



# MedStar Harbor Hospital

MedStar Franklin Square Medical Center  
MedStar Georgetown University Hospital  
MedStar Good Samaritan Hospital  
**MedStar Harbor Hospital**  
MedStar Montgomery Medical Center  
MedStar National Rehabilitation Network  
MedStar Southern Maryland Hospital Center  
MedStar St. Mary's Hospital  
MedStar Union Memorial Hospital  
MedStar Washington Hospital Center  
MedStar Family Choice  
MedStar Medical Group  
MedStar PromptCare  
MedStar Visiting Nurse Association  
MedStar Institute for Innovation  
MedStar Health Research Institute

LIVING WILL AND  
ADVANCE DIRECTIVES

**Exercise Your Right:**  
**Put Your Healthcare Decisions  
in Writing.**

*Knowledge and Compassion*  
**Focused on You**



# Maryland Advance Directive

## A Message from the Maryland Attorney General

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 healthcare 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 healthcare planning through "advance directives." An advance directive can be used to name a healthcare agent. This is someone you trust to make healthcare decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

This form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Healthcare Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses. This pamphlet will explain each part. The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are not required by law to use these forms. Different forms, written the way you want, may also be used.

This form can be filled out without going to a lawyer. But if there is anything you do not understand about the law or your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future. In Part III of the form, you need two witnesses to your signature. Nearly any adult (age 18 or older) can be a witness. If you name a healthcare 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 every so often. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as 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 already have a prior Maryland advance directive, living will or a durable power of attorney for health care, that document is still valid. Also, if you made an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

**Tragically, accident or illness  
can take away a person's ability  
to make healthcare decisions.  
But decisions still have to be made.**

# Maryland Advance Directive

A Message from the Maryland Attorney General (*continued*)

## **Part I of the Advance Directive: Selection of Healthcare Agent**

You can name anyone you want (except, in general, someone who works for a healthcare facility where you are receiving care) to be your healthcare agent. To name a healthcare agent, use Part I of the advance directive form. (Some people refer to this kind of advance directive as a “durable power of attorney for health care.”) 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 healthcare decisions. You can also decide when you want your agent to have this power—right away, or only after a doctor says that you are not able to decide for yourself. You can pick a family member as a healthcare 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 healthcare agent. Also, consider picking one or two back-up agents, in case your first choice isn’t available when needed. Be sure to inform your chosen healthcare agent and make sure that he or she understands what’s most important to you. When the time comes for decisions, your healthcare agent should follow your written directions.

The form included with this pamphlet does not give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

## **Part II of the Advance Directive: Treatment Preferences (“Living Will”)**

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a healthcare agent and make decisions about treatment in an advance directive, it’s important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer’s disease.

**Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity.**

# Consider Your Choices: CPR or No CPR

## Your Choices

There are many decisions related to healthcare treatments that are difficult for individuals to make—particularly ones involving “life-sustaining” treatments. Please read this information so you and your loved ones can make an informed decision about CPR. The staff

members of MedStar Harbor Hospital ask that you decide in advance whether you want CPR or “No CPR.” And let others know your wishes. If you have any questions, ask your healthcare provider.

## What is CPR?

Perhaps the most dramatic of life-sustaining treatments is cardiopulmonary resuscitation (CPR). CPR is a technique used to restart the heart of someone whose heart has stopped beating and who has stopped breathing.

## What happens after CPR?

CPR is often successful in “bringing back” an otherwise healthy person whose heart has suddenly stopped, usually because of an accident or a sudden heart attack.

## Does CPR hurt?

The chest massage can break ribs, and the electric shock can burn the skin on the chest. The person typically does not “feel” the CPR at the time, because he or she is in a coma. However, the person’s chest may be sore when he/she awakens.

## What might the health team do in performing CPR?

CPR may be performed by simply applying an electric shock to the person’s chest to restart the heart. CPR may also include:

- Pushing hard on the chest to help pump blood
- Giving powerful heart stimulant drugs
- Placing a tube through the mouth into the windpipe to breathe for the person

## Are there situations when CPR is not successful?

If the cause of cardiopulmonary arrest is a chronic condition, and if the person has multiple medical problems, CPR is much less successful. For instance, after the heart has temporarily been restarted, most elderly, chronically ill patients who suffer

cardiopulmonary arrests while in the hospital do not survive or get well enough to leave the hospital.

## What happens if it takes a long time to get oxygen to the brain?

If too long a time elapses between the stopping of the heart and its restarting, the lack of oxygen to the brain can cause damage. The resuscitated person might then linger in a coma or a vegetative state, which may also require mechanical support (a ventilator) to breathe.

## Who needs to decide about CPR?

It is important for anyone entering the hospital to consider carefully whether he or she wants CPR if there is cardiopulmonary arrest. Persons who do NOT want CPR must make their wishes known. Patients who request CPR or who are undecided receive CPR and other emergency procedures if they suffer an arrest.

## If the decision is “No CPR,” will the staff give different treatment?

No. A decision of “No CPR” will not affect any other type of care a patient receives.

A “No CPR” decision is quite compatible with choosing full treatment for other medical problems.

## Can a person change his or her mind?

Yes. A patient who initially made a “No CPR” decision can later change his or her mind by merely telling the healthcare provider. A patient does not have to revoke a “No CPR” order in writing.

**At MedStar Harbor Hospital, we respect decisions that patients and their loved ones make. We encourage you to discuss CPR with your healthcare provider.**

# Advance Directive:

## Planning for Future Healthcare Decisions

By: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Print Name) (Month/Day/Year)

Using this advance directive form to do healthcare planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures.

Part I of this form lets you answer this question: If you cannot (or do not want to) make your own healthcare decisions, who do you want to make them for you? The person you pick is called your healthcare agent. Make sure you talk to your healthcare agent (and any back-up agents) about this important role.

Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state and end-stage condition. You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive. Make sure you give a copy of the completed form to your healthcare agent, your healthcare provider and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

### PART I: SELECTION OF HEALTHCARE AGENT

#### A. Selection of Primary Agent

I select the following individual as my agent to make healthcare decisions for me:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

\_\_\_\_\_  
(home and cell)

#### B. Selection of Back-up Agents (Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

\_\_\_\_\_  
(home and cell)

**PART I: SELECTION OF HEALTHCARE AGENT**

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable, unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

\_\_\_\_\_  
(home and cell)

**C. Powers and Rights of Healthcare Agent**

I want my agent to have full power to make healthcare decisions for me, including the power to:

1. Consent or not to medical procedures and treatments that my healthcare providers offer, including things that are intended to keep me alive, like ventilators and feeding tubes.
2. Decide who my healthcare providers should be.
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
  - a. Ride with me in an ambulance if ever I need to be rushed to the hospital
  - b. Be able to visit me if I am in a hospital or any other healthcare facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank.)

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

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

**D. How My Agent is to Decide Specific Issues**

I trust my agent’s judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens and risks of the choices presented by my healthcare providers.

**E. People My Agent Should Consult (Optional; form valid if left blank)**

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent’s power to make decisions.

Name(s)/Telephone Number(s):

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

*(continued on next page)*



## PART I: SELECTION OF HEALTHCARE AGENT

### F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

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

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### G. Access to My Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my healthcare provider wants to discuss with that person my capacity to make my own healthcare decisions, I authorize my doctor to disclose protected health information that relates to that issue.
2. Once my agent has full power to act under this document, my agent may 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.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

### H. Effectiveness of This Part

Read both of these statements carefully. Then, initial one only. (Please use your initials rather than an X, checkmark or other types of marks.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to. \_\_\_\_\_
- >>OR<<
2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting healthcare provider agree that I have lost this ability permanently. \_\_\_\_\_

If the only thing you want to do is select a healthcare agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II.



## PART II: TREATMENT PREFERENCES (“LIVING WILL”)

### A. Statement of Goals and Values (Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what’s most important to me during the last part of my life:

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### B. Preference in Case of Terminal Condition

If you want to state what your preference is, initial one only. (Please do not use an X or checkmark.) If you do not want to state a preference here, cross through the whole section.

If my healthcare providers certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. \_\_\_\_\_

### C. Preference in Case of Persistent Vegetative State

If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.

If my healthcare providers certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. \_\_\_\_\_

*(continued on next page)*

## PART II: TREATMENT PREFERENCES (“LIVING WILL”)

### D. Preference in Case of End-Stage Condition

If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.

If my healthcare providers certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
\_\_\_\_\_

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means. \_\_\_\_\_

### E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain. \_\_\_\_\_

### F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

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

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### G. Effect of Stated Preferences

Read both of these statements carefully. Then, initial one only.

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my healthcare providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest. \_\_\_\_\_

>>OR<<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my healthcare providers to follow my stated preferences exactly as written, even if they think that some alternative is better. \_\_\_\_\_

## PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

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(Signature of Declarant)

(Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

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(Signature of Witness)

(Date)

Telephone Number(s): \_\_\_\_\_

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(Signature of Witness)

(Date)

Telephone Number(s): \_\_\_\_\_

Please note:

1. Anyone selected as a healthcare agent in Part I may not be a witness.
2. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death.

Maryland law does not require this document to be notarized.

## Did You Remember To ...

- Fill out Part I if you want to name a healthcare agent?
- Name one or two back-up agents in case your first choice as healthcare agent is not available when needed?
- Talk to your agent and back-up agents about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific healthcare decisions in the advance directive?
- If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?
- Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- Look over the "After My Death" form to see if you want to fill out any part of it?
- Make sure your healthcare agent (if you named one), your family and your healthcare provider know about your advance care planning?
- Give a copy of your advance directive to your healthcare agent, family members, healthcare provider, and hospital or nursing home if you are a patient there?

*This packet of information was designed in accordance with the Patient Self-Determination Act of 1990, a federal law, and the Maryland Health Care Decision Act of 1993. These laws require hospitals to inform adults being admitted to inpatient units about Advance Directives and documented discussion with a physician. You may detach and complete the enclosed official documents for your medical record. Be sure to give a copy to your physician, family and healthcare agent. You should also carry a copy with you.*

*When signing these legal documents, you must have two witnesses. The person you designate as your Healthcare Agent may not be a witness. Also, at least one of your witnesses may not have a financial interest in your death. If you are a patient at MedStar Harbor Hospital and need more information about your Advance Directives, please ask the nurse taking care of you or your healthcare provider.*

Patients have the right to receive care regardless of race, creed, sex, national origin, sources of payment for care, or whether they have formulated an advance directive.

# Important Phone Numbers

|                                                       |              |
|-------------------------------------------------------|--------------|
| Main Hospital Number .....                            | 410-350-3200 |
| Emergency Department .....                            | 410-350-3510 |
| TTY–Maryland Relay (for hearing impaired) .....       | 800-201-7165 |
| Patient Representative .....                          | 410-350-3487 |
| Intensive/Coronary Care Units .....                   | 410-350-3393 |
| Case Management .....                                 | 410-350-3330 |
| MedStar Harbor Hospital Physician Referral Line ..... | 410-350-2563 |

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## Cut out and complete the card to the right.

Place it in the wallet or purse you carry most often, along with your driver’s license and health insurance card.

**ATTENTION: MARYLAND HEALTHCARE PROVIDERS**

I have created the following advance directives:  
(Check one or more as appropriate.)

- Selection of a Healthcare Agent
- Treatment Preferences (Living Will)

For more information, please contact:

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_







**MedStarHarbor.org**



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