People, Paperwork, and Problems
Objectives

- Understand the paperwork for advance care planning.
- Identify barriers to having your healthcare wishes followed.
- Make a plan to finish well.
“Sorry I’m late, but they had me on a life support system for two months.”
Remember Death Panels?
(there are none)
Advance Planning Involves

- Making wishes for health care known in advance of a life-threatening illness or injury
  - Best way to make them known, is in a document
    - State forms
      - Living Will
      - Power of Attorney/Proxy Directives
- Other documents
- Other plans
Things to Know

- Preferences for treatment in the event of a life limiting or life threatening illness
- Values
- Fears or concerns
- Prognosis: What is realistic?
- Goals of care and treatment
- Life goals
Best Planning

- Recurring conversation, over time, with changes in health
- Uncover gaps in understanding
- Talk about values, beliefs, preferences, goals related to healthcare
- Document wishes and goals
- Access to the documents
Key Concepts & Principles

- Surrogate means someone other than the patient is making decisions
- Primary ethical and legal obligations are to the patient
  - Must make decisions consistent with known wishes of the patient
  - Family is secondary even if they are the surrogates
- Health care provider determines the decision maker
  - Medical directive
  - Known wishes
  - Law
Competence and Capacity

- Competence is a legal determination
  - Global incapacity or specific
- Decision Making Capacity (CURA)
  - Ability to choose
  - Ability to understand relevant information
  - Ability to reason
  - Ability to appreciate the situation and its consequences
Who speaks for you?

- Best Interests
  - No clear idea
  - Reasonable person in similar circumstances
  - Implied consent
- Substituted Judgment
  - Specific statements
  - Goals, values, wishes
  - Step into the patients shoes
“Daddy wouldn’t want that!”

- 62 yo man, 3 days after surgery he consented to, recovering normally in the ICU. Wife arrives with her lawyer, patient’s living will and power of attorney in hand. Daughter also present. Wife demands patient be taken off ventilator. Daughter says, “Daddy did not want to be stuck on life support.”
Living Will

- Applies when
  - A person can’t make decisions
  - Judged to be in a terminal or irreversible condition
  - End of life document
- Instructions
  - Desire a natural death
  - Artificial nutrition (feeding tubes, IV lines)
  - Organ donation
- Completion
  - Need two witnesses or a notary
- Also known as
  - Living will declaration, Advance Medical Directive or Direction, Advance Care Plan
ADVANCE DIRECTIVE FOR HEALTH CARE* (Tennessee)

I, ________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part 1: Agent**

I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

- **Name:**
- **Relationship:**
- **Home Phone:**
- **Work Phone:**
- **Address:**
- **Mobile Phone:**
- **Other Phone:**

**Alternate Agent**

If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

- **Name:**
- **Relationship:**
- **Home Phone:**
- **Work Phone:**
- **Address:**
- **Mobile Phone:**
- **Other Phone:**

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective**

- I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
- I do not give such permission (this form applies only when I no longer have capacity).

**Part 2: Indicate Your Wishes for Quality of Life**

By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life):

- I am willing to live with ________________ (check all that apply):
  - Permanent Unconsciousness:
  - Permanent Confusion:
  - Dependent in all Activities of Daily Living:
  - End-Stage Illnesses:

**Indicate Your Wishes for Treatment**

If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

- My wishes are as follows (check all that apply):
  - CPR / Cardiopulmonary Resuscitation:
  - Life Support / Artificial Support:
  - Treatment of New Conditions:
  - Tube feeding/IV fluids:

**PLEASE SIGN ON PAGE 2**

Approved by Health Care Facilities Board 9/11/14
Part 2 Indicate Your Wishes for Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

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| ☑   | ☐  | **Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
| ☑   | ☐  | **Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
| ☑   | ☐  | **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I do not want.

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| ☐   | ☑  | **CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
| ☑   | ☐  | **Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
| ☑   | ☐  | **Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
| ☑   | ☐  | **Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Part 3. Other instructions, such as hospice care, burial arrangements, etc.: 

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

(Attach additional pages if necessary)

Part 4. Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one): 

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: ____________________

☐ No organ/tissue donation.

SIGNATURE

Part 5. Your signature must either be witnessed by two competent adults (“Block A”) or by a notary public (“Block B”).

Signature: __________________________ Date: __________________________

(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form.

   Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.

   Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF ________________

I, ______________________, a Notary Public in and for the State and County named above, do hereby acknowledge the identity of the person signing this instrument as the person appearing on the basis of satisfactory evidence to be the person who signed as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: __________________________

Signature of Notary Public: __________________________

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of these documents.
Part 3. Other instructions, such as hospice care, burial arrangements, etc.:

(Attach additional pages if necessary)

Part 4. Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue  ☐ My entire body  ☐ Only the following organs/tissues: __________

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   Signature of witness number 2

Block B. You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF ______________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

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* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.
Five Wishes

- The person I want to make care decisions for me when I can’t.
- The kind of medical treatment I want or don’t want.
- How comfortable I want to be.
- How I want people to treat me.
- What I want my loved ones to know.
JUST SO YOU KNOW...

I NEVER WANT TO LIVE IN A VEGETATIVE STATE, DEPENDENT ON SOME MACHINE.

IF THAT EVER HAPPENS, JUST UNPLUG ME, OK?

OK.

Hey!
“But she’s the wife…?”

- 68 year old man admitted with a paralysis due to metastatic cancer. Had said on admission he would not want a tracheostomy when the neurological symptoms first appeared.
- Has been married to his wife (#2) for 30 years.
- In 2014 he created a new MPOA naming his daughter as primary decision maker and son as alternate. (1st marriage children)
- Daughter believes God will heal him and wants to take him home on mechanical ventilation. Wife works and cannot care for him and is distressed as this is not his wish.
Proxy Directives

- Applies when
  - Anytime a person can’t make decisions, including end of life care
- Instructions
  - Appoint a decision maker and alternate(s)
  - Can make any medical decision the person could have
  - Supersedes family relationships
- Completion
  - Need two witnesses or a notary
- Other names
  - Durable Power of Attorney for Health Care, Medical POA, Health Care POA, Health Care Agent
# ADVANCE DIRECTIVE FOR HEALTH CARE

(Tennessee)

[Instructions: Parts 1 and 2 may be used together or independently. Please mark only the unused part(s). Part 3, Block A or Block B must be completed for all uses.]

I, ____________________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part 1: Agent.** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

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My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective**

- [ ] I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. [ ] I do not give such permission (this form applies only when I no longer have capacity).

**Part 2: Indicate Your Wishes for Quality of Life.** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

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**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

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PLEASE SIGN ON PAGE 2

Approved by Health Care Facilities Board: 9/11/24

Page 1 of 2
ADVANCE DIRECTIVE FOR HEALTH CARE* (Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, __________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: __________________ Relation: ___________ Home Phone: ___________ Work Phone: ___________
Address: ___________________ Mobile Phone: ___________ Other Phone: ___________

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: __________________ Relation: ___________ Home Phone: ___________ Work Phone: ____
Address: ___________________ Mobile Phone: ___________ Other Phone: ___________

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).
Part 3. Other instructions, such as hospice care, burial arrangements, etc.: 

(Attach additional pages if necessary)

Part 4. Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one): 

☐ Any organ/tissue  ☐ My entire body  ☐ Only the following organs/tissues: 

☐ No organ/tissue donation.

SIGNATURE

Part 5. Your signature must either be witnessed by two competent adults (“Block A”) or by a notary public (“Block B”).

Signature: ____________________________ Date: __________________

(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form. 

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption, and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil, by operation of law, or by testamentary disposition. I witnessed the patient’s signature on this form.

Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE COUNTY OF __________________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “Patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no undue stress, duress, or undue influence.

My commission expires: __________________________ Signature of Notary Public: __________________________

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.
DECLARATION FOR
MENTAL HEALTH
TREATMENT
Bad Lawyering

- Families may have made medical decisions when they are the agent on a general/financial POA
- Must have a paragraph/instruction about healthcare decision making
- Must be specific to making medical decisions, not just paying for healthcare
- They still may be the right decision maker or surrogate
“Who is Frank?”

- 73 year old woman with diabetes, history of recent pneumonia on top of chronic lung disease. In the ICU on the ventilator, medicines to keep her blood pressure up, sedated. Uncertain prognosis.

- Daughter informs the nurses that she is concerned that her dad might try to cause trouble. Her parents split up 12+ years ago but didn’t divorce.

- Nice man at patient’s bedside named Frank, knows everything about her illness, her medications, primary care doc says he always comes to appointments with her. They have lived together for about 10 years.
No Paperwork/No People

- **Health Surrogate Selection**
  - An adult who has shown special care and concern, who is familiar with the person’s values and who is reasonably available.
  - **Preference for**
    - Spouse
    - Adult child
    - Parent
    - Sibling
    - Any other relative
    - Adult who satisfies #1

- **No people/no paperwork**
  - Doctors decide with assistance from other doctors, ethics committees, or ethicists
DNR Orders

- Hospital
  - DOES NOT mean “do not treat”
  - NOT automatic with living will

- Out of Hospital
  - Applies between facilities
  - Applies at home
  - Discharge planning
  - Tennessee POST Form
    - Universal DNR: DNR that applies across facilities
A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST")
This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ["patient"]). Any section not completed indicates full treatment for that section. When need occurs, fill out these orders, then contact physician.

Date of Birth

Section A
Check One Box Only
CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.
- Reuscitate (CPR)
- Do Not Attempt Reuscitation (DNAR / no CPR) (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B
Check One Box Only
MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

- Comfort Measures. Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.
- Limited Additional Interventions. In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BIPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: basic medical treatment.
- Full Treatment. In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Full treatment including in the intensive care unit.

Other instructions:

Section C
Check One
ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

- No artificial nutrition by tube.
- Defined period of artificial nutrition by tube.
- Long-term artificial nutrition by tube.

Other instructions:

Section D
Discuss with:
- Patient/Resident
- Health care agent
- Court-appointed guardian
- Health care surrogate
- Parent of minor
- Other (Specify)
The Basis for these Orders Is: (Must be completed)
- Patient's preferences
- Patient's best interest (patient lacks capacity or preferences unknown)
- Medical indications
- Other

Physician/NP/CNS/PA Name (Print)
Physician/NP/CNS/PA Signature
Date
NCP/CNS/PA Phone Number

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative
Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (Print)
Signature
Relationship (write "self" if patient)

Agent/Surrogate
Relationship
Phone Number

Health Care Professional Preparing Form
Preparer Title
Phone Number
Date Prepared

TDH, Division of Health Licensure and Regulation, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37243

PH-4193 (Rev 7/15) RDA-10137
Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen “Do Not Attempt Resuscitation”.

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with “Comfort Measures Only”, should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only”.

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment”.

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient’s health status, or
3. The patient’s treatment preferences change.

Draw line through sections A through D and write “VOID” in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.
Ethical Will

- Not a legal document; doesn’t distribute material wealth
  - A heartfelt expression of what truly matters most in your life, what you value, ethics
  - A way to share your values, blessings, life’s lessons, hopes and dreams for the future, love, and forgiveness with your family, friends, and community
  - Shared when you are still alive
  - Helpful as a companion to other legal documents, estate planning, healthcare decision making

- Other names
  - Legacy letter, wisdom document, life legacies, celebration of life, spiritual legacy, personal legacy
Best Planning

- Recurring conversation, over time, with changes in health
- Uncover gaps in understanding
- Talk about values, beliefs, preferences, goals related to healthcare
- Document wishes and goals
- Access to the documents
Resources

- The Conversation Project
  - http://theconversationproject.org/

- National Hospice and Palliative Care Organization
  - https://www.nhpco.org/
  - http://www.caringinfo.org

- National Health Care Decisions Day
  - https://www.nhdd.org/

- Death Over Dinner
  - https://deathoverdinner.org/

- Ethical Wills/Legacy Letters
  - https://celebrationsoflife.net/ethicalwills/
HERE LIES R.J. SIMS,
LIFELONG PARANOID

THIS IS A LOT!

SCHWARTZ
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