are cared for in a manner consistent with the individual's wishes and value system.

This publication is designed to inform families of their right to give instructions about their own health care. It describes the Uniform Health-Care Decisions Act enacted by the Mississippi Legislature in 1998, includes a sample health-care directive form, and answers consumer questions about advance health-care directives in Mississippi.

Before 1998, two separate documents were needed to accomplish the two major objectives of advance directives. A durable power of attorney for health care designated and empowered another individual to make health care decisions if you were incapacitated. A living will was needed if you wished to state, in advance, a desire to have life-sustaining medical mechanisms withdrawn from your body in the event of a terminal condition. The Uniform Health Care Decisions Act allows these documents to be

combined into one advance directive for health care.

What is an advance health-care directive?

An advance health-care directive is a legal document that states your wishes, in advance, regarding potential health-care decisions. The Mississippi optional advance health-care directive is a three-part form that can provide instructions in the following ways:

- to state your wishes regarding "extraordinary techniques that prolong life through artificial means";
- to give other specific instructions regarding your own health care;
- to name someone (your agent) to make health-care decisions for you (named in the power of attorney for health care, part 1 of the advance directive form in this publication);
- to designate your primary physician.

How do I draw up an advance directive for health care?

You may have your attorney draft an advance directive for health care. Many attorneys will execute a health-care directive in conjunction with preparing the client's will.

Another alternative is to complete the optional form given in this publication. You may modify this form to suit your own situation. You may use a different format for your health-care directive as long as you meet certain requirements in the law. These requirements include the following:

- 1) The document must be dated;
- 2) It must be signed by the individual (principal) directing his or her own health-care wishes;
- 3) It must be either notarized or signed by two witnesses.

Am I required to make a new advance directive if I had already completed a living will and/or durable power of attorney for health care before 1998?

According to a June 4, 1998, ruling from the Mississippi Office of the Attorney General, the living will form prescribed in the 1984 Living Will Law is still valid. If the form was properly executed and signed by two witnesses, you are not required to revise your living will. Likewise, you are not required to revise a power of attorney for health care that was drafted before the new law.

If you choose to update your previous health-care directives, you can combine the two documents into one advance health-care directive. In addition, by using the new optional form, you can designate a primary physician and specify other wishes that may have been left out of earlier documents.

What should I do about old living wills and power of attorney for health care documents?

The advance directive that is properly executed and contains the most recent date will be used. It is always a good idea to destroy old documents to avoid any confusion.

Should my new advance directive for health care be filed with the State Department of Health or the Chancery Court?

The State Department of Health no longer files living wills. You are not required to file an advance directive for health care with any court. Some families decide to file power of attorney documents with the Chancery Court to make the documents a matter of public record.

Although it is not necessary to file the advance health-care directive, you should keep the signed original in a safe place. Give a copy to your agent, your alternate agent, and your physician. Tell your agent where the original document is stored. If you enter a hospital or nursing home, you should have a copy placed in your files at that facility. You may also want clergy, family, friends, and/or your attorney to have a copy. The law does provide that a copy of the document can be used as a substitute for the original.

Am I required to use a special form for my advance health-care directive?

No, you are not required to use any specific form. The advance health-care directive form included in this publication is the optional form given in the Uniform Health-Care Decisions Act. You may use it or another form. You may also use a modified version of the form in this publication. The act does require that a power of attorney for health care include the date executed and the signature of the principal executing it; and it must be either notarized or witnessed by at least two people.

What is an agent and who can be my agent?

An agent is the person designated in a power of attorney for health care (part 1 of the form in this publication) to make health-care decisions for you. Unless you limit the agent's authority, your agent can make all your health-care decisions for you. Be sure to identify any limitations to your agent's authority or any special instructions in the power of attorney for health care document.

Your agent can be a family member or friend. An owner, operator, or employee of a residential long-term care facility where you are receiving care is not allowed to be your agent unless that person is also related to you.

When does the power of attorney for health care take effect?

The power of attorney for health care commonly takes effect when you are no longer able to make health-care decisions for yourself. Your primary physician will determine whether you have the capacity to make your own decisions, unless you specify otherwise in your advance health-care directive. If you wish, the power of attorney for health care can take effect immediately.

Who should witness my advance health-care directive?

Your advance health-care directive should be witnessed by two people who can attest to your mental capacity, or it should be signed before a notary public. A witness may not be any of the following:

- 1) a health-care provider
- 2) an employee of a health-care provider or health-care facility
- 3) your agent designated in the directive

At least one witness must be someone who is not related to you and who is not entitled to any part of your estate.

Can I change my mind?

Certainly! If you change your mind, you can revoke, or cancel, your advance health-care directive at any time. Mississippi law states that the power of attorney portion of the document can be revoked only by signing a written notification or by personally notifying the supervising health-care provider. You can revoke other parts of the advance health-care directive simply by communicating this in any manner you wish. A power of attorney for health care that designates a spouse as agent is automatically revoked in the event of divorce, annulment, or legal separation. If your most recent advance health-care directive conflicts with an earlier version, the earlier directive is automatically revoked to the extent it conflicts with the newer version.

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

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate;
- (d) 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 at the end and have the form witnessed by one of the two alternative methods listed on page 10. 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 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 any time.

PART I

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)

(address of agent)

(city)

(state)

(zip code)

(home phone of agent)

(work phone of agent)

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 individual you choose as first alternate agent)

(address of first alternate agent)

(city)

(state)

(zip code)

(home phone of first alternate agent)

(work phone of first alternate agent)

OPTIONAL: If I revoke the authority of my agent and first alternate agent 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 individual you choose as second alternate agent)

(address of second alternate agent)

(city)

(state)

(zip code)

(home phone of second alternate agent)

(work phone of second alternate agent)

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 have 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:

(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:

(add sheets if needed)

PART 3

**PRIMARY PHYSICIAN
(OPTIONAL)**

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

(name of your primary physician)

(address of primary physician) (city) (state) (zip code)

(phone of primary physician)

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 your alternate primary physician)

(address of alternate primary physician) (city) (state) (zip code)

(phone of alternate primary physician)

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

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

(date)

(sign your name)

(address)

(print your name)

(city)

(state)

(13) WITNESSES: This power of attorney 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 or acknowledge your signature, or (b) acknowledged 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.

(date)

(signature of witness)

(address of witness)

(print name of witness)

(city) (state)

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.

(date)

(signature of witness)

(address of witness)

(print name of witness)

(city) (state)

ALTERNATIVE NO. 2

State of _____ County of _____

On this _____ day of _____, in the year _____, before me, _____ (name of notary public), 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.

(Signature of Notary Public)



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