ADVANCE DIRECTIVES AND DNR ORDERS
AND A WORD ABOUT WITHHOLD/WITHDRAW

I. Definitions.

Know Your Terms:

A. DNR Orders.

A physician's order that "heroic" or extraordinary means should not be employed on behalf of his or her patient in the event a patient is found with no Vital Signs. Such orders are often referred to as "DNR" orders, "No Code" orders or "No CPR" orders.

B. Competent Patient.

An adult (over 19 years of age) who is conscious, able to understand the nature and severity of his or her illness or condition, able to understand the relative risks and alternatives and consequences of the proposed treatment, and able to make informed and deliberate choices about the treatment of his or her illness or condition. The patient's mental condition should be documented in the patient's medical record.

C. Incompetent Patient.

A patient who is unable to understand the nature and severity of his or her illness or condition, or is unable to understand the relative risks and alternatives and consequences of the proposed treatment, or is unable to make informed choices about the treatment of his or her illness or condition.

D. Resuscitation.

Extraordinary or "heroic" means employed to maintain the life of a patient including, without limitation, the following: intubation/ventilation, use of ambu bag, closed chest cardiac massage or defibrillation. Resuscitation does not refer to ordinary or reasonable methods used to maintain life or health.

If you have questions, please contact:
Kenny W. Keith   (205) 547-5540   email: kkeith@gilpingivhan.com
E. **Attending or Personal Physician.**

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

F. **Terminal Condition or Injury.**

Either (i) an illness or injury for which death is imminent and there is no reasonable prospect of cure or recovery, or (ii) an illness or injury causing a condition that is hopeless unless artificially supported through the use of a life-sustaining procedure.

G. **Family.**

Includes close relatives such as spouse, parents, grown children, brothers, sisters, and more remote relatives or "significant other" where appropriate.

H. **Advance Directive.**

An Advance Directive is either a Living Will, an express health proxy contained in a Durable Power of Attorney, or an express pronouncement of a patient, either oral or in writing, made to a third party regarding how that patient wanted to be cared for in the event the patient becomes unable to direct his or her care. The following describes these forms of Advance Directives:

1. **Living Will.**

A living will is a document, executed by a competent patient pursuant to the 1997 Alabama Natural Death Act, Code of Ala. § 22-8A-1, et seq. (1997), as amended, containing instructions regarding withholding and withdrawing of life-sustaining treatments under certain conditions.

2. **Durable Power of Attorney with a Health Care Proxy.**

A Durable Power of Attorney with a Health Care Proxy is a writing made in accordance with the 1997 Durable Power of Attorney Act Code of Ala., § 26-1-2, et seq. (1997), as amended, containing clear and express directions to the named attorney-in-fact (the "Attorney-In-Fact") concerning health care matters.

If you have questions, please contact:

Kenny W. Keith  
(205) 547-5540  
email: kkeith@gilpingivhan.com
(3) **Oral or Written Directions of a Patient.**

A clear and unambiguous statement by a Competent Patient to a care giver, preferably the Attending Physician, either oral or written, regarding how decisions concerning the health care of the patient are be carried out if the patient becomes unable to give such directions. Evidence of such a statement should be documented and made a part of the patient's medical record.

I. **Vital Signs.** The pulse, respiration and blood pressure.

II. **The Competent Patient.**

The Facility can enter a DNR Order into the medical record of a competent patient (notwithstanding the fact that he or she has not executed a Living Will, Durable Power of Attorney, or otherwise complied with the requirements of the 1997 Alabama Natural Death Act) if the patient has consulted with his or her attending physician who has documented in the patient's medical record that he or she has explained to the patient and the patient understands his or her illness and condition and the probable consequences of refusing Resuscitation.

In the case of a Competent Patient who has requested the entry of a DNR Order, approval of Family is not required, and the Family's wishes cannot overrule the informed decision of a Competent Patient. Permission from the patient should be sought to explain the patient's decision to the patient's Family and the Facility's intention to abide by that decision.

In all cases where a Competent Patient requests entry of a DNR Order, the Attending Physician or his or her designee must be informed as soon as practicable that such orders are being requested and so that the Attending Physician can complete the Alabama Emergency Services Do Not Attempt Resuscitation Order.

**Under no circumstances may a DNR Order be entered by a verbal directive from the Patient’s Physician.**

---

*If you have questions, please contact:*

Kenny W. Keith   (205) 547-5540   email: kkeith@gilpingivhan.com
III.  **The Incompetent Patient.**

A DNR Order may be entered in an Incompetent Patient's medical record only by one of the following methods:

A.  **Express Directions Pursuant to an Advance Directive.**

   By express directions contained in a Living Will, given by a duly appointed Attorney-In-Fact under a Durable Power of Attorney with Health Care Proxy provisions, given by a duly appointed health care surrogate, or pursuant to Oral or Written Instructions, each specifically addressing DNR Orders.  Provided one of the foregoing is present, a DNR Order can be implemented even if the patient does not have a Terminal Condition.

B.  **Implementation of an Advance Directive.**

   By implementation of an Advance Directive, when a patient has a Terminal Condition, as follows.  The Family may not overrule the entry of a DNR Order entered pursuant to an Advance Directive.

   1.  **Living Will.**

      (a)  A Living Will only takes effect if a patient has been determined to two physicians who have personally examined the patient, one of whom shall be the Attending Physician. Once this determination and certification have been made, the Attending Physician may enter a DNR Order into the patient's medical record. Notwithstanding the foregoing, a patient's desire shall at all times supersede the effect of the Living Will or a DNR Order.

   2.  **Durable Power of Attorney.**

      (a)  The Facility shall document that the Attorney-In-Fact (who has been granted express health proxy powers pursuant to a Durable Power of Attorney) has given specific instructions regarding a DNR Order.

---

*If you have questions, please contact:*

Kenny W. Keith     (205) 547-5540    email: kkeith@gilpingivhan.com
(b) Once a patient has been diagnosed by two physicians who have personally examined the patient, one of whom shall be the Attending Physician, as being incompetent and having a Terminal Condition, the Attending Physician may enter a DNR Order into the patient's medical record. Notwithstanding the foregoing, a patient's desire shall at all times supersede the effect a Durable Power of Attorney or a DNR Order. The decisions of a duly appointed health proxy takes precedence over the provisions of a Living Will unless the Living Will or proxy designation provides otherwise.

3. If the DNR Order is entered pursuant to an Advance Directive, a copy of the Advance Directive and of the documentation of how it was implemented must be entered in the patient record.

C. No Advance Directive. If an incompetent patient does not have an Advance Directive, or if none of the elements above are present, a DNR Order may be entered through the Health Care Surrogacy appointment process.

IV. Inappropriate Demands.

When Family members persist in demanding Resuscitation or DNR Orders which are clinically inappropriate, or not in the patient's interest, or against the patient's will, staff shall immediately inform Administration.

V. Revocation of DNR Orders.

A. Competent Patient. A Competent Patient may at any time request the revocation and removal of a DNR Order from his or her medical record. The patient shall communicate his or her desire to his or her Attending Physician, who shall immediately remove and revoke the DNR Order.

B. Incompetent Patient. An Incompetent Patient's Family may request the revocation and removal of a DNR Order from the patient's medical record only when the DNR Order was entered pursuant to the Family's request through a valid designation of health care proxy or surrogacy. The family shall communicate their desire to the Attending Physician who shall immediately remove and revoke Do Not Resuscitate Order Form from the patient's medical record.

If you have questions, please contact:
Kenny W. Keith (205) 547-5540 email: kkeith@gilpingivhan.com
VI. HOW DO YOU KNOW WHAT TO DO?

A. Every facility should have a system in place for identifying the Code Status for its patients at a moment’s notice.
   
   1. Color coding/dots on MARS or on centrally located list
   
   2. DNR designation on cover of patient’s medical record
   
   3. Color coding/dots on care guides.

B. Every facility should have a system in place for removing these markers should patient’s code status change.

If you have questions, please contact:
Kenny W. Keith (205) 547-5540 email: kkeith@gilpingivhan.com
ATTACHMENT A

ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

I, ___________________, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

If I become terminally ill or injured:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either “yes” or “no”:
I want to have life sustaining treatment if I am terminally ill or injured.

___ Yes  ___ No

*Artificially provided food and hydration* (Food and water through a tube or an IV)
– I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either “yes” or “no”:*

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

___ Yes  ___ No

**If I Become Permanently Unconscious:**

*Permanent unconsciousness* is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

*Life sustaining treatment* – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

*Place your initials by either “yes” or “no”:*

I want to have life-sustaining treatment if I am permanently unconscious.

___ Yes  ___ No

*Artificially provided food and hydration* (Food and water through a tube or an IV)
– I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

*Place your initials by either “yes” or “no”:*

I want to have food and water provided through a tube or an IV if I am permanently unconscious.
____ Yes  ____ No

**Other Directions:** Please list any other things you want done or not done.

In addition to the directions I have listed on this form, I also want the following:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

*If you do not have other directions, place your initials here:*

____ No, I do not have any other directions.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

*Place your initials by only one answer:*

_____ I **do not** want to name a health care proxy. *(If you check this answer, go to Section 3.)*

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

**First choice for proxy:** ________________________________________________

Relationship to me: ____________________________________________________

Address: ______________________________________________________________

City: __________________________  State _______  Zip  ___________

Day-time phone number: _________________________________________________

Night-time phone number: _______________________________________________

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

**Second choice for proxy:** ______________________________________________

Relationship to me: ____________________________________________________

Address: ______________________________________________________________
Instructions for Proxy

Place your initials by either “yes” or “no”:

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.  ____ Yes  ____ No

Place your initials by only one of the following:

_____ I want my health care proxy to follow only the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

I understand the following:

▪ If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

▪ If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

▪ If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

  __________________________________________
  __________________________________________

Your name:  _______________________________________________________

The month, day, and year of your birth:  _______________________________

Your signature:  ____________________________________________________

Date signed:  _______________________________________________________


I am witnessing this form because I believe this person to be of sound mind. I did not sign the person’s signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: ________________________________
Signature: ________________________________
Date: ________________________________

Name of second witness: ________________________________
Signature: ________________________________
Date: ________________________________

I, ________________________________, am willing to serve as the health care proxy.
Signature: ________________________________
Date: ________________________________

Signature of Second Choice for Proxy:
I, ________________________________, am willing to serve as the health care proxy if the first choice cannot serve.
Signature: ________________________________
Date: ________________________________
ATTACHMENT B

CERTIFICATE OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME: _____________________________________________
SURROGATE'S NAME: __________________________________________

I certify that:

(a) I am at least nineteen years old.

(b) The patient whose name is given above either has not, to my knowledge, made an advance directive for health care (living will or durable power of attorney), or the patient has executed an advance directive for health care, but the document fails to address his or her present circumstances.

(c) I have consulted with the physician who is now overseeing the patient's care.

(d) I am qualified to act as a surrogate health care decision maker for this patient because:

I. My relationship to the patient is the one indicated by checkmark below.

II. I have spoken to or attempted to speak to all other adults, if there are any, who fit into my category, and to all those who fit into a higher category (on the list below, a higher category is one listed before my category). Each such person that I spoke to has either agreed that I may act as surrogate, or has expressed no objection to my acting as surrogate.

III. If I have not spoken to any such person, it is because the person is in an unknown location, or because he or she is in a location so remote that he or she cannot, as a practical matter, be contacted in a timely fashion, or because he or she has been adjudged incompetent and remains incompetent today.

   ____ 1. I am the judicially-appointed guardian of the patient. My guardianship appointment specifically gives me the authority to make health care decisions for the patient.

   ____ 2. I am the husband or wife of the patient.

   ____ 3. I am a child of the patient.

   ____ 4. I am a parent of the patient.

   ____ 5. I am a brother or sister of the patient.
6. I am another person related to the patient by blood. To my knowledge, the patient has no living relatives, or the patient's closer living relatives either cannot or will not serve as surrogates. I am the patient's ______________________.

7. The patient has no known relatives who are able and willing to act as surrogate. I am a representative of the ethics committee at the facility where the patient is being treated or I am a representative of some other committee duly appointed to make health care decisions for this patient.

(e) I understand that under the laws of Alabama certification on this form of any information known by me to be false is a Class C felony, which has a penalty of up to ten years imprisonment, and a fine of up to $5,000.

____________________________________
Signature of Surrogate

Sworn to (or affirmed) and subscribed before me this ____ day of ____________, ___.

____________________________________
Notary Public