

INTERNAL MANAGEMENT POLICY & PROCEDURE

Applicability: ☐ ADULT Operations Only ☐ JUVENILE Operations Only ☒ DEPARTMENT-WIDE

IMPP #: 16-115D

PAGE #: 1 of 6

HEALTH CARE SERVICES: Advance Directives

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POLICY

All adult residents in the Kansas Department of Corrections have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition. K.S.A. 65-28,101

The withholding or withdrawal of resuscitative or life-support services pursuant to an Advance Directive or DNR order, is consistent with sound medical practice and is not associated with assisting suicide, voluntary euthanasia, or expediting the resident's death. K.S.A. 65-28,108 & K.S.A. 65-28,109.

DEFINITIONS

Advance Directive: A legally recognized document to express the wishes of an individual regarding end of life medical care in advance of need to make sure a person's wishes are followed when they become mentally or physically unable to make medical decisions. A Durable Power of Attorney for Health Care Decisions (DPOA-HCD), Living Will, and Do Not Resuscitate (DNR) are the three types of Advance Directives in Kansas.

Attending Physician: The physician selected by or assigned to the patient who has primary responsibility for the treatment and care of the patient.

Capacity: Refers to the ability of a patient to make his or her own medical decisions. The capacitated resident has the ability to both understand information relevant to a medical decision and to appreciate the consequences of that decision. Residents are considered to be capacitated unless the physician or psychiatrist has assessed and documented otherwise.

Competency: Refers to the ability of a resident to provide for his or her own needs. A resident is considered competent unless declared otherwise by a judge in a court of law.

Declaration: A witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of K.S.A. 65-28,103.

Do Not Resuscitate (DNR) Directive: A signed, dated, and witnessed form that lets an adult say in advance his/her decision that if his/her heart stops beating or breathing stops, no medical procedure is to be performed to restart the heart or breathing. Other appropriate emergency medical care by pre-hospital caregivers or medical care directed by a doctor may be given. The form is authorized by Kansas law. The person must be a mentally and emotionally competent adult at least 18 years of age when the form is signed.

Do-Not-Resuscitate (DNR) Identification Device: An identification device specified by the Kansas Department of Corrections that is worn for identifying a person who has executed or issued a DNR order.

Durable Power of Attorney for Health Care Decisions (DPOA-HCD): A signed and notarized or witnessed legal document that is a type of Advance Directive, which allows a resident to name someone to make health care decisions for him/her during a time of disability or incapacity. It is broader than a Living Will because it includes all medical decisions not just those pertaining to life sustaining medical treatment. It is signed by the competent/capacitated person, but does not go into effect until the attending physician certifies and documents in the health record that the resident is incapacitated. It is left to the appointed individual to determine what the resident would want. (The person who has the DPOA-HCD is called the health care agent, proxy, surrogate, or DPOA-HCD).

Incapacity: Refers to the inability of a resident to make his or her own medical decisions. The incapacitated resident lacks the capacity to both understand information relevant to a medical decision and to appreciate the consequences of that decision. This is a clinical assessment made by a physician or a psychiatrist.

Incompetency: Refers to a resident who is unable to provide for his or her own needs. A resident can be declared incompetent by a judge in a court of law.

Life-Sustaining Procedure: Any medical procedure or intervention which, when applied to a qualified patient, would serve only to prolong the dying process and where, in the judgment of the attending physician, death is going to occur whether or not such procedure or intervention is utilized.

Life-Sustaining Treatment: A medical procedure or intervention that uses mechanical or other artificial means to sustain, restore or supplant a vital function. The term does not include the administration of pain management medication or the performance of a medical procedure considered necessary to provide comfort care, or any other medical care provided to alleviate a resident's pain.

Living Will: A signed and notarized or witnessed document that allows a person to state in advance that his/her dying is not to be artificially prolonged in cases of terminal illness. Only the patient may make this decision. Relatives and even the patient's legal guardian do not have the authority to make this decision. The form is authorized by Kansas law.

Qualified Patient: A patient who has executed a declaration that has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom must be the attending physician.

Terminal Condition: An incurable or irreversible condition caused by injury, disease or illness that according to reasonable medical judgment would produce death within six (6) months or less if the condition runs its normal course, and in which the application of life-sustaining procedures would serve only to postpone the moment of the resident's death.

Transportable Physician's Orders for Patient Preferences: Contains standing medical orders applicable across various care settings and actionable by emergency medical personnel.

PROCEDURES

I. Establishing a Living Will/Health Care Directive

- A. A resident's specific wishes may be communicated in advance in a Health Care Directive (HCD)-Living Will Declaration (Attachment A) or by giving someone else the authority to make such decisions on their behalf in a Durable Power of Attorney for Health Care Decisions (DPOA-HCD) (Attachment B), and in all cases, shall be weighed against legitimate governmental interests, including the security and orderly operation of correctional facilities.
 - 1. A resident may at any time sign a HCD outlining his or her wishes with regard to the withholding or withdrawal of life-sustaining procedures in a terminal condition by executing a written "Declaration", per instructions in Attachment A, which substantially complies with K.S.A. 65-28,103(c), declaring the resident's desire for such action. This discussion shall be recorded in the resident's health record.

- B. A resident may initiate a Do-Not-Resuscitate Directive (Attachment C) to prevent CPR from being initiated in the event their heart ceases to beat or if their respirations cease when the licensed site physician has signed the form indicating the request is medical appropriate.
- C. Healthcare staff may assist a resident in completing the "Living Will/Advance Directive for Healthcare."
- D. A resident may use a private attorney at their own expense to prepare a "Living Will/Advance Directive for Health Care" if so desired.
- E. The resident and healthcare personnel must comply with all other provisions of the Natural Death Act, K.S.A. 65-28,101 *et seq.* Information regarding this declaration must be provided at intake, any time upon the resident's request, and when a resident has been diagnosed with a terminal illness.
 - 1. The Health Services Administrator (H.S.A.) at each facility and the unit team must have forms and Advance Directive information packets available to provide to residents upon request. Such packets are to include:
 - a. Health Care Directive-Living Will Declaration (Attachment A);
 - b. Durable Power of Attorney for Health Care Decisions (Attachment B);
 - c. Do-Not-Resuscitate Directive (Attachment C);
 - d. Transportable Physician Orders for Patient Preferences (TPOPP) Instructions and Form (Attachment D).
 - e. Frequently Asked Questions About Advance Directives (Wichita Medical Research Education Foundation [WMREF]) (Attachment E);
 - f. Kansas Advance Directives Brochure (WMREF) (Attachment F);
 - g. Life Sustaining Treatments Brochure (WMREF) (Attachment G);
 - h. Medically Assisted Nutrition and Hydration Brochure (WMREF) (Attachment H); and
 - i. Choosing an Agent Brochure (Choosing an Agent) (Attachment I).
- F. The Living Will Declaration must be:
 - 1. In writing;
 - 2. Signed by the person making the declaration, or by another person in the declarant's presence and by the declarant's expressed direction;
 - 3. Dated;
 - 4. Signed in the presence of two (2) or more witnesses at least 18 years of age neither of whom must be:
 - a. The person who signed the declaration on behalf of and at the direction of the person making the declaration;
 - b. Related to the declarant by blood or marriage;
 - c. Entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any Will of the declarant or codicil thereto; or

- d. Directly responsible for declarant's health care.
- G. Employees of the Department of Corrections or any contractor providing health care to residents may not sign the declaration as a witness.
 - 1. Witnesses may be volunteers, employees of contractors not involved in providing health care to residents, Legal Services for Prisoners, Inc. staff, visitors except as specified above or other residents.
- H. Once executed, the Advance Directive must be:
 - 1. Scanned into the resident's electronic health record;
 - 2. A copy placed in the resident's central file; and
 - 3. The original document given to the resident.
 - 4. An E.H.R. alert is to be placed and activated.
- I. When a resident establishes a "Living Will/Advance Directive for Health Care" while in an outside Hospital/health care facility that outside facility may follow its own procedures and protocols.
- J. An attending physician who has been notified of the existence of a declaration without delay after the diagnosis of a terminal condition of the declarant, must take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient. K.S.A. 65-28,105.

II. Durable Power of Attorney for Health Care Decisions

- A. A resident may, at any time, establish a Durable Power of Attorney for Health Care Decisions (DPOA-HCD) (Attachment B). In so doing, the resident designates an agent to make health care decisions when the resident is unable to do so and establishes the powers of that agent.
 - 1. The DPOA-HCD does not become effective until the physician has certified and documented in the health record that the resident is incapacitated.
 - 2. Any currently incarcerated resident may not serve as a DPOA-HCD for any resident.
 - 3. KDOC employees may not serve as a DPOA-HCD for any resident.
 - 4. A KDOC employee who is related to a resident may serve as the DPOA-HCD if no other family members are available.
 - 5. Employees of the Department of Corrections or any contractor providing health care to residents may not be the DPOA-HCD.

III. Activation of Advance Directive

- A. When it is determined that a resident has become incapacitated by illness, injury, or old age, the attending physician and a second physician may determine that the terms of the "Living Will for Health Care" are to be carried out. The second physician may be any physician licensed to practice Medicine in Kansas not directly involved in the care of the patient.
- B. In the event more than one (1) valid advance directive has been executed and not revoked, the last advance directive so executed must be construed to be the last wishes of the resident.
- C. The Health Care Provider shall notify the H.S.A. or designee, and the Warden or designee, by KDOC email, that an "Advance Directive/Living Will/DNR" has been activated.

- D. The Regional Medical Director (RMD), Site Medical Director, H.S.A., and Warden or designee shall determine the appropriate setting for the resident (i.e. infirmary, hospital, or current setting).

III. Withholding or Withdrawing Life-Sustaining Treatment

- A. In order for medically necessary and indicated life-sustaining treatment to be withheld or withdrawn:
 - 1. The resident must have a valid Health Care Directive on file.
 - 2. There is a diagnosis of a terminal condition by the attending physician or a diagnosis of a permanent unconscious state by two (2) physicians, documented in the resident's health record.
- B. The attending physician shall ensure that all steps comply with the healthcare directive and are consistent with the resident's wishes.

IV. Transportable Physician Orders for Patient Preferences (TPOPP)

- A. Community emergency response personnel and other community health care providers may not recognize department forms; therefore, a resident who wishes for life-sustaining treatment to be withheld or withdrawn needs to also have a valid Transportable Physician Orders for Patient Preferences (TPOPP) (Attachment D) on file.
- B. A valid Health Care Directive or TPOPP does not preclude administration of medications or procedures necessary to alleviate pain.
- C. The TPOPP must be scanned into the electronic health record or completed by means of an electronic form within the electronic health record and must accompany all transfers to and from facilities in addition transports to community healthcare entities.

V. Revocation

- A. A resident can revoke an Advance Directive verbally, in writing, or by physically destroying the document at any time.
 - 1. The attending physician or the physician's designee must record an "administrative note" in the resident's health record of the time, date and place of the revocation, and, if different, the time, date and place that the physician received notice of the revocation.
 - 2. An alert shall be activated in the electronic health record to indicate the advanced directive has been revoked.
 - 3. The attending physician or the physician's designee must write, "REVOKED" on each page of the directive and scan the corrected document into the electronic health record.
 - 4. Once an Advance Directive has been revoked, the resident must be treated as if an Advance Directive never existed. The healthcare staff is immediately obligated to initiate all life sustaining measures as indicated by the resident's immediate needs.

VI. Self-Harm

- A. Advance Directives to withhold life-sustaining treatment, DNR's, TPOPP's, and Durable Power of Attorney for Health Care Decisions are not valid in cases where an otherwise healthy resident has taken deliberate action to harm him/herself, including attempted suicide.

VII. Residents Unable to Consent to or Refuse Treatment

- A. If a resident has not prepared a Living Will, advanced directive, or DNR; and is unable to actually consent, all providers may presume the resident prefers life and shall provide resuscitation as required.
- B. Outside providers shall follow their own consent procedures. KDOC medical or facility staff shall provide family contact information as needed.
- C. If consent cannot be obtained by either agency or outside provider; the H.S.A. shall contact the RMD. The RMD or designee shall notify the Office of Healthcare Compliance and KDOC legal counsel to determine if guardianship proceedings need to be initiated.

VIII. This IMPP must serve as final policy in all departmental facilities, and no General Orders shall be developed or implemented on this subject.

NOTE: The policy and procedures set forth herein are intended to establish directives and guidelines for staff and residents and those entities that are contractually bound to adhere to them. They are not intended to establish State created liberty interests for employees or residents, or an independent duty owed by the Department of Corrections to employees, residents, or third parties. Similarly, those references to the standards of various accrediting entities as may be contained within this document are included solely to manifest the commonality of purpose and direction as shared by the content of the document and the content of the referenced standards. Any such references within this document neither imply accredited status by a Departmental facility or organizational unit, nor indicate compliance with the standards so cited. The policy and procedures contained within this document are intended to be compliant with all applicable statutes and/or regulatory requirements of the Federal Government and the state of Kansas. This policy and procedure are not intended to establish or create new constitutional rights or to enlarge or expand upon existing constitutional rights or duties.

REPORTS

None.

REFERENCES

K.S.A. 65-28,101 *et seq.*; 65-4941

HISTORY

Original 12-24-24

ATTACHMENTS

Attachments	Title of Attachments	Pages
A	Health Care Directive—Living Will Declaration	1 page
B	Durable Power of Attorney for Health Care Decisions	1 page
C	Do Not Resuscitate Directive	1 page
D	Transportable Physician Orders for Patient Preferences (TPOPP)	2 pages
E	Frequently Asked Questions About Advance Directives	4 pages
F	Kansas Advance Directives Brochure	2 pages
G	Life Sustaining Treatments Brochure	2 pages
H	Medically Assisted Nutrition and Hydration Brochure	2 pages
I	Choosing an Agent Brochure	2 pages

HEALTH CARE DIRECTIVE LIVING WILL DECLARATION KANSAS DEPARTMENT OF CORRECTIONS

I, _____, being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare: If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or	withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal. I understand the full import of this declaration and I am emotionally and mentally competent to make this decision. Any Living Will declaration I have previously made is hereby revoked.
Declarations made this _____ (day) of _____ (month, year) Signature: _____ X _____ Date of Birth _____ Address: _____ Street City State Zip	

This document must be witnessed by two individuals or acknowledged by a notary public.

Notary Public: STATE OF _____ COUNTY OF _____ This instrument was acknowledged before me this _____ day of _____ (month, year) Signature of Notary _____ Or Witnesses: The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under a will of declarant or codicil thereto, or directly responsible for declarant's medical care. Name _____ Address: _____ City, State, Zip _____		Notary Seal: Name _____ Address: _____ City, State, Zip _____
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DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name) _____ (date of birth) _____, appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent: _____ Telephone _____ Telephone _____

Agent's address: _____ City _____ State/Zip _____

Name of First Alternate Agent: _____ Telephone _____ Telephone _____

Agent's address: _____ City _____ State/Zip _____

Name of Second Alternate Agent: _____ Telephone _____ Telephone _____

Agent's address: _____ City _____ State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

- ☐ I wish to be a donor for organs and tissues.
- ☐ I have attached information about treatment choices I wish to have honored by my agent. ____ page(s) attached.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; *or*
2. Revoke any existing Living Will Declaration I may have.

X _____ date _____
signature

Notary Public:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

Notary Seal:

OR

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____
(Signature)

Date: _____

X _____
(Signature)

Date: _____



This document is based on Kansas Statutes Annotated, (58-625 through 632)
Additional forms and information are available through

Wichita Medical Research & Education Foundation
3306 E. Central, Wichita, KS 67208
316-686-7172

www.wichitamedicalresearch.org

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DNR
DO-NOT-RESUSCITATE DIRECTIVE

K.S.A. 65-4941, ET. SEQ.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (Your name) _____, request that effective today, emergency care for me will be limited as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation, (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotoxic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining other medical care, especially comfort measures and pain medication.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR directive shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home or facility.

X _____
(Signature) (Date)

X _____
(Witness Signature) (Date)

Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient's decision to refuse CPR.

- In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. **DNR**

X _____
(Attending Physician's Signature) (Date)

(Address) (Facility, Clinic or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X _____
(Signature) (Date)



Form #130 Rev. 4/2003. © 2011 Wichita Medical Research & Education Foundation

We thank Kansas Health Ethics, Inc. (now closed) for their efforts in the development of this and other documents. For more information about obtaining copies of this document contact Wichita Medical Research & Education Foundation, 316-686-7172 or tcarter@wichitamedicalsearch.org, www.wichitamedicalsearch.org

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED			
Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP) This Medical Order set is based on the patient's current medical condition and preferences. Any section not completed indicates full treatment for that section. The original form need not be present at the time of emergency. A copied, faxed or electronic version of this form is valid.			
Last Name:	First Name:	Middle Initial:	FOR EDUCATIONAL USE ONLY
Date of Birth:	Last 4 SSN:	<i>(For Patient Identifiers)</i>	
A. CHECK ONE	CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.		
	If patient is not in cardiopulmonary arrest, follow orders in B and C.		
	☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)		☐ Do Not Attempt Resuscitation (DNAR/no CPR/Allow Natural Death)
B. CHECK ONE	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.		
	☐ Full Treatment. In addition to treatment described in Comfort Measures Only and Selected Additional Interventions (see below), use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care. TREATMENT GOAL: ATTEMPT TO PROLONG LIFE BY ALL MEDICALLY EFFECTIVE MEANS.		
	☐ Selected Additional Interventions. In addition to treatment described in Comfort Measures Only (see below), use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. TREATMENT GOAL: ATTEMPT TO RESTORE FUNCTION WITH TREATMENTS FOR REVERSIBLE CONDITIONS.		
	☐ Comfort Measures Only. Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs cannot be met in current location. TREATMENT GOAL: ATTEMPT TO MAXIMIZE COMFORT THROUGH SYMPTOM MANAGEMENT ONLY.		
	Additional Orders: _____		
C. CHECK ONE	MEDICALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.		
	☐ Long term medically administered nutrition, including feeding tubes. ☐ Medically administered nutrition, including feeding tubes, for trial period: _____ ☐ No medically administered nutrition, including feeding tubes.		
	Additional Orders: _____		
D. CHECK ALL THAT APPLY	INFORMATION AND SIGNATURES		
	Discussed with: ☐ Patient ☐ Agent/DPOA healthcare ☐ Parent of minor ☐ Legal guardian ☐ Health care surrogate ☐ Other (specify): _____		
	Signature of patient or recognized decision maker <i>(All fields required)</i> By signing this form, the recognized decision maker acknowledges that this request regarding above treatment measures is consistent with the known desires, and with the best interest, of the individual who is the subject of the form.		
	Print name:	Signature:	Relationship:
	FOR EDUCATIONAL USE ONLY		
	Address:		Phone:
	Signature of authorized healthcare provider <i>(All fields required)</i> My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.		
	Print name of authorized provider and Physician:		Phone:
	Signature of authorized provider:		Date:
	FOR EDUCATIONAL USE ONLY		

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED		
Last Name:	First Name: FOR EDUCATIONAL USE ONLY	Middle Initial:
Date of Birth:	Last 4 SSN:	
E.	ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS	
Healthcare Directive or other Advance Directive		☐ No ☐ Yes
Durable Power of Attorney for Healthcare Decisions document*		☐ No ☐ Yes
*Name of Agent: _____		Phone: _____
Health Care Providers Assisting with Form Preparation		
Name:	Title:	Phone:
Name:	Title:	Phone:
Instructions for Completing TPOPP - Completing a TPOPP form is always voluntary. TPOPP is a useful tool for the understanding of and implementation of physicians' orders that are reflective of the current medical condition and preferences of a patient. The orders are to be respected by all receiving providers in compliance with institutional policy. On admission to the hospital setting, a physician who will issue appropriate orders for that inpatient setting will assess the patient. - TPOPP is a physician order set and as such does not replace Advance Directives but should serve to clarify them. - TPOPP must be completed by a health care provider based on patient preferences and medical indications. Upon completion it must be signed by a physician, APRN, or PA; and patient (<i>or representative</i>) in compliance with scope of practice, regulation, and state law to be valid. - Use of original form is strongly encouraged. Photocopies and Faxes of signed TPOPP forms are valid. A copy shall be retained in patient's medical record and accompany the patient to all settings. Using TPOPP - Any incomplete section of TPOPP implies full treatment for that section. SECTION A: - If found pulseless and not breathing, no defibrillator (<i>including automated external defibrillators</i>) or chest compressions should be used on a person if "Do Not Attempt Resuscitation" is selected. SECTION B: - 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 (<i>e.g., treatment of a hip fracture</i>). - Non-invasive positive airway pressure includes continuous positive airway pressure (<i>CPAP</i>), bi-level positive airway pressure (<i>BiPAP</i>), and bag valve mask (<i>BVM</i>) assisted respirations. Reviewing TPOPP TPOPP form should be reviewed when: - The person is transferred from one care setting or care level to another, or - There is a substantial change in the person's health status, or - The person's treatment preferences change. Modifying and Voiding TPOPP - A patient with capacity can, at any time, request alternative treatment or revoke a TPOPP by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line. - A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/APRN/PA, based on the known desires of the patient or, if unknown, the patient's best interests.		
For more information or to obtain more forms: TPOPP@practicalbioethics.org		
HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT		

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES

General Questions

- 1. *What are the three kinds of Advance Directives in Kansas?***
Durable Power of Attorney for Health Care (DPOA-HC), Living Will and Do Not Resuscitate.
- 2. *How is the durable power of attorney for health care (DPOA-HC) different from a general power of attorney?***
The durable power of attorney for health care (DPOA-HC) covers ONLY health care decisions. The general durable power of attorney covers financial matters and property decisions.
- 3. *May I choose the same agent for financial and health care decisions?***
Yes, you may choose the same person to be your DPOA for health care and finances. You must make sure to use separate documents for each DPOA position. Your health care facilities and physicians will only need the DPOA for Health Care documents.
- 4. *Where do I get the advance directive forms?***
In Kansas, you may go to the website: wichitamedicalresearch.org Click on menu item titled Kansas Advance Directives, then locate the form you wish to print. You may also request forms at any admissions office of any local hospital. If you need another state's forms, go to website www.nhpco.org and click on advance directives and select specific state's forms.
- 5. *I have filled out my Advance Directive forms. Where do I get the forms notarized?***
Notary is available at local Kroger/Dillon's stores or your local bank or hospital. Wichita Medical Research and Education Foundation also provide notary service at no cost, but call for an appointment first.
- 6. *Do I get the forms witnessed or notarized? Is it better to have my forms notarized or witnessed?***
You may have the forms witnessed OR notarized. Some states require notary. Kansas does not require notary.
- 7. *Who can witness my signature?***
Two persons who recognize that you are the person you say you are. They do not have to understand the form or what you are signing. They are only recognizing you and your signature.
- 8. *Are my Advance Directive forms honored in other states when I travel?***
Yes. All 50 states have advance directives. Advance directives travel with you and are honored in all states.
- 9. *I have filled out my Advance Directive forms. What do I do with them?***
When you have signed the forms, make at least five or more copies of your documents and give them to your DPOA-HC (agents), your physicians, your lawyer, spiritual leader or anyone else who may be involved with your health care. Make sure your agent(s), family members and friends know where your documents are kept. Please keep your originals in a safe place. Keep one copy where it is easy to find and make more copies if needed. A copy of these documents has the same effect as the original. It is your responsibility to have a copy ready when it is needed. Take a copy with you when you go into a hospital, nursing home, hospice or other care facility.
- 10. *What if my family disagrees with the DPOA-HC I have chosen? What if they want something different from my wishes?***
The physician is required to recognize the durable power of attorney for health care as the legal decision maker for the patient. If there is discord/disagreement about what you wanted and what the family members think you wanted, then the physician will continue to speak with the DPOA-HC and family members until an agreement is made about your wishes. Understand the chosen DPOA-HC (agents) are the only ones with the legal right to make decisions for you. It is important that you discuss your wishes and values now with your family so they will know what you want done at the end of life.
- 11. *What is a HIPPA release? Is a HIPPA release an advance directive?***
HIPPA stands for Health Insurance Portability and Accountability Act established in 1996 to protect patient's health care information. No, a HIPPA release is not an advance directive. In the HIPPA release document,

you can designate those whom may receive your health care information from the physician or health care professionals. These persons may or may not be your DPOA-HC.

12. *Where can I get a HIPPA Release form?*

You can get a HIPPA release form from the staff at the office of your health care provider (physician or clinic's office).

**Choosing Your Durable Power of Attorney for Health Care (DPOA-HC)
and other questions re:DPOA-HC**

1. *What are some guidelines for choosing my agent (DPOA-HC)?*

Choose someone you trust to listen to your wishes, ask questions of the health care staff, and make decisions that you would want made. You will need to share health care information with this person(s) to assist them in making decisions if you were unable to make them for yourself.

2. *My son lives in Canada; can he be my DPOA for Health Care?*

Yes, your son in Canada can be your DPOA-HC. Your DPOA-HC does not have to live in the U.S.A. or near you. The important thing is that the person be available by phone to discuss decisions when they need to be made.

3. *I am my mother's DPOA for Health Care. May I sign her DNR?*

No, you may not sign a DNR form for your mother or anyone else. In Kansas, the Do Not Resuscitate (DNR) form is a directive which means the DNR Directive may be signed by the patient only and the patient's physician. IF your mother loses capacity (ability to make decisions for herself), and the physician or you feel a DNR status is appropriate, after discussion, when agreed upon by patient decision makers(s) and the attending physician, the *physician* can sign a DNR ORDER on the chart. IF the patient is at home, a DNR order can be written on a prescription pad by the attending physician and posted in the home.

4. *I have my daughter listed as my agent on my DPOA for health care and have changed my mind and want it to be my son. Can I just mark out her name and add his, or do I need to fill out new forms?*

No. You need to fill out new forms. The DPOA-HC form is a legal form and it is not recommended to mark things out on a legal form. If you have capacity, you can fill out new forms. IF you lose capacity, you cannot change the form and no one can change the form for you or fill out a new form for you. Be sure to communicate with your children why you are changing the DPOA-HC so there is less chance of disagreement about decisions.

5. *How many people may I choose for my DPOA-HC?*

The WMREF form has three (3) spaces for agents' names and information. You may choose 1 or more. Choose individuals whom you believe will honor your wishes, be available and be assertive in representing your health care wishes.

6. *Can my minor child be my DPOA for Health Care?*

No. The statute states that the DPOA-HC must be 18 years or older. Consult an attorney if you want further information.

7. *My only living relative is my daughter who is mentally handicapped. May I appoint her as my DPOA?*

Your DPOA-HC will need to make decisions for you when you are unable to do so. Your daughter would need to understand situations and questions posed by the physician and health care team and make decisions for you. You may wish to choose a friend or someone from your church or other contacts to appoint as your DPOA-HC if your daughter is unable to make decisions for you.

Living Will

1. *What is a Living Will?*

A Living Will is a declaration that is applicable to situations where you would "have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have examined you." Each of the 50 states of the U.S.A. has this advance directive, Living Will. This document applies to terminal conditions where patients are expected to die and "*where the application of life-sustaining procedures would serve only to artificially prolong the dying process.*" Many feel the Living Will helps to identify someone's wishes about end of life care, but it is not specific.

2. *What is the difference between a DPOA-HC and a Living Will?*

A DPOA-HC designates whom you want to make health care decisions for you when you are not able to make decisions for yourself. A Living Will is a document applied to terminal conditions and it is for you to sign about your desire *“that my dying shall not be artificially prolonged...if you have an incurable injury, disease or illness...”* The Living Will does not have the names of your DPOA-HC on the form. You need the DPOA-HC form for many different situations other than terminal condition when you cannot make decisions for yourself and it designates your decision makers.

DNR -- Do Not Resuscitate Directive

1. *What does DNR mean?*

DNR means DO NOT RESUSCITATE. CPR is an abbreviation for cardio-pulmonary resuscitation (heart and lung resuscitation) and DNR means no CPR will be done. No chest compressions, no artificial breathing will be done if the person's heart stops and/or breathing stops.

2. *May I sign a DNR for my relative?*

NO. In Kansas, the DNR is a directive signed by the patient only. If the patient has lost capacity or cannot sign the DNR Directive, you may talk to the physician and if appropriate, the physician can sign a DNR Order on the order sheet of the health care facility. If the patient is at home, the physician can sign a DNR Order on a prescription pad and this is posted in the home.

3. *My father cannot sign documents (he is not mentally of capacity) and needs a DNR. What can I do to get a DNR in place?*

Ask the attending physician (the private doctor for your father, or medical director of the nursing home, or the physician caring for your father) about your father's need for a DNR. The physician can sign a DNR ORDER if appropriate and agreed upon.

4. *I am the guardian for a relative in long term care. My relative no longer has capacity to make decisions for himself. How do I get a Do Not Resuscitate Order in place?*

With guardianship, you must talk to the attending physician who completes a form required by the court system. You should talk to your patient's case manager and your attorney and ask about the steps to proceed to court to obtain a DNR for your relative. A judge will have to decide if the DNR is necessary. Sometimes this may take several weeks.

5. *Does a DNR require a physician's signature?*

Yes, in order to be valid and honored, a physician has to sign and date the DNR.

6. *What is a Physician's Order?*

A Physician's order is a written order about the care of the patient/resident. These orders are written in the chart at a health care facility. A Do Not Resuscitate order can also be written on a prescription pad and this paper is then posted in the residence of the patient.

7. *Will EMS (Emergency Medical Service) honor a DNR bracelet that signifies the patient does not want to be resuscitated?*

YES. For a patient/resident to obtain a DNR bracelet, you must send in the DNR Directive or Order signed by a physician to the appropriate company you are buying the bracelet from. A DNR bracelet can be worn at all times and you do not have to have the DNR paper with you.

TPOPP (Transportable Physician Order for Patient Preferences)

1. *What is a TPOPP (Transportable Physician Order for Patient Preferences) form?*

A TPOPP form is a physician order set that outlines the patient's wishes for end of life care...or specific wishes for care. A TPOPP form does not replace Advance Directives, but is more specific about CPR, medical interventions and treatment goals, medically administered nutrition. This form can be signed by the patient/resident/agent/DPOA-HC/parent of a minor, or a legal guardian.

2. *Who may use a TPOPP form?*

A patient or resident of a health care facility who is expected to die in the next year may use a TPOPP form, or someone who wants to clarify the end of life care for their loved one. The TPOPP form will clarify patient preferences and medical indications for treatment more clearly than advance directives.

3. *Where do I get a TPOPP form?*

You may obtain a TPOPP form from your physician. For more information about TPOPP, go to www.TPOPPWichita.org or watch the YouTube segment on TPOPP: <https://www.youtube.com/watch?v=xHI7q69131M>

4. *If I have Advance Directive forms, do I need a TPOPP form?*

If you have a terminal condition, or advanced chronic illness (COPD, heart disease, diabetes, etc.) and your physician believes you may die in the next year, a TPOPP form is appropriate for you to complete. Completing a TPOPP form is always voluntary and maybe part of an individual's advance care planning process, but it does not take the place of the DPOA-HC form, or living will. (The DPOA-HC form is for anyone and could be for making decisions for someone who will recover from an injury or illness.)

The TPOPP form is NOT a "Do Not Resuscitate (DNR) Directive" but it is a doctor's order set and if part A signifies Do Not Attempt Resuscitation, CPR should not be done.

5. *If I have a TPOPP form, do I need Advance Directive forms?*

YES. A DPOA-HC form is not always used at the end of life. It could be used for making decisions for someone who will recover, but cannot make decisions for themselves for a temporary period of time. You still need a DPOA-HC form so that you have someone to make decisions for you IF you have lost capacity. The DPOA-HC can sign the TPOPP form on section D as the "recognized decision maker." If you do not have anyone to make decisions for you, the TPOPP form filled out by you with your physician will help clarify your decisions about end of life care.

**FOR OTHER QUESTIONS, call Wichita Medical Research & Education
Foundation (WMREF).
(316) 686-7172**

What is Advance Care Planning?

Advance Care Planning is a process for helping you understand possible future health care choices. Reflect on your own values and goals and discuss your choices with those persons closest to you. You may also put your wishes in writing in case you become unable to make your own decisions in the future.

YOUR healthcare and end of life decisions may be the most important choices facing you in the future. People are better prepared to make difficult end-of-life decisions if they understand their overall healthcare status. Ask questions of your physician(s) about your health.

YOU should decide about the kind of care you want while you are able to make your own decisions.

THINK about what you would want done for you.

TALK with your family and friends about your health care and end-of-life decision making. Advance care planning is all about making choices for yourself and communicating with family and friends about end-of-life care.

ACT Complete the attached forms and share with your family, physician, health care agent and attorney.

Document #160 Rev.9/11
Copies of this leaflet and other advance directive documents are available from:

www.wichitamedicalresearch.org

**Wichita Medical Research
& Education Foundation
3306 E. Central
Wichita, KS 67208
316-686-7172**



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Kansas Advance Directives

*A Summary of Advance
Healthcare Directives
Recognized in Kansas*

Advance Medical Treatment Directive



Physician's Do-Not-Resuscitate Order (DNR)

Patient's Do-Not-Resuscitate Directive (DNR)

Durable Power of Attorney for Health Care Decisions (DPOA for HC)

K.S.A. 58-625 THROUGH 632

This form is sometimes called the Healthcare Power of Attorney. It is a signed and notarized or witnessed legal paper. It allows a person to name someone to make health care decisions for him/her during a time of disability or incapacity.

(The person who has the power of attorney is called the health care agent, proxy or surrogate.)

- The terms of the form may be fairly general or very specific, as desired. The powers granted usually include:
 - decisions about going to the hospital
 - choice of doctors
 - long term care
 - The terms of this paper **may** include:
 - Refusing or withdrawing consent for the use of life sustaining procedures (even when the person is in a coma or persistent vegetative state)
 - Consent for organ donation and autopsy.
 - The form is allowed by Kansas law.
 - The person signing the DPOA for HC must be an adult (at least 18 years old) and competent when the document is signed. A person is usually assumed to be competent and does not need to prove it in the absence of actual notice of the opposite.
 - Witnesses must be at least 18 years of age. They cannot be the agent or related to the person by blood, marriage or adoption. They cannot have a financial interest in the person's medical care or estate.
 - The Healthcare Power of Attorney may be effective immediately, or may be made effective only when the person lacks the capacity (as determined by a physician) to make or communicate decisions.
 - The healthcare agent may not cancel a person's Living Will.
-

Living Will

K.S.A. 65-28, 101 ET.SEQ.

A Living Will is a signed and notarized or witnessed form that allows a person to state in advance that his/her dying should not be artificially prolonged in cases of terminal illness. This decision may be made only by the patient or by a person the patient has designated as Durable Power of Attorney for Healthcare. Relatives and even the patient's legal guardian do not have the authority to make this decision.

- The form is authorized by Kansas Law.
 - The person must be an adult (at least 18 years old) and competent when the living will is signed.
 - Witnesses must be at least 18 years of age. They cannot be the agent or related to the person by blood, marriage or adoption. They cannot have a financial interest in the person's medical care or estate.
 - The Living Will applies only when the person has been diagnosed and certified as terminally ill by two doctors. One of the doctors is the patient's attending physician. (Terminally ill usually means that death will probably occur within six months regardless of whether life-sustaining treatments are used.)
 - The Living Will does not apply to a person in a coma or persistent vegetative state unless the person is also diagnosed as terminally ill.
 - Pain relief or other comfort care may be given with the Living Will.
-

Advance Medical Treatment Directive (Common Law)

An Advance Medical Treatment Directive (Common Law type) can be any paper in which a person records his/her wishes regarding future medical treatment.

- The form is not specifically authorized by Kansas Law.
 - It may be a checklist, a narrative statement, or a letter to the physician or the person's healthcare agent.
-

Patient's Do-Not-Resuscitate Directive (DNR)

K.S.A. 65-4941.ET.SEQ.

A Patient's DNR Directive is a signed, dated, and witnessed form that lets an adult say in advance his/her decision that if his/her heart stops beating or breathing stops, no medical procedure will be done to restart the heart or breathing.

- Other appropriate emergency medical care by pre-hospital care givers or medical care directed by a doctor may be given.
 - The form is authorized by Kansas law.
 - The person must be an adult and competent when the paper is signed (at least 18 years old).
 - The paper must also be signed by the attending doctor as "medically appropriate" unless the person's church or religion recognizes treatment by spiritual means only.
-

Physician's Do-Not-Resuscitate Order (DNR)

A physician's DNR Order (as distinguished from a patient's DNR Directive) may be any doctor's way of making a "do not resuscitate" order (sometimes referred to as "no code") in a medical care facility, and adult care home, or an emergency medical service (if the method or order was established prior to April 14, 1994.)

- It may be a separate paper or merely a physician's order in the patient's record.
 - Informed consent should be given by the patient or the patient's healthcare agent.
-

This leaflet is not intended to give legal advice. In executing any document, a person should read all accompanying instruction. Additional information may be obtained from healthcare providers or attorneys.

(continued)

“no code”. Individuals can also sign a DNR advance directive requesting that resuscitation not be attempted when the heart and/or breathing stop.

Despite what may be portrayed on television, CPR is only successful in providing a long term benefit a small percentage of times. A patient already dealing with other life-threatening illnesses must seriously consider whether to have this procedure if his/her heart stops beating. Pain and great discomfort can result from all of the procedures (ethically known as **burden**). The pressure applied to the chest can even break ribs.

Stopping Life-Sustaining Treatment

As stated earlier, it can be difficult to decide whether treatments are life-sustaining or death-prolonging. Each patient and/or family will need to make this decision depending on many different circumstances. Medical ethics describes this process in terms of weighing the “**benefits**” and the “**burdens**” involved in every medical treatment. The health care team can help with this decision.

Make the Decision Yours

Every patient has a right to make a decision about desired treatments or withdrawal of treatments for herself/himself before a crisis occurs. To protect this right, people need to make their wishes known. This can be done through conversations with persons who would be involved in care. Also, a Durable Power of Attorney for Healthcare should be completed. This document names an agent to speak when the person is no longer able to communicate or make decisions. Medical providers and lawyers can supply a copy of this document. It is also available from Wichita Medical Research & Education Foundation.



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Document #170 Life-Sustaining Treatments

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Life-Sustaining Treatments



What are life-sustaining treatments?

In the past, when our bodies were unable to take care of basic needs (air, food, water, heart and kidney function, etc.) death would result. The more basic the need (for example, air), the more quickly death occurred.

Today, medical technology has made treatments available to supply these basic needs. These have come to be known as “life-sustaining” or “life-support” treatments. In cases where the body has been seriously affected by injury or disease these treatments have also been called “death prolonging”.

It can be hard to determine when these treatments are “life-sustaining” and when they are “death-prolonging”. This brochure can help you sort out the questions involved in coming to a good decision.

Common Life-Sustaining Treatments

Antibiotics

Until the use of penicillin in the early 1940's serious infections such as pneumonia could not be treated. They often resulted in death. Today pneumonia can be treated. Should that always be done? The answer to that question depends on each situation. The case of an individual with cancer which has spread throughout the body (metastasized) is different from that of a person suffering from no other illness.

Respirator (Breathing Machine)

The body's most basic need is oxygen. Without oxygen death occurs within a few minutes. In the past, not being able to breathe because of injury or disease could not be treated. Today, medicine has the technology available to provide this basic need. The machine used for this is called a respirator or ventilator. A tube placed down the windpipe supplies air to the lungs. This tube makes it impossible for the patient to talk. Another tube is used to remove fluids from the lungs.

When this technology is used to buy time for the patient to recover, it has great value (ethically known as **benefit**). As is the case with other medical technology, when it only delays the dying process there is little to be gained with its use (ethically known as **burden**). It is not a comfort measure for the patient.

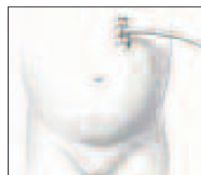
Medically Assisted Nutrition and Hydration (Food and Water)

Without food and water the human body cannot long survive. In the recent past the inability to swallow soon resulted in death. A wide range of medical treatments are now available to supply these basic needs when a patient can no longer eat and drink.

These treatments are used to assist in giving the patient food and water. There are two general types of technology used:

1. Peripheral: This method is commonly referred to as IVs. A tube attached to a needle is placed in one of the patient's blood vessels. Through this tube the patient can be given medicine, food, and water.

2. Enteral: In this category a tube is inserted directly into the digestive system. This can be either into the stomach or small intestine. These devices are often referred to as feeding tubes.



Understanding the way these medical devices work can be challenging. Medical professionals can explain in more detail the benefits and risks of the various technologies available.

What is more difficult is deciding when to use these treatments. Some people who may give you information about these technologies are:

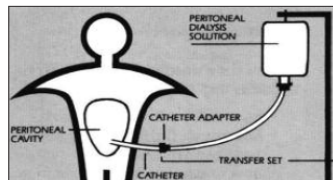
- The patient's physician and/or nurse
- A clergy person

Dialysis

The kidneys remove waste products (called toxins) from the blood. When the kidneys

fail to function (renal failure) the patient becomes poisoned with these products and will die. Doctors can use technology to replace the body's kidney function. This is known as dialysis. Two kinds of dialysis are done using needles and tubing (IVs):

1. Peritoneal: A complex solution is put into the body's abdomen through a permanently placed



tube. This fluid absorbs the waste products from the blood vessels found in the lining (called the peritoneum) of the abdomen. The fluid is then flushed out.

2. Hemodialysis: This procedure removes the blood from the body and runs it through a machine. The machine removes the toxins and returns the cleaned blood to the body. This is done through large needles and tubing (IVs).

Each dialysis treatment takes 2-3 hours. Hemodialysis is done at a treatment center two to three times a week or, in some cases, every day. Peritoneal dialysis does not have to be done at a dialysis center.

These treatments are not without risk. Once again, coming to a decision about starting or continuing these treatments is difficult. Getting guidance from a professional may be helpful.

Cardiopulmonary Resuscitation (CPR)

Human life requires oxygen. This is provided to our bodies through the function of our lungs and heart.

When a person is not breathing, oxygen can be forced into the lungs. This can be done by mouth-to-mouth breathing or by mechanical means.

When a heart stops, it can be started by pushing down on the chest, using drugs to revive the heart (given directly into the heart through a long needle), and using paddles which supply shocks to the chest.

When the efforts to restart the heart and breathing are combined, the procedure is known as CPR. CPR can be given in a variety of settings, and many people have been trained to do this procedure. When CPR works it saves lives (ethically known as **benefit**).

If someone's heart stops in the hospital setting, CPR will automatically be tried unless there are specific physician orders to the contrary. These orders are known as do not resuscitate (DNR) or

(continued)

Is there a difference between withholding and withdrawing medical treatment to give food and/or water?

Medical treatments are recommended when the doctor believes a patient may get better (ethically, known as a **benefit**). The doctor may recommend the treatment be stopped when there is no realistic possibility of making the patient better (ethically known as **burden**).

What can be done to provide comfort to a dying patient who is no longer eating or drinking?

Keeping a dying patient comfortable is very important. Comfort care is also known as palliative care. Doctors, nurses, chaplains, health care aides, social workers, and volunteers will do whatever is necessary to keep a dying patient comfortable. Ask these professionals about pain control and comfort care, including the side effects of not getting food and water.

This care can be provided by a hospice program and the doctor will know when it is appropriate for hospice to be involved.

Keep in mind that the age-old role of medicine is summed up well with the following quote:

What is the role of medicine?

*“To cure sometimes;
to relieve often;
to comfort always.”*



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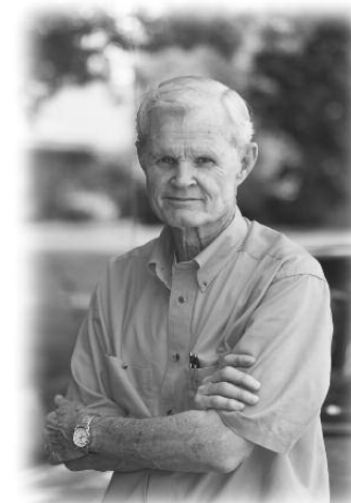
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Document #180
Medically Assisted Nutrition and Hydration

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Medically Assisted Nutrition and Hydration



*When a loved one is not
eating or drinking . . .*

Old age, illness, or an injury may make eating or drinking through the mouth impossible. Prior to modern medicine, such a condition would soon result in death. Today, several ways are available to provide food and drink to a patient unable to swallow. These are called “medically assisted nutrition and hydration”. There are several things you should know in order to make decisions about these medical treatments.

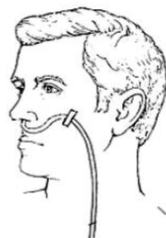
What is medically assisted nutrition and hydration?

Medically assisted nutrition and hydration is a medical treatment which helps someone who cannot swallow get food and water.

Here are some medical ways to give food and water:

NG (nasogastric) tube:

A small tube is placed through the nose, down the throat, and into the stomach. It is meant to provide food, water, or medicine for only short periods of time. The tube can be uncomfortable and may upset the patient. It may cause sore throat and vomiting. Ask the health care team about what else may happen.



PEG (percutaneous endoscopic gastrostomy)

tube: A tube that is used for long term use.

This tube is put in a hole cut through the abdomen and the food is placed directly into the stomach. Side effects could be infection and diarrhea. Ask the health care team about what else may happen.



TPN (total parenteral [intravenous] nutrition):

This is also known as an IV line (a needle placed in the vein.) All required nourishment is given through this intravenous line.

Why would someone not eat or drink?

It could be simple. They do not like the food. They need help eating. Sadness or worry may cause lack of appetite.

They may be in the early stages of dying because of injury or disease. This means that the body is beginning to shut down and no longer needs food or water.

Is providing food and water necessary for good care?

Food and water are necessary to stay alive. But when someone is gravely ill because of injury or disease, food and water given through medical means (known as “medically assisted nutrition/hydration”) may not be helpful. In these situations good care may demand we not force feed a loved one. This may do more harm than good.

As is true for any medical intervention, the patient makes the decision whether or not to take the medical treatment. Seriously ill patients often are not able to make these decisions. That is why it is important to give written directions about future possible medical interventions. This can be done through a Living Will Declaration or a Durable Power of Attorney for Health Care. All medical providers have these documents available. They are also available through Wichita Medical Research & Education Foundation.

Are food and water necessary to keep dying patients comfortable?

A person who is in good physical condition obviously needs food and water. Hunger and thirst are uncomfortable. Someone who is dying does not have this same need. The opposite can be true; excessive food and water given through medical means can cause great discomfort.

Lack of water may cause the lips to be sore and the mouth dry. These conditions can be taken care of by lip balm, ice chips and swabbing the mouth with soothing liquids. Medical professionals who provide care for the dying are very familiar with these and other comfort measures.

Does the patient who does not eat starve to death?

The first question to ask is: Why is the patient not eating? Many times it is because there is a medical condition (injury or disease) that makes swallowing impossible or the patient no longer has an appetite because of the disease (for example, cancer). Death occurs because of the injury or disease, not from starvation.

Before modern medicine was able to provide medically assisted nutrition/hydration for people unable to swallow, we did not hesitate to say they died from the stroke, the heart attack, the cancer, the car accident, etc.



*Comfort and dignity should
always be the goal of care
at the end of life.*

Who *Can't* be an Agent

State rules for who may be an agent vary, but the most common persons who cannot be an agent are these:

- Under age 18
- Your healthcare provider
- A person who works for your healthcare provider

(However, if your mate or close relative is one of the above they may serve as your agent.)

Recommendations as to Who *Can* Be an Agent

Your agent can be an individual that you choose. The most common choices for an agent are family and friends. The chart inside can help you choose.

By Kansas State Law, an Agent *Can...*

- Consent, refuse consent, or withdraw consent to care
- Decide which of these you should have: hospital, hospice, nursing home, or home health care
- Employ or fire healthcare personnel
- Ask for and get healthcare information
- Decide about organ donation, an autopsy, and what to do with your body when you die

By Kansas State Law, an Agent *Cannot...*

- Stop or change any decisions you have made in a "Living Will" declaration



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Choosing an Agent

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*How do you decide who
should be your agent,
the person who becomes
your substitute voice
in healthcare?*

Choosing an Agent

The person you choose to make healthcare decisions for you may have another title if you are in another state. This person can be called a healthcare agent, proxy, representative, attorney-in-fact, surrogate, or even patient advocate.

This brochure refers to that person as an agent.

You have decided it is time to complete a Durable Power of Attorney for Health Care form. You want to be prepared in case something happens to you and you are unable to speak for yourself. You want your wishes to be known and followed. How do you decide who should be your agent, the person who becomes your substitute voice?

Your agent should be someone you trust, a person who is close enough to you to know what your values are in relation to quality of life. He/she needs to be a person who will take the time to listen to you and learn how you feel about such end of life issues as use of IV's and feeding tubes, and other life-sustaining treatments.

Agent #1	Agent #2	Agent #3	
			< NAMES OF POTENTIAL AGENTS
			1. Meets the legal needs in your state.
			2. Is willing to speak on your behalf.
			3. Can act on your wishes and does not let their feelings take away from your wishes.
			4. Lives close by or can reach you easily when needed.
			5. Knows you well and knows what you want.
			6. Could handle making decisions.
			7. Will talk with you right now about issues for your care and will listen to you.
			8. Will be able to help you for a long time.
			9. Can handle family members, friends, and medical people if there are problems.
			10. Can be strong in facing a doctor or an institution if they do not answer\act in a way that helps you.

Selecting Your Agent

When you decide to select someone to speak for you in a medical crisis, there are some things to think about. This tool will help you choose the best person. It is best to have a primary agent and at least one alternate.

Consider 3 people using the chart to the left. Which person(s) is (are) the best to be your Healthcare Agent(s)?

What to do After you Pick a Healthcare Agent?

- Talk to your agent about what they do for you.
- Ask if they are willing to be your agent.
- Talk about your healthcare wishes, values, and fears.
- Write down your "agent" and "fears."
- Make sure your agent gets the first copy of your wishes and gets a copy of any attachments.
- Tell family members and friends who you select.

Resources:

The worksheet adapted by the American Bar Association's Commission on Legal Problems of the Elderly from R. Pearlman, et. al., Your Life Your Choices - Planning for Future Medical Decisions: How to Prepare a Personalized Living Will, Veterans Administration Medical Center, Seattle, Washington.

K.S.A. 58-625 through 632



Comfort and dignity should always be the goal of care at the end of life.