

# A Guide to Maryland Law on Health Care Decisions



## Advance Directives



*Compliments of*

*Cereta A. Lee*

*Prince George's County*

*Register of Wills*

**“Assisting the Families of Prince George’s County  
in their Time of Need”**

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# *Our Will is to Serve.*



*Cereta A. Lee*  
*Prince George's County*  
*Register of Wills*

**"Assisting the Families of Prince George's County  
in their Time of Need"**

Dear Fellow Prince Georgian,

I am pleased to offer information to you and your family about Advance Directives. A difficult subject to deal with is a life-threatening illness. If you plan now, however, your choices can be respected and you can relieve some of the burden from your loved ones in the future.

One type of Advance Directive is a Living Will or a Health Care Proxy (included in this packet). It describes the medical care you want (or don't want) if you become terminally ill or in a persistent vegetative state. This legal document takes effect if you can't communicate your own healthcare decisions.

The enclosed forms can assist you in planning your Advance Directive. However, if you have any legal questions about your personal situation, we encourage you to consult your lawyer.

If you decide to make an Advance Directive, be sure to talk about it with your family and your doctor. The conversation is just as important as the document. A copy of any Advance Directive should be put in your medical records. You should also bring a copy of your Advance Directive if you are admitted to a hospital.

I hope that this information is helpful to you and your family. Additional information about Advance Directives can be found on the Internet at: <http://www.oag.state.md.us/healthpol/advancedirectives.htm>.

Please feel free to contact the office for any questions or assistance with estate planning.

Sincerely,

*Cereta A. Lee*

Register of Wills, Prince George's County

## **HEALTH CARE PLANNING USING ADVANCE DIRECTIVES**

*(Optional Forms Included)*

### ***Your Right To Decide***

Adults can decide for themselves whether they want medical treatment. This right to decide ) to say yes or no to proposed treatment ) applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning, through “advance directives.” An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your treatment preferences are, especially about treatments that might be used to sustain your life.

The Health Care Decisions Act sets out two optional forms, which are included with this pamphlet. The shorter one is titled “**Living Will.**” The longer one is titled “**Advance Directive,**” and it has two parts, Part A and Part B. This pamphlet will explain how to use them. These forms are intended to be guides. You may complete all of a form, or only the parts you want to use. You are *not* required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called *Five Wishes*, is available (for a small fee) from the nonprofit organization Aging With Dignity. You can get information about that document from the Internet at [www.agingwithdignity.org](http://www.agingwithdignity.org) or write to: Aging with Dignity, P.O. Box 1661, Tallahassee, FL 32302.

These optional forms can be filled out without going to a lawyer. But if there is anything you do not understand, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues. You should tell your doctor that you made an advance directive and give your doctor a copy.

You need two witnesses to your signature on these forms. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and neither your family nor anyone except you can change it. You should review what you've done once in a while. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, while you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you made an advance directive in another state, it is *legally valid* in Maryland. Also, if you have a Maryland living will or a durable power of attorney for health care prepared before October 1, 1993, that document is *still valid*. You might want to review these documents to see if you prefer to make a new advance directive instead.

### ***Health Care Agents***

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. **To name a health care agent, use Part A of the advance directive form.** Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power ) right away, or only after your doctors agree that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking a back-up agent, in case your first choice isn't available when needed. Don't pick someone without telling the person. Make sure that the person you pick understands what's most important to you. When the time comes for decisions, your health care agent should do what you would want.

The forms included with this pamphlet do *not* give anyone power to handle your money. There isn't a standard form we can send. Talk to your lawyer about planning for financial issues in case of incapacity.

## Health Care Instructions

You also have the right to use an advance directive to say what you want about future treatment issues. If you both name a health care agent *and* make decisions about treatment in an advance directive, your agent will be bound by whatever decisions you make unless you say otherwise.

If you want, **you can make a limited kind of advance directive called a living will.** A living will lets you decide about life-sustaining procedures in two situations: death from a terminal condition is imminent despite the application of life-sustaining procedures, and a condition of permanent unconsciousness called a persistent vegetative state.

**You also have the right to give broader health care instructions by using Part B of the longer form.** Part B of the advance directive lets you decide about life-sustaining procedures in three situations: terminal condition, persistent vegetative state, *and* end-stage condition. An end-stage condition is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example is advanced Alzheimer's disease. You can also use Part B of the advance directive to make health care decisions in addition to those dealing with lifesustaining procedures. If you fill out Part B, you should *not* fill out the living will form too.

Both the living will form and Part B let you decide separately, if you want, about artificially supplied nutrition and hydration, often called "tube feeding." Also, women who fill out either form can say whether pregnancy is to have any effect on their treatment decisions.

### ***Did You Remember To ...***

- Fill out, sign, and have witnessed **Part A of the advance directive** if you want to name a health care agent?
- Name a back-up agent in case your first choice as health care agent is not available when needed?
- Talk to your agent and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions that your agent must follow?

- Fill out (choosing carefully among alternatives), sign, and have witnessed **either a living will or the broader Part B of the advance directive**, but only if you want to make specific decisions?
- Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?

### **FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES IN MARYLAND**

#### **1. Must I use any particular form?**

No. Optional forms are provided, but you may change them or use different forms altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

#### **2. Who can be picked as a health care agent?**

Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

#### **3. Who can witness an advance directive?**

Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for **any** of your advance directives. Also, **one** of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) who is not the one you have named to handle your estate after your death.

#### **4. Do the forms have to be notarized?**

No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

#### **5. Do any of these documents deal with financial matters?**

No. If you want to plan for financial matters, talk with your lawyer.

#### **6. When using these forms to make a decision, how do I show the choices that I have made?**

Write your **initials** next to the statement that says what you want. **Don't** use

checkmarks or X's. Then draw lines all the way through other statements that do not say what you want. Please don't make inconsistent choices. For example, if you initial any or all of items 1, 2, and 3 on Part B of the advance directive, **do not** initial item 5. Draw lines through it instead. Also, be very careful about item 4. Draw lines through it if you want to make sure that you get enough pain relief medication.

**7. Should I fill out both the living will form and the advance directive form?**

It depends on what you want to do. If all you want to do is name a health care agent, just fill out Part A of the advance directive, and talk to the person about how they should decide issues for you. If you want to give treatment instructions, fill out *either* the living will form *or* Part B of the advance directive (not both). The living will form lets you decide about life-sustaining procedures in the event of terminal condition or persistent vegetative state. Part B lets you decide about lifesustaining procedures not only in the event of terminal condition or persistent vegetative state but also "end-stage condition." Part B also lets you make health care decisions that deal with situations other than life-sustaining procedures. Be aware that, if you name a health care agent *and* give treatment instructions, the agent will be bound by your decisions unless you say otherwise.

**8. Are these forms valid in another state?**

It depends on the law of the other state. Most states will honor an advance directive made somewhere else.

**9. How can I get forms for another state?**

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: <http://www.caringinfo.org>.

**10. To whom should I give copies of my advance directive?**

Give copies to your doctor, your health care agent if you name one, hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes.

**11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?**

Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the forms. See Advance Directive Part A, Numbers 2, 3A, and 6.

**12. If I have an advance directive, do I also need an Emergency Medical Services Palliative Care/Do Not Resuscitate Order?**

Yes. If you **don't** want ambulance personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have an EMS Palliative Care/DNR Order signed by your private physician.

**13. Does the EMS Palliative Care/DNR Order have to be in a particular form?**

Yes. Ambulance personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, a standardized order form has been developed. Have your doctor or health care facility contact the Maryland Institute for Emergency Medical Services System (MIEMSS) at (410) 706-4367 to obtain information on EMS Palliative Care/DNR Orders.

**14. Can I use an advance directive to make an organ donation?**

Yes. A special form for that purpose is included.

**IF YOU HAVE OTHER QUESTIONS, PLEASE TALK TO YOUR DOCTOR OR YOUR LAWYER. OR, IF YOU HAVE A QUESTION ABOUT THE FORMS THAT IS NOT ANSWERED HERE OR ELSEWHERE IN THIS BROCHURE, YOU CAN CALL THE HEALTH POLICY DIVISION OF THE ATTORNEY GENERAL'S OFFICE AT (410) 576-6327 OR E-MAIL US AT [ADFORMS@OAG.STATE.MD.US](mailto:ADFORMS@OAG.STATE.MD.US).**

*REVISED JUNE 2005*

**ADVANCE DIRECTIVE**  
**PART A**  
**APPOINTMENT OF HEALTH CARE AGENT**  
*(Optional Form)*

(Cross through this whole part of the form if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, cross through any items in the form that you do not want to apply.)

1. I, \_\_\_\_\_, residing  
at \_\_\_\_\_

\_\_\_\_\_

appoint the following individual as my agent to make health care decisions for me:

\_\_\_\_\_

*(Full Name, Address, and Telephone Number of Agent)*

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

\_\_\_\_\_

\_\_\_\_\_

*(Full Name, Address, and Telephone Number of Back-up Agent)*

2. In accordance with the Health Insurance Portability and Accountability Act (“HIPAA”), a health care agent is a personal representative and is entitled to request and receive protected health information.

3. My agent has full power and authority to make health care decisions for me, including the power to:

A. In accordance with HIPAA and as my personal representative, request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and other protected health information, and consent to disclosure of this information;

B. Employ and discharge my health care providers;

C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life sustaining procedures.

4. The authority of my agent is subject to the following provisions and limitations:

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5. If I am pregnant, my agent shall follow these specific instructions:

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6. My agent's authority becomes operative (*initial only the one option that applies*):

\_\_\_\_\_ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; provided however, when this document is signed, each individual identified in paragraph (1) is, in accordance with HIPAA, my personal representative for all purposes related to any assessment of my capacity to make an informed decision regarding my health care; or

\_\_\_\_\_ When this document is signed.

7. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

8. My agent shall not be liable for the costs of care based solely on this authorization.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

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

\_\_\_\_\_  
(Signature of Declarant)

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual.

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Signatures and Addresses of Two Witnesses)

**ADVANCE DIRECTIVE  
PART B  
HEALTH CARE INSTRUCTIONS  
(Optional Form)**

*(Cross through this whole part of the form if you do not want to use it to give health care instructions. If you do want to complete this portion of the form, **initial** those statements you want to be included in the document and **cross through** those statements that do not apply.)*

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (**Initial** all those that apply.)

1. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

2. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery:

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

3. If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

4. \_\_\_\_\_ I direct that, no matter what my condition, medication to relieve pain and suffering not be given to me if the medication would shorten my remaining life.

5. \_\_\_\_\_ I direct that, no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.

6. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

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

7. I direct (*in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care*):

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

By signing below, I indicate that I am emotionally and mentally competent to make this Advance Directive and that I understand the purpose and effect of this document.

\_\_\_\_\_  
(Date) (Signature of Declarant)

The declarant signed or acknowledged signing these health care instructions in my presence and, based upon my personal observation, appears to be a competent individual.

\_\_\_\_\_  
(Witness) (Witness)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Signatures and Addresses of Two Witnesses)

# LIVING WILL

(Optional Form)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (*Initial* those statements you wish to be included in the document and *cross through* those statements which do not apply.)

A. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

\_\_\_\_\_ I direct that, even in a terminal condition, I be given all available medical treatment in accordance with acceptable health care standards.

B. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery:

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

\_\_\_\_\_ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

\_\_\_\_\_ I direct that, even in a terminal condition, I be given all available medical treatment in accordance with acceptable health care standards.

C. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

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

By signing below, I indicate that I am emotionally and mentally competent to make this Living Will and that I understand its purpose and effect.

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

\_\_\_\_\_  
(Signature of Declarant)

The declarant signed or acknowledged signing this Living Will in my presence and, based upon my personal observation, the declarant appears to be a competent individual.

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

(Signatures and Addresses of Two Witnesses)

**ORGAN DONATION ADDENDUM**

[Note: If you want to be an organ donor, you can attach this page to your living will or advance directive. Sign it and have it witnessed.]

Upon my death, I wish to donate:

\_\_\_\_\_ Any needed organs, tissues, or eyes.

\_\_\_\_\_ Only the following organs, tissues, or eyes:

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

I authorize the use of my organs, tissues, or eyes:

\_\_\_\_\_ for transplantation;

\_\_\_\_\_ for therapy;

\_\_\_\_\_ for research;

\_\_\_\_\_ for medical education;

\_\_\_\_\_ for any purpose authorized by law.

I understand that before any vital organ, tissue, or eye may be removed for transplantation, I must be pronounced dead. After death, I direct that all support measures be continued to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue and eye recovery has been completed.

I understand that my estate will not be charged for any costs associated with my decision to donate my organs, tissues, or eyes or the actual disposition of my organs, tissues, or eyes.

By signing below, I indicate that I am emotionally and mentally competent to make this organ donation addendum and that I understand the purpose and effect of this document.

\_\_\_\_\_ (Date) \_\_\_\_\_ (Signature of Declarant)

The declarant signed or acknowledged signing this organ donation addendum in my presence and based upon my personal observation appears to be a competent individual.

\_\_\_\_\_ (Witness) \_\_\_\_\_ (Witness)

*(Signature of Two Witnesses)*