# FAITHFUL AT THE END OF LIFE

## PRO-LIFE ADVANCE MEDICAL DIRECTIVES

A PUBLICATION OF GREATER COLUMBUS RIGHT TO LIFE

# IN CASE OF EMERGENCY

**My name is: _____**

**My faith/church is: _____.**
**I have a protective HCPOA. My agent is: _____ and can be reached at _____. My alternate agent is_____ and can be reached at_____. Please contact my agent(s) and a chaplain. More contact information may be on the reverse.**

# SECTION ONE: ACKNOWLEDGEMENTS

Greater Columbus Right to Life is grateful to the contributions of those who have made *Faithful at the End of Life: Pro-Life Advance Medical Directives* and *Faithful at the End of Life: Pro-Life Advance Medical Directives, Catholic Edition* possible. Each has given of their time and talent to ensure that the faithful pro-life of Ohio have a resource that helps them to start complex discussions in a guided manner that is faithful to their beliefs, is consistent with Ohio law, and provides model health care directives that conform to pro-life and faith values.

We are especially grateful to:

Attorney Peggy Wolock and Greater Columbus Right to Life Executive Director Beth Vanderkooi for their work to develop, organize, and write this resource.

Attorney Matt Faehnle: Mr. Faehnle is currently in private practice with a special focus on Estate Planning and Estate & Trust Administration. Mr. Faehnle is a Member of the Columbus Bar Association, Ohio State Bar Association, and the Thomas More Society and has more than 20 years of experience in the Estate Planning field.

This program and its materials are provided to the community as a service of Greater Columbus Right to Life and our partner and endorsing organizations. It has undergone extensive technical and legal review to ensure that it complies with Ohio law as of the date of its publication (February 1, 2020), but users are advised that it will be updated from time to time as changes are made to Ohio law or as is useful or necessary.

Ohio law permits an individual to adopt advance medical directives without the assistance of a lawyer, and you can use the enclosed forms and instructions in the same way that you can utilize other "standard forms" provided by bar associations, health care facilities, and similar organizations. However, these are important legal documents and you may wish to consult an attorney for advice. Neither Greater Columbus Right to Life nor any of our partner or endorsing organizations can provide you with legal advice, and we make no guarantees and assume no liability for the content.

**NOTE:** Although we have made every effort to provide bioethics information that unite the faithfully pro-life without regard to denomination, we do not make any guarantee that the bioethics background information in this document conforms to your specific faith beliefs. If you have specific questions about the teachings of your faith, please consult with a trusted faith leader. It is noteworthy that we have produced a "Catholic" version of this document. That version varies from this one in theological references and resources, but the Health Care Power of Attorney and Advance Directive form and the Addendums is the same. If you are a faith leader who would like to endorse this document as conforming to your church's teachings or if you would like to work on subsequent developments, please contact Greater Columbus Right to Life.

*The mission of Greater Columbus Right to Life is to promote a culture that protects innocent human life from conception until natural death Through prayer, education and community advocacy, we help individuals, churches, and community organizations to better understand, communicate, and share the pro-life message.*

*We are especially motivated to end abortion, embryonic stem cell research, euthanasia, and physician-assisted suicide, and we work to protect religious freedom and defend the rights of conscience related to our pro-life mission.*

*The Columbus Right to Life Education Foundation, operating today as Greater Columbus Right to Life, has been recognized as a 501(c)(3) charitable educational foundation by the IRS since 1976, although our organization started long before that as a group of faith and civic-minded individuals who gathered together for prayer, education, and fellowship devoted to fighting for the culture of life. We primarily serve Franklin, Delaware, Morrow, Union, Madison, Pickaway, Fairfield, and Licking Counties, while providing assistance regionally as possible. We are central Ohio's only grassroots education and advocacy organization that focuses on the full spectrum of life issues.*

# SECTION TWO: INTRODUCTION

*"For you created my inmost being; you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful, I know that full well. My frame was not hidden from you when I was made in the secret place, when I was woven together in the depths of the earth. Your eyes saw my unformed body; all the days ordained for me were written in your book." Psalm 139: 13-16*

We strongly believe in the sanctity of life and the protection and preservation of life at all stages from conception until natural death. Life is a gift from God, and we each have the right and the duty to live our lives in accordance with God's plan.

We are each unique and infinitely valuable, which means that our medical situations can be complex or unique. Discussions related to advance medical directives and end-of-life care are complicated for many reasons. For many, they are difficult to start because there is a reluctance to talk about illness, suffering, and death. Others falsely assume that it is not necessary to consider these matters in their current stage of life. Still others do not talk about it because no one brings it up or they incorrectly assume that having the discussion will require legal or financial planning that is beyond their means. Many fear discussions of sickness, suffering, and death as though talking about them will bring them about.

In reality, each of us will die. Many of us will face unexpected illnesses and some of us will experience times when we are not able to make medical decisions for ourselves. When these natural parts of human life on Earth happen, it is important that we have identified a person (or persons) who can help to make decisions about our care and treatment when we are unable to do so, that the person we have identified has the legal ability to make those decisions, and that we have discussed our beliefs and wishes with that person so that he or she can help us to live our full lives in respect and furtherance of the sacredness of God's gift of life.

Making such decisions not only honors our faith and our beliefs, but in a very concrete way removes a significant burden from those who love us the most. Whether medical decision-making is required under anticipated or unanticipated circumstances, it can often be one of the more stressful or emotional moments in the lives of those who love us. Having clear directives, indicating an agent and a back-up agent, and starting difficult conversations in advance is a good way to assure your loved one that you trust him or her to follow your wishes and God's will for your life.

# HOW TO USE THIS DOCUMENT

In providing this document, we intend to create a roadmap for you to use in order to gain a basic understanding of common ethical, medical, and legal terminology, the major provisions of Ohio law as it relates to advance medical directives, and some special considerations that you as a person of faith who holds specific pro-life beliefs may want to consider in terms of both standard legal documents and medical terms. We also want to provide you with a tool to help start an end-of-life conversation and move beyond the fears that often guide them. Finally, we want to provide pro-life and faithful Ohioans with a model form that can be used with or without the assistance of an attorney to indicate your wishes if you are not able to make decisions for yourself. We do want to note that it is not possible to develop a resource that conforms to every denomination, so if you have specific questions please speak with your faith leader.

# WHY A PRO-LIFE ADVANCE DIRECTIVE?

When we talk about the sacred nature of human life, we talk about the inherent dignity of the human person and our grave responsibility to preserve and protect it by all reasonable means. Therefore, we reject the intentional taking of innocent human life at both its very earliest stages (such as in the case of abortion) and at its end stages (such as in the case of assisted suicide or euthanasia). At the same time, we recognize that while human life on earth is a good and fruitful thing, we also believe that our lives reach their full perfection only in eternal life. We pray that this document will be educational and useful, that it helps us to understand how to better recognize the dignity of all human life, and that it invites each one of us to place our trust in God as we make all decisions – including those at the end of life.

*"Jesus Christ is the source—the only source—of meaning in life. He provides the only satisfactory explanation for why we're here and where we're going. Because of this good news, the final heartbeat for the Christian is not the mysterious conclusion to a meaningless existence. It is, rather, the grand beginning to a life that will never end. That same Lord is waiting to embrace and forgive anyone who comes to Him in humility and repentance."*

—James C. Dobson,

(Life on the Edge: The Next Generation's Guide to a Meaningful Future)

# LIMITATIONS OF THIS DOCUMENT

Although we have tried to include helpful hints, checklists, and background information, it is important to know that Ohio law limits the types of decisions that can be made in pre-printed advance medical directives to those related to your health and medical care. This is especially important if you are signing this form without the help of an attorney. This document does not take the place of a will, a general or financial power of attorney, documents establishing guardianship for any dependents you might have, or any other personal or business decision-making. We also want you

to understand that nothing in this packet constitutes legal advice. If you have specific legal questions you should contact an attorney who can help you. You are welcome to take this document to your attorney or you may be able to contact your local partner organization for a list of attorneys who have self-identified as supporting this document or specializing in pro-life advance medical directives. You may also want to talk through some of the subjects with your family, your clergy, and your friends. ***Finally, it is important to know that the advance medical directives described and recommended in this document in no way limit your right to make health care decisions for yourself for as long as you are able. Advance medical directives are only used when you are not able to make decisions for yourself.***

Your HCPOA will only take effect when you are not able to make decisions for yourself.

# UNDERSTANDING THE TYPES OF ADVANCE MEDICAL DIRECTIVES

This book is intended to provide education and informed consent about four types of legal documents that constitute advance medical directives in Ohio. These are the Health Care Power of Attorney (HCPOA), the Living Will, Do Not Resuscitate (DNR) laws, and Anatomical Gifts (organ donation). There is a fifth type of medical directive that has undergone considerable policy discussion in Ohio and other states but is not currently in effect in Ohio[1]: Medical (or Physician) Orders for Life Sustaining Treatment (MOLST/POLST). We will also provide some limited background on MOLST/POLST for context.

## Health Care Power of Attorney (HCPOA)

Ohio law allows Ohioans to appoint a person (called an "agent" here) to make health care decisions for them should they lose the ability to make decisions for themselves, whether temporarily or in the case of someone who is terminally ill or permanently unconscious. You can also authorize in the form for your agent to have access to otherwise protected information about your health to help make decisions (such as past medical conditions or treatments that would be private under HIPAA). Any competent adult can execute an HCPOA (sometimes called a durable power of attorney for health care). You can sign an HCPOA with or without the assistance of an attorney. If you do not use an attorney, Ohio law allows for a standard form to be used, but the document is limited to only permit medical or health care related decisions to be made. We are providing an HCPOA form that complies with Ohio law, Christian teaching, and pro-life principles in this document, but there are additional forms that can be used. ***We strongly recommend that all adults have a health care power of attorney.***

We strongly recommend that all adults have a health care power of attorney.

[1] As of October 1, 2020

## Living Will

Ohio law permits but does not require individuals to sign a document called a Living Will (sometimes called a Living Will Declaration) that permits them to specify the health care that they want to receive if they become terminally ill or permanently unconscious and cannot make their wishes known. If you are deemed terminally ill and have signed a Living Will, artificially or technologically supplied food and water can be removed, no life-sustaining treatment will be provided and a DNR order will be put in place. If you are deemed in a permanently unconscious state and have signed a Living Will, no life-sustaining treatment will be provided, and a DNR order will be put in place. It is important to know that the provisions contained in a Living Will are legal declarations that cannot be overridden by your spouse, a family member, or even your Health Care Power of Attorney – even if your loved ones believe it is not an accurate portrayal of your wishes in your current situation. If you have signed both documents, the Living Will as it is interpreted will guide your treatment if it has been determined that you are terminally ill or permanently unconscious. ***We join numerous other faith-based and pro-life organizations in strongly encouraging that members of the pro-life faithful have a Health Care Power of Attorney rather than a Living Will, and that they revoke a Living Will if they have one.*** We refer you to the discussion on bioethical and moral considerations in this booklet for a better understanding of why this is.

We strongly encourage that you have a Health Care Power of Attorney rather than a Living Will.

## Do Not Resuscitate Laws (DNR)

A DNR is a physician order that an individual (or an agent listed in your HCPOA) discusses with a physician as it relates to administering cardiopulmonary resuscitation (CPR), generally in a hospital or nursing home situation. It provides a notice to medical personnel that you do not want actions taken if your heart stops beating (cardiac arrest) or if you stop breathing (respiratory arrest). The decision to enter into a DNR order should be taken with grave consideration of the medical facts of a person's condition. To help understand this issue, please see Section 3 that discusses proportionate response and the benefits/burdens of ordinary vs extraordinary care. If you have a DNR order and your heart or breathing stops, you will not receive CPR, which can include everything from mouth-to-mouth resuscitation to chest compressions. There are two types of DNR orders in Ohio. The first is called a DNR Comfort Care or DNRCC. The second is called DNR Comfort Care-Arrest or DNRCC-Arrest. "DNR Comfort Care orders (DNRCC) require that only comfort measures be administered before, during, or after the time a person's heart or breathing stops….DNR Comfort Care-Arrest (DNRCC-Arrest) orders permit the use of life-saving measures (such as powerful heart or blood pressure medications) before a person's heart or breathing stops. However, only comfort care may be provided after a person's heart or breathing stops."[2] Comfort

[2] Do Not Resuscitate (DNR) Orders and Comfort Care, Cleveland Clinic, Ethics Resources and Services, September 2010 available at: https://my.clevelandclinic.org/ccf/media/files/Bioethics/DNR%20Handout%204_28.pdf. Accessed February 13, 2020.

Care is "any action taken to promote patient comfort, such as administering pain medications or offering emotional support." [3]

## Organ Donation Declaration

Ohio law allows an individual to register to become an eye, organ, or tissue donor by 1) registering with Ohio's Organ and Tissue Registry (Donate Life Ohio) at the Bureau of Motor Vehicles, 2) registering online, or 3) by filling out and mailing in a registration card to the Ohio Donor Registry.

If an individual is registered as a donor on the Ohio Donor Registry, that person's registration constitutes a legal agreement to authorize donating their organs, tissue, and eyes, upon their death for all purposes authorized by law. Someone's next of kin or agent under a health care power of attorney will likely be asked to make the determination to donate organs or tissue when the time comes, ***but they cannot revoke prior consent if it has been properly given by an adult.*** It is very important to understand that organ donation has enabled many people to live beautiful lives, fulfilling both the purpose of medical science and the culture of life[4]. However, we especially encourage you to better understand the standards under which death is established and to consider the moral issues that are involved. If you are unsure as to how to proceed, we recommend that you talk to a member of the clergy or other trusted advisor or refer to the resources in Section Eight.

## Medical (or Physician) Orders for Life Sustaining Treatment (MOLST/POLST)

While Ohio policy makers have discussed MOLST and POLST orders, they are not currently an element of Ohio law[5]. MOLST orders are technically not "advance" directives because they are medical orders dictating how a patient wants treatment to proceed based on his or her current conditions. They are growing in popularity in the United States but have largely been opposed by pro-life organizations and faith-based medical associations. We mention them in this document because a) they are a perpetual policy discussion and their legality is subject to change, and b) it is helpful to have information because you may encounter them with loved ones from another state or when traveling.

*None of us lives to himself, and none of us dies to himself. If we live, we live to the Lord, and if we die, we die to the Lord; so then, whether we live or whether we die, we are the Lord's. – Romans 14:8*

# WHY IS THIS NECESSARY?

There are two ways to answer this question. The first and easiest is to explain why a person should have an advance medical directive, particularly an HCPOA. An HCPOA is a legal document recognized by medical and related entities that permits someone to make decisions on your behalf if you are unable to do so. Our medical and legal systems are increasingly complex and having an HCPOA is the best way to ensure that someone who knows you, your beliefs, and your wishes can make decisions on your behalf.

[3] Ibid.
[4] St. John Paull II. *Evangelium Vitae: 25 March 1995.*
[5] As of October 1, 2020

The second is to explain why we are recommending this form rather than the "standard form" that has been used in Ohio for many years. This is a slightly more complicated answer. The standard form to which we refer here is a form that is backed by many well-respected entities including the Ohio Bar Association, the Ohio Hospital Association, the Ohio State Medical Association, and more. These are excellent organizations that represent a wide variety of professionals from various backgrounds, faiths, and beliefs, and that form represents the consensus of those organizations when it comes to legal and medical issues. As technology and culture have changed, however, there is a growing concern among those who look at end-of-life issues through a moral lens that adheres to pro-life and Christian values. Our concern is that the other form does not include enough background and educational information and gives an incomplete view of the issue, that the language in some areas is confusing (for example on hydration or nutrition), and that its guidance conflicts with standard pro-life faith-based teaching. For example, the standard form recommends that an individual have both an HCPOA and a Living Will. Most churches that hold a pro-life view see some or all of these as problematic. Furthermore, it is especially important that any HCPOA you sign meets the standards established in Ohio law, which this form does.

- *Advance directives are an important aspect of ethical care. It is imperative for patients and their physicians to discuss goals of care in an unhurried, uninterrupted, and thorough manner. Out of respect for the patient's dignity, it is essential that the patient understand the potential benefits and burdens of aggressive end-of-life treatment before decisions are made.*
- *Whereas suffering can produce strength of character (Romans 5:4), no patient is obligated to forego analgesic interventions. Medical professionals should offer any palliation possible to relieve their patients' pain and suffering, to the exclusion of intentionally hastening death.*
- *When natural death approaches, the option of withholding or withdrawing treatment should always be considered.*
- *Patients have the right to refuse any medical treatment. Honoring a patient's advance directive for nontreatment does not equate to euthanasia.*
- *A decision to withdraw a medical treatment should not be interpreted as withdrawal of care. Even when nothing more can be done medically to treat a patient's illness, there is still much that can be done for the patient. While treatments may be discontinued, care should always remain.*

*-Christian Medical and Dental Association, position statements 2020*

# SECTION THREE: A FAITHFUL APPROACH TO THE END OF LIFE

One of the things which makes end-of-life care so complicated is that the moral and ethical considerations which guide care are not strictly formulaic. This, by the way, is the reason that so many churches and pro-life organizations generally advise against a Living Will. We cannot predict what may happen in a future situation. It is helpful to remember that if you have a Health Care Power of Attorney, the person (or people) you designate will be able to make any legal medical decision for you, including the decision to start or end treatments. If you have a Living Will, once two doctors determine that it is applicable, that piece of paper – as interpreted by your doctor – will make decisions: not your loved ones.

Just as most Christians believe that we should not unduly hasten or cause death, it is important to realize that this does not impart an obligation to prolong life at all costs, especially when death is imminent or treatment is more of a burden to a patient than it is a benefit.

This understanding of benefit versus burden to the patient sets the standard for moral and ethical decision making in end-of-life care. The decision to forego aggressive medical treatment is not the same as euthanasia or even passive euthanasia. Medical procedures which no longer correspond to the real situation of a patient, either because are disproportionate to any expected result or because they impose an excessive burden on the patient are not required to meet an ethical standard.

*Death and life are stern and awful realities. To say that anything "is a matter of life and death," is to bring one of the most emphatic and solemn subjects under our notice. Now, the question we are considering this morning is of this character, and we must deal with it as it becomes us, when we investigate a subject involving the everlasting interest of souls.* – Rev. Billy Graham

# HOW DO WE DECIDE?

Ethicists use the terms “ordinary” and “extraordinary" to help us to understand what sort of treatments should be pursued. Unfortunately, in the moral and ethical sense, these words are used slightly differently than you may use them in your day-to-day life or how they are perhaps used in a medical setting.

Generally, the term *ordinary* is understood as something that is “common” and *extraordinary* might be understood as something that is “rare.” When the medical community uses the term *ordinary* it generally means a treatment that is scientifically established, statistically successful, and reasonably available. Likewise, the medical community uses the term *extraordinary* to mean treatments that are experimental or not commonly available.

When we use them in a Christian ethical context and throughout this document, however, what distinguishes the two terms is if the treatment is beneficial (ordinary) or burdensome (extraordinary) to the patient given his or her medical circumstances. We do this by weighing the benefit of any action or treatment to the patient against any burden that treatment may place on him or her. If the treatment presents a proportional benefit, we are ethically obligated to use it. If it is more of a burden, foregoing the treatment is permitted; it is not the moral equivalent of taking a life.

As an example, a common response to someone who is not breathing is performing CPR. Within the context of moral teaching, we would need some more information to determine if it is ordinary (beneficial) or extraordinary (burdensome). In the case of a person who is otherwise healthy and just slipped and fell into the swimming pool, performing CPR is a clear benefit and it would not be moral to deny or refuse CPR if it could be performed. In the case of a person who has an advanced illness and falls into that same swimming pool, CPR is most likely a benefit and is probably reasonable. In the case of a person with advanced terminal illness who is nearing death or with a medical diagnosis that means CPR is not likely to help and very likely to cause severe pain, it may be more of a burden and could therefore become “extraordinary” and not desirable.

*If you are making decisions about health care for yourself or a loved one at a difficult time, the most important question to answer is “Does this provide real, proportionate benefit, or is this more of a burden?”*

Media has sometimes given us an unrealistic view of the effectiveness of certain treatments, including CPR. If CPR is no longer an overall benefit to a patient, it is appropriate from both a medical and an ethical perspective to talk to your doctor about a Do Not Resuscitate Order (DNR). ***Every patient and every medical situation is different, so there is not a one-size-fits-all response. If you are making decisions about health care for yourself or a loved one at a difficult time the most important question to answer is, “Does this provide real, proportionate benefit, or is this more of a burden?”***

## How Do We Decide If Something Is A Burden?

There have traditionally been four standards used to determine burden: excessive pain, grave effort, intense fear or repugnance, and great cost.

**Excessive Pain**: A patient is not obligated to undergo a procedure that is excessively painful in the hopes of living.

**Grave Effort**: A patient is not obligated to move to a place that is nearby to treatment or travel long distances in order to seek care.

**Intense Fear or Repugnance**: If a patient has a genuine fear or distaste for a procedure that is greater than his illness or death, then he is not obligated to seek that treatment.

**Great Cost**: A patient is not obligated to bankrupt herself, her family, or her community in order to prolong her life.

Burdensome Treatment:
1. Is Excessively Painful,
2. Requires Grave Effort,
3. Causes Intense Fear or Repugnance, or
4. Incurs Great Cost

These standards inform end-of-life care whether the question is to begin treatment, continue it once it has started, or to end it. For example: if a patient has cancer, chemotherapy is a reasonable treatment. However, if the patient 1) is not responding to treatment, or 2) the treatment is so physically devastating that he/she would prefer to live out what remains of his/her natural life, or 3) the only available treatment would require moving from his/her hometown and family, or 4) the only options left are expensive untested treatments that he/she does not believe have a good chance of success: then any or all of these factors can reasonably and ethically be considered as reasons to forego or discontinue medical intervention.

## What About Hydration and Nutrition?

The purpose of hydration and nutrition is to sustain a person's life. A patient who cannot eat or drink on his or her own should generally be provided with hydration and nutrition if their lack will hasten death, if their administration is not an excessive burden, and if the patient's body is able to safely assimilate them.

## What About Organ Donation?

Organ donation has enabled many people to live beautiful lives, fulfilling both the purpose of medical science and the culture of life. There are several ways you can indicate that you wish to be an organ and/or tissue donor. We recommend notifying your family and your agent that under the appropriate situations you would like to be a donor. You can also register as an organ donor through Donate Life Ohio. Currently this can be done by 1) indicating a desire to be a donor when renewing a drivers' license, 2) registering online, or 3) filling out and mailing in a registration card to the Ohio Donor Registry.

It is important to know that if you are a registered donor through Donate Life Ohio, this is not a mere indication to your family that you wish to be an organ donor: it is your **legal consent** to be an organ or tissue donor. Ohio law is very clear that no person can revoke or amend an adult's

registration to be an organ donor,[6] even if they believe that the definition of death being applied by medical practitioners does not conform to your faith beliefs. Moreover, once you have consented (for example by saying "yes" at the BMV), you do not need to periodically reconfirm your consent. It is final and for good, unless you revoke that designation. This includes if you consented as a minor and have now come of legal age.

For this reason, *we* ***strongly suggest that any person who has previously consented to Ohio's organ and tissue donation registry revoke that prior consent and instead discuss with your family and your agent what your wishes are regarding organ and tissue donation and the circumstances under which you believe it is appropriate to donate organs and tissue.***

If you have previously consented to be listed on Ohio's organ donor registry and would like to amend or revoke that consent, there are three ways that your consent can be amended or revoked. They are 1) verbally indicate at the BMV when renewing your license, 2) amend or revoke your registration online at wwwdonatelifeohio.org, or 3) print out a copy of the consent/amend/revoke form and mail it to the listed address.

To assist in this discussion, please refer to Section Eight: "Additional References for Further Study." We especially encourage you to better understand the standards under which death is established to make sure that it fits your moral definition.

# WHAT NOW?

Now that you have a better understanding of some of these terms, it is time to consider who you want to name as your agent in your Health Care Power of Attorney and when a good opportunity to talk to your family about these things may be.

We have also included some additional resources in Section Eight that may be a good opportunity to learn more about these matters. Remember, these can be complex and emotional topics, even when there is not a health situation prompting them. Getting in the practice of reviewing your documents every few years is a good idea, especially because under Ohio law there are several things that can happen to invalidate your HCPOA. These include:

- The death, incapacity, or resignation of your agent (unless there is an alternate agent named),
- You revoke the HCPOA; (for example, signing a new HCPOA will revoke the prior HCPOA),
- Your agent is your spouse and an action is filed for the divorce, dissolution or annulment of the marriage (unless otherwise specified in the HCPOA), or,
- There is a legal protection order that identifies you as needing protection from your agent.[7]

Your death will also end the authority of your agent, at which time state law or additional documents (such as your will or a kinship designation) will stipulate who can make decisions. We have also included some related checklists to help facilitate conversations with your family and to

[6] Ohio Revised Code §2108.05(C)

[7] Ohio Revised Code §§ 1337.30(B)(3) and 1337.13(H).

help direct your loved ones to fulfill your wishes should you die unexpectedly. These are provided as a helpful checklist, but please remember that just as your HCPOA cannot be used while you are able to make decisions for yourself, it also ceases at your death.

*This page intentionally left blank*

# SECTION FOUR: INSTRUCTIONS

The attached form is a legal document. You should read through these instructions and the form to be sure that you understand it prior to signing it. You may sign it with or without the assistance of an attorney, but if you have any questions you should seek the assistance of an attorney.

If you choose to sign this document without the assistance of an attorney, your signature must be witnessed by two adults who are eligible witnesses or by a notary public. The following **cannot** serve as witnesses:

- the person you name as your agent,
- the guardian of your person or estate (if you have one),
- any alternate or successor agent or guardian (if you have one),
- anyone related to you by blood, marriage, or adoption,
- your attending physician, or
- the administrator of any nursing home where you are receiving care.

At the end of the form, we have provided several addendums that you may opt to include. If you opt to include an addendum, please only select one option per topic.

**Definitions**[1]

**Adult** means a person who is 18 years of age or older.

**Agent** or **attorney-in-fact** means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

**Attending physician** means the physician to whom a principal or the family of a principal has assigned primary responsibility for the treatment or care of the principal or, if the responsibility has not been assigned, the physician who has accepted that responsibility.

**Brain death** means that, if neurological criteria are used to determine death, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.[2]

[1] Unless otherwise noted, these definitions are from Chapter 1337 of the Ohio Revised Code.
[2] The Ohio Revised Code does not define "brain death" per se, although the definition of death found at Ohio Revised Code Section 2108.40 does state that an individual is dead if the individual has sustained "irreversible cessation of all functions of the brain, including the brain stem."

**CPR** means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.[3]

**Do Not Resuscitate or DNR Order** means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.[4]

**Guardian** means a person appointed by a probate court pursuant to Chapter 2111 of the Revised Code to have the care and management of the person of an incompetent or his/her estate.

**Health care** means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health.

**Health care decision** means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.

**Health care facility** means any of the following: a hospital, hospice care program, pediatric respite care program, or other institution that specializes in comfort care of patients in a terminal condition or permanently unconscious state, a nursing home, a home health agency, an intermediate care facility for individuals with intellectual disabilities, or a regulated community mental health organization.

**Health care personnel** means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

**Permanently unconscious state** means a state of permanent unconsciousness in a principal[5] that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal's attending physician and one other physician who has examined the principal, is characterized by both irreversible unawareness of one's being and environment and total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.

**Physician** means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

**Terminal condition** means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) There can be no recovery, and (2) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

**Ward** means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

---

[3] See Ohio Health Care Power of Attorney, Definitions Section, page one, available at: www.ohiobar.org.
[4] Ibid, see also, Ohio Revised Code Section 2133.21.
[5] The Ohio Revised Code uses the term "principal." Principal is simply another word for the person/patient.

# DIRECTIONS

Turn to Section Five: *Advance Directive and Health Care Power of Attorney*. The main form is seventeen pages long. Please read through each page and provide the information requested. You should also write or type your name in the space provided at the bottom of each page.

**Page One:**

- Print or type your full legal name and date of birth.
- Name your agent, the person who will make health care decisions for you. Your agent can be anyone you select.
- If you want to authorize your agent to obtain otherwise protected health care information, select this box. Selecting this box will authorize your agent to see past and future health care information to make decisions about your care.

**Page Two:**

- If your agent is unable or unwilling to make decisions for you, you can name an alternate agent or agents. If you wish to name those agents, please provide their names and contact information. ***We recommend that you do this***.

**Page Nine:**

- We have provided a list of optional addendums for you to sign with this document. Please check the boxes for any addendum that you have signed. Note that in some circumstances you may sign *either* "Option 1" or "Option 2." ***Only sign one of the options for each topic.***
- Addendum are identified as A-1 through A-8 of this document. *You do not have to sign any of these addendums.* Failing to sign any of the addendums will not prevent your agent from making a decision on those topics for you. However, if you sign one or more of the addendums, your agent will be obligated to follow your specific wishes.

**Page Ten:**

- Once you have read the entire document, you may sign and date the document in front of either your attorney, two witnesses that meet the standards described on page one of these instructions, or a notary public.

**Pages Eleven and Twelve**

- Pages 11 and 12 are for signature witnesses.

**Page Thirteen**

- You should use this space to share the names of individuals or places where original signed copies of this form are. You can also use it to insert the name of your attorney if the document was provided by an attorney.
- Make your wishes known to your family members, your medical care providers, and your other advisors. Let them know that you executed this document and give each agent a copy.

**Pages Fifteen through Seventeen**

- This is language that is required by the State of Ohio. Not all provisions may apply to this *Advance Directive and Health Care Power of Attorney*.

# ADDENDUM

If you would like to sign an addendum as noted on page nine, the following applies to the addendums. There are eight pages of addendum options, paginated A-1 through A-8. If you have previously consented to organ donation and you have amended or revoked that consent, you may also wish to attach a copy of your amended or revoked consent. However, note that your amended or revoked consent must be made directly by 1) verbally revoking or amending at the BMV, 2) amending or revoking consent online at www.donatelifeohio.org, or 3) mailing in the form found online at that same website.

**Page A-1**
Instructions to honor my pro-life beliefs and Christian Faith. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

**Page A-2**
If you are a woman of child-bearing age, you may wish to review this addendum. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

**Pages A-3 and A-4**
If you would like to nominate a Guardian of the Person, you may use one of these documents to nominate a guardian, should guardianship proceedings be started, for your person. *If you wish to sign one of these addendums, please sign and date the page for the option you chose and check the appropriate box on Page 9.*

**Page A-5**
If you would like to nominate a Guardian of the Estate, you may wish to sign this page. Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

**Page A-6**
If you have not completed a Living Will, you should check that box to make it clear that you have not. If you have previously signed a Living Will, you may check "yes" to specify that you would like to revoke the prior Living Will. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

**Pages A-7 and A-8**
You may sign either option if you wish to make specific provisions regarding organ donation. *If you wish to sign one of these addendums, please sign and date the page for the option you chose and check the appropriate box on Page 9.*
***Note on Addendums: Failing to sign any of the addendums will not prevent your agent from making a decision on those topics for you. However, if you sign one or more of the addendums, your agent will have more information and will be better able to follow your specific wishes.***

# OPTIONAL DOCUMENTS AND ADDITIONAL FORMS

In addition, we have included several optional forms/checklists/resources that you may find helpful. None of these are part of the *Advance Directive and Health Care Power of Attorney,* but they may be useful to you, your agent, and your family. You may use these forms or create your own.

**Page O-1**
This is an optional letter to your agent. You may use this letter or draft your own letter. It is not a legally binding document, but it may help your agent to better understand some of your decisions and will help express your beliefs.

**Page O-2**
This is a listing of your spiritual and religious needs. It includes information that may be helpful, especially if your agent does not share your faith background.

**Pages O-3 through O-5**
This is additional information that may be helpful, including your church, your preferred burial arrangements, and information on people or resources that may be helpful. It is important to note that once you are no longer alive, the agent under a Health Care Power of Attorney will no longer have authority to make decisions on your behalf. At that time, decision making will fall to your next of kin, beneficiaries, executor of your estate, etc. This information can be helpful for your agent and loved ones so that they know who will be responsible for making funeral plans and who is the executor of your estate (if you have one).

Please remember that none of these optional forms are legal documents; they are merely tools that can help to guide your agent and your loved ones in decision-making. If you wish to establish legally binding requirements on your kin or estate after your death, you should contact your legal advisor and consider including this as part of your will or other estate documents. For example, some people may wish to require a Mass of Christian Burial as part of their estate planning.

*This page intentionally left blank*

# SECTION FIVE: ADVANCE DIRECTIVE AND HEALTH CARE POWER OF ATTORNEY

*(Please turn to the next page)*

## ENDORSED BY:

Greater Columbus Right to Life
Growing a Community of Life

Foundation for Life

Miami County Right to Life

Champaign County Right to Life

*This page intentionally left blank*

# State of Ohio

## ADVANCE DIRECTIVE AND HEALTH CARE POWER OF ATTORNEY

_____

**(Print Full Name)**

_____

**(Birth Date)**

This is my Advance Directive and Health Care Power of Attorney. I revoke all prior advance directives for health care and health care proxies, including Living Wills and Health Care Powers of Attorney signed by me. I further revoke my consent to any prior DNR order, POLST (Physician Orders for Life-Sustaining Treatment), MOLST (Medical Orders for Life Sustaining Treatment), or similar order. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

**NAMING OF MY AGENT AND ALTERNATE AGENT(S)**

The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name and relationship: _____

Address: _____

Telephone number(s): _____

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.**

**Guidance to Agent.** My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

**Naming of alternate agent(s).** If my agent named above is unable or unwilling to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents (cross out any unused lines):

First Alternate Agent's name and relationship:_____

Address: _____

Telephone number(s): _____

Second Alternate Agent's name and relationship:_____

Address: _____

Telephone number(s): _____

Each alternate shall have and exercise all of the authority conferred in this Advance Directive and Health Care Power of Attorney. Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

*A future separation, dissolution, divorce, or annulment of my marriage (or the filing for any of the aforementioned items) will revoke the selection of my current spouse as my health care agent. See, also, R.C. 1337.30(B)(3). Similarly, if my agent is subject to any type of protection order in which I am the alleged victim, he/she will not be competent to serve as my agent under this document. See R.C. 1337.13(H).*

## AUTHORITY OF AGENT

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make those decisions for myself if I had the ability to do so.

The power and authority granted to my agent in this document is effective only if I am unable to give informed consent with respect to health care decisions, and only for the duration of my inability to make such decisions.

In exercising this authority, my attorney in fact shall make health care decisions that are consistent with my desires as stated in this document or in matters not addressed by my instructions in this document, as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, side effects, benefits and alternatives associated with treatment or non-treatment. My agent shall not authorize a course of treatment which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing.

The provisions of this Health Care Power of Attorney apply to any diagnosis, whether I am in a terminal condition, a permanently unconscious state, or otherwise.

These provisions are effective during any period of time in which I am unable to communicate my informed consent because of illness or injury.

Where necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, my agent has the power and authority to do any and all of the following:

1. To make decisions for me with respect to any health care procedure (including surgery), consent to care, treatment, interventions, or other measure, including palliative care. Any decisions of my health care agent shall be subject to the provisions and limitations expressed in this document.

2. To request, review, and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all of my medical and health care facility records. I expressly give my agent the authority to review, copy and utilize my medical and health care facility records for purposes of HIPAA. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

3. My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

4. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

5. To execute on my behalf any releases or other documents that may be required in order to obtain medical and related information.

6. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Advance Directive and Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

7. To select, employ, and discharge health care personnel, such as physicians, nurses, therapists and other medical professionals, including individuals and services providing home health care, as my agent shall determine to be appropriate.

8. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

9. To apply for Medicare, Medicaid, or other programs or insurance benefits for me. My agent can see my personal files, like bank records, to find out what is needed to fill out these forms.

10. My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger.

11. To visit me in any institution to which I have been transported for emergency care, observation, or admitted for inpatient or outpatient health care, and to authorize visitation subject to physician orders and policies of the institution to which I have been transported or admitted. Institution shall include, but not be limited to, a hospital, skilled nursing facility, hospice or other health care facility.

12. To transport me or arrange for my transportation to a place where this Advance Directive and Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.

13. To execute on my behalf any or all of the following:

    a. Documents that are written consents to medical treatment, or other similar orders;
    b. Documents giving or withholding consent for a Do Not Resuscitate (DNR) order;
    c. Documents that are written requests that I be transferred to another facility, written requests to be discharged against medical advice, or other similar requests; and
    d. Any other document necessary or desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

## INSTRUCTIONS FOR HEALTH CARE DECISIONS

I direct my health care provider(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, or reduce or prevent the deterioration in, any physical or mental condition. Nothing is to be done or omitted with the intent to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery;

all to the full extent necessary to correct, reverse, or alleviate life-threatening or health-impairing conditions, or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

The instructions in this designation are intended to be followed even if it is alleged that I attempted suicide after I signed this designation.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the actual or anticipated "quality" of my life. I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) to follow the above policy, even if I am judged to be incompetent.

During the time in which I have lost the capacity to make informed decisions for myself, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, including in the following situations.

***When My Death is Imminent***

If I have an incurable terminal illness or injury, and I will die imminently - meaning that at least two reasonably prudent physicians, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me - the following may be withheld or withdrawn:

- cardiopulmonary resuscitation (CPR);
- surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer; and
- a treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

***When I am Terminally Ill***

If I have an incurable terminal illness or injury and, even though death is not imminent, I am in the final stage of that terminal condition (meaning that at least two reasonably prudent physicians, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me) the following may be withheld or withdrawn:

- surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer, and
- a treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

However, treatment should not be withdrawn if my health care agent judges there are special and significant reasons why it should continue.

***Providing me with Food and Fluids (Nutrition and Hydration)***

I believe that food and water are not medical treatment nor medical procedures, but basic necessities which should be provided to me regardless of my physical or mental condition. I direct that food and fluids (nutrition and hydration) be provided to me orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

If my death is truly imminent; or I am unable to assimilate foods and fluids; or if there is some other serious medical problem preventing nourishment; or food or fluids endanger my condition; then the medically assisted supply of nutrition and hydration may be considered unnecessary and discontinued. The meaning of the words "imminent" and "unnecessary" for the purpose of this instruction are those which I have discussed with my agent.

***Providing me with Pain Relief/Medication***

Adequate efforts should be taken to relieve my pain though I do not want to be overmedicated to the point where I am unable to comprehend my situation and communicate with those around me. If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain. If I am dying and pain management should require increasingly greater dosages of medication, I direct that they be increased in increments sufficient to manage the pain, even if this increase should hasten my death. I know that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life. Although pain relief may be necessary, it should never be intended to cause death by suppression of breathing or terminal sedation. Pain medication should not be given to me for the purpose of hastening my death.

**LIMITATIONS OF AUTHORITY FOR AGENT AND OTHERS.**

I have discussed my principles and beliefs with my agent. I trust my agent to make appropriate health care decisions on my behalf based upon past and future discussions, subject only to the limitations, provisions, and directions expressed in this document.

1. I clearly intend that, if I am unable to make health care decisions, my agent or alternate agents, if any, will make health care decisions for me. I expressly eliminate any authority of a health care provider or any agent or employee of a health care provider, ethics committee, or insurance company to seek removal or replacement of my agent.

2. I should not be deprived of consciousness without a compelling reason.

3. I direct that my life not be ended by doctor-prescribed suicide, assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death. I oppose suicide and euthanasia. Treatment or support must not be provided or withheld for the purpose of causing my death.

4. I do not wish to be treated by any health care provider or health care facility which permits, prescribes, provides, or promotes assisted suicide (via prescription or device or

other means) unless emergency treatment is necessary and no other health care provider/health care facility is reasonably available.

5. I *do not authorize* any treatments that are derived from any tissue, organ or other substance from an unborn, newborn or stillborn child, including but not limited to embryonic stem cells. However, this prohibition does not apply a) if such are derived from an ectopic pregnancy, or b) to vaccines my agent deems appropriate, or to c) any other treatment that my agent deems appropriate and is not the proximate cause of the death of any child.

6. I also reject any treatments that use an organ or tissue of another person, unless reasonable efforts have been made to ensure that the procurement of such organ or tissue did not cause, contribute to, or hasten that person's death.

7. My agent shall not have the authority to make decisions for me, or sign documents on my behalf that are inconsistent with the terms of this Advance Directive and Health Care Power of Attorney.

8. Definition of "brain death" for the purposes of making decisions for my care:
While either cardio-respiratory signs or neurological criteria may be used to determine my death, if neurological criteria are used, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.

**NOMINATION OF GUARDIAN**. I nominate the person serving as my health care agent to serve as my guardian if one is needed, unless I have designated a different individual in one of the "Guardian of the Person" addendums (See A-3 and/or A-4)

**NO EXPIRATION DATE.** This Advance Directive and Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time. This Advance Directive and Health Care Power of Attorney is valid unless revoked.

**ENFORCEMENT BY AGENT AND FINANCIAL RESPONSIBILITY.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document. I direct my agent to use the power and authority granted in this document to ensure (by taking legal action if necessary) that my rights are protected. My agent shall not be liable for the costs of treatment pursuant to my agent's authorization, based solely on that authorization.

**RELEASE OF AGENT'S PERSONAL LIABILITY.** My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests. (R.C. Section 1337.35)

*Note: This document does not confer immunity on, nor release, any physician or health care institution from liability.*

**PROTECTION FROM LIABILITY FOR PEOPLE RELYING ON THIS DOCUMENT.** No person who may act in reliance upon the representations of my agent for the scope of authority granted to the agent shall incur any liability as to me or to my estate as a result of permitting the agent to exercise this authority, nor is any such person who deals with my agent responsible to determine or ensure the proper application of funds or property.

**INTERPRETING THE TERMS IN THIS DOCUMENT.** I have discussed the meanings of the words used in this Advance Directive and Health Care Power of Attorney with my agent, and my agent's interpretation of them is definitive.

**INVALIDITY AND SEVERABILITY.** To the extent my Advance Directive and Health Care Power of Attorney shall not be enforceable, these provisions are to be honored as the further expression of my intent. I deny the authority of any person or entity to treat or care for me, in a manner inconsistent with my Advance Directive and Health Care Power of Attorney. **Any invalid or unenforceable power, authority or provision of this instrument shall not affect any other power, authority or provision or the appointment of my agent to make health care decisions for me.**

**SUBSEQUENT ADVANCE DIRECTIVES AND MEDICAL ORDERS**. In the event that I execute another advance directive or give consent to a DNR order, POLST (Physician Orders for Life-Sustaining Treatment), MOLST (Medical Orders for Life Sustaining Treatment), or similar order at a later date and have not explicitly revoked this advance directive and health care power of attorney, I direct that this advance directive and health care power of attorney shall take precedence to the extent that any such additional directive, order, or consent conflicts with my wishes as expressed to my agent or as stated in this advance directive and health care power of attorney.

**COPIES AND ORIGINALS.** Any person may rely on a copy of this document [R.C. Section 1337.26(D)]

**OUT OF STATE APPLICATION**. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. Section 1337.26(C).

**OHIO NOTICE**. Ohio law requires that I be given the notice printed at the end of this document. I have read this notice before signing this.

## Addendums

By checking boxes below, I indicate my intention to include those provisions in my Advance Directive and Health Care Power of Attorney, and those items are hereby incorporated by reference. If a box is not checked, that provision is not to be included in my Advance Directive and Health Care Power of Attorney.

☐ Instructions to honor my pro-life beliefs and my faith

☐ Additional Health Care Instructions for a woman of child-bearing age

☐ Guardian of the Person provision – Option 1

☐ Guardian of the Person provision – Option 2

☐ Guardian of the Estate provision

☐ Note on Living Will

☐ Organ donation – Option 1

☐ Organ donation – Option 2

## SIGNATURE OF PRINCIPAL

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Advance Directive and Health Care Power of Attorney with the probate court for safekeeping. [R.C. Section 1337.12(E)(3)]

I understand that I must sign this Advance Directive and Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public. [R.C. Section 1337.12]

I sign my name to this Advance Directive and Health Care Power of Attorney on

_____20___, at _____, Ohio.

_____
Principal

[Choose Witnesses or a Notary Acknowledgment.]

WITNESSES [R.C. Section 1337.12(B)]

*[The following persons CANNOT serve as a witness to this Health Care Power of Attorney:*

- *Your agent, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate or successor agent or guardian, if any;*
- *Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of any nursing home where you are receiving care.]*

***I attest that the principal signed or acknowledged this Advance Directive and Health Care Power of Attorney in my presence, and that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.***

_____ / _____/ _____
Witness One's Signature Witness One's Printed Name Date

_____
Witness One's Address

_____ / _____/ _____
Witness Two's Signature Witness Two's Printed Name Date

_____
Witness Two's Address

## NOTARY ACKNOWLEDGEMENT

State of Ohio )
) ss:
County of _____ )

On _____, before me, the undersigned notary public, personally appeared,

_____, principal of the above Advance Directive and Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

_____
Notary Public

My Commission Expires: _____

My Commission is Permanent: ☐

**NOTE: You should make your wishes known to your family members, your medical care providers and your other advisors. Original signature documents should be provided to the agents listed herein, and might also be given to your physician, your health care facility, and possibly others. Be sure to keep a distribution list so you can notify all holders of copies if you revoke your document.*

Original signed copies of this document have been provided to:

_____

_____

_____

_____

_____

_____

This document was prepared by: ***Insert name, address, and phone number of attorney if an attorney prepared this document.***

_____

_____

_____

_____

_____

The "Notice to Adult Executing this Document" that follows on the next page is required by Ohio law for any printed durable power of attorney for health care that is sold or otherwise distributed in the State of Ohio for use by adults *who are not advised by an attorney*.

Some of the explanation in this notice may not pertain to the *State of Ohio Advance Directive and Health Care Power of Attorney* since it is more life-affirming than durable powers of attorney for health care that are typically used in the State of Ohio. This notice has been included simply to comport with Ohio law. In addition, the copyright date "March 2015" pertains to the "Notice to Adult Executing this Document" section only: not the *State of Ohio Advance Directive and Health Care Power of Attorney*.

# NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney-in-fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney-in-fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney-in-fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney-in-fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney-in-fact has general authority to make health care decisions for you under this document, the attorney-in-fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, the either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which
(i) there can be no recovery and
(ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney-in-fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then subject to (4) below, your attorney-in-fact would be authorized to refuse to withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) **Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:**

**(a) You are in a terminal condition or in a permanently unconscious state.**

**(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**

**(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney-in-fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**

**(i) Including a statement in capital letters that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**

**(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**

**(d) Your attending physician determines, in good faith, that you authorized the attorney-in-fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.**

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney-in-fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney-in-fact by including them in this document or by making them known to him in another manner.

When acting pursuant to this document, the attorney-in-fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney-in-fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney-in-fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney-in-fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your Durable Power of Attorney for Health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney-in-fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney-in-fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid Durable Power of Attorney for Health Care with it, it will revoke any prior, valid Durable Power of Attorney for Health Care that you created, unless you indicate otherwise in this document.

This document is not valid as a Durable Power of Attorney for Health Care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney-in-fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

ADDENDUM

This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

*This page intentionally left blank*

# SECTION SIX: ADDENDUMS

*(Please turn to next page)*

*This page intentionally left blank*

# INSTRUCTIONS TO HONOR MY PRO-LIFE BELIEFS AND MY CHRISTIAN FAITH

I strongly believe in pro-life principles and I do not agree with "Living Wills" and other similar directives biased in favor of death. I do not want any action taken that would directly cause or hasten my death. I believe that euthanasia is the deliberate act of taking the life of another, whether by active intervention or by omitting an action with the intention of causing death. I believe that euthanasia constitutes an unwarranted destruction of human life and is never morally permissible. I also believe that suicide (and assisted suicide) are never morally permissible.

Accordingly, this *Advance Directive and Health Care Power of Attorney* is to be interpreted in favor of continued life. I am a competent adult who understands and accepts the consequences, purposes and effects of this document. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. I direct that those caring for me avoid doing anything which is contrary to my pro-life beliefs. I wish to follow the moral teachings of my Church and to receive all the obligatory care that my faith teaches we have a duty to accept. However, I also know that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome to me.

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, with the faith teaching expressed in the documents listed in this *Advance Directive and Health Care Power of Attorney*, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my circumstances and treatment options. If action is taken to reduce treatment or care, please contact a pastor, priest, or other appropriate minister if at all possible.

_____ _____

Signature Date

*This page intentionally left blank*

# ADDITIONAL HEALTH CARE INSTRUCTIONS FOR A WOMAN OF CHILD-BEARING AGE

If I am pregnant, I direct that, regardless of my physical or mental condition, all medically indicated procedures, including medically assisted nutrition and hydration, be provided to sustain my life and the life of my unborn child until birth or at least until the child's viability is attained. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead[1] if there is a chance that doing so might allow my child to be born alive. No one is authorized to consent to any treatment or procedure for me whose sole immediate and directly intended effect is the termination of my pregnancy before the viability of my unborn child is attained.

I understand that I may morally accept or refuse operations, medications and forms of treatment that have as their direct purpose the cure of a serious pathological condition when these interventions cannot be safely postponed until the viability of my unborn child is attained, even if such interventions indirectly result in the death of my child.

_____ _____

Signature Date

[1] See definitions section for the definition of brain death for the purposes of this *Advance Directive and Health Care Power of Attorney*

*This page intentionally left blank*

# GUARDIAN OF THE PERSON PROVISION – OPTION 1

**Nomination of Guardian**
[R.C. Section 1337.28(A) and R.C. Section 2111.121]
[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

- I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship. [R.C. Section 2111.121(C)]
- I understand that the court will honor my nominations except for good cause shown or disqualification. [R.C. Section 2111.121(B)]
- I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing, and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend, or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension, or termination is in my best interests. [R.C. Section 1337.28(C)].

**I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person.** However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

| | |
|---|---|
| | By writing my initials, signature, a check mark or other mark in this box, I nominate my agent and alternate agent(s), if any to be **guardian of my person**, in the order named above. |

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order [cross out any unused lines]:

| | |
|---|---|
| | Guardian of my person's name and relationship: _____ |

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

_____ _____
Signature Date

*This page intentionally left blank*

# GUARDIAN OF THE PERSON PROVISION – OPTION 2

(A) _____(Initials) I nominate the person serving as my health care agent to serve as my guardian.

OR

(B) _____(Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

_____

Telephone Numbers: _____

_____
(Home, Work, and Mobile)

_____ _____
Signature Date

*This page intentionally left blank*

# GUARDIAN OF THE ESTATE

**GUARDIAN OF THE ESTATE**
Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

☐ By placing my initials, signature, check or other mark in this box, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

*If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order [cross out any unused lines]:*

☐ *Guardian of my estate and relationship:* _____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

☐ By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor guardian of my estate. [R.C. Section 1337.28(B)]

*If I do **not** make any mark in this box, it means that I expect the guardian or successor guardian of my estate to be bonded. [R.C. 1337.28 (B)]*

_____ _____
Signature Date

*This page intentionally left blank*

# NOTE ON LIVING WILL

I have completed a Living Will: Yes ☐ No ☐

I hereby revoke any prior Living Will Yes ☐

_____ _____

Signature Date

**Recommendations: If an individual has not signed a living will, the "no" box should be checked to make that clear.**

**If an individual previously signed a living will, the second "yes" box should be checked to make clear the individual's intention to revoke the living will.**

*This page intentionally left blank*

# ORGAN DONATION – OPTION 1

I do not want to be an organ donor.

_____ _____

Signature Date

*Please note: If you have previously consented to be listed on Ohio's organ donor registry and would like to amend or revoke that consent, there are three ways that your consent can be amended or revoked. They are 1) verbally indicate at the BMV when renewing your license, 2) amend or revoke your registration online at wwwdonatelifeohio.org, or 3) print out a copy of the consent/amend/revoke form and mail it to the listed address. It is important that you take this additional step to ensure that your intentions will be legally honored/enforced.*

*This page intentionally left blank*

# ORGAN DONATION – OPTION 2

Upon my death (*please initial one*):

_____ I do not wish to give my body or any organ.
_____ I wish to give my body.
_____ I wish to give any needed organs, tissues, or parts.
_____ I wish to give only non-vital organs
_____ I wish to give only the following organs, tissues, or parts:

_____

_____

_____

_____

No ovum or sperm shall be extracted – from my anatomical gift, from my organ or tissue donation, or as a tissue donation – for the purpose of creating an embryo.

Donated tissues or organs are not to be removed until it has been medically determined that I have died. In order to prevent any conflict of interest, the physician who determines my death should not be a member of the transplant team. While either cardio-respiratory signs or neurological criteria may be used to determine my death, if neurological criteria are used, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.

My gift is to be used for the following purposes (*please initial the choices you desire*):

_____ Any purpose authorized by law that does not violate the teachings of my faith
_____ Transplantation
_____ Therapy
_____ Research
_____ Medical Education

My body or any remaining parts or organs not used are to be treated with respect and charity, because of my faith and hope in the Resurrection of the Dead. Proper Christian burial of my body or cremains, and reverent disposition of other remains should be provided.

_____ _____
Signature Date

*Please note: If you have previously consented to be listed on Ohio's organ donor registry and would like to amend or revoke that consent, there are three ways that your consent can be amended or revoked. They are 1) verbally indicate at the BMV when renewing your license, 2) amend or revoke your registration online at wwwdonatelifeohio.org, or 3) print out a copy of the consent/amend/revoke form and mail it to the listed address. It is important that you take this additional step to ensure that your intentions will be legally honored/enforced.*

*This page intentionally left blank*

# SECTION SEVEN: OPTIONAL DOCUMENTS

Note: These are not legally binding, but may be useful in directing your agent and loved ones

*(Please turn to the next page)*

*This page intentionally left blank*

# LETTER TO MY AGENT (SAMPLE)

If you are reading this, it probably means that I am unable to make healthcare decisions for myself. Please know that I picked you as an agent because I trust you and I know that you will do the best you can. My Advance Directive and Health Care Power of Attorney tries to address the issues you might face when making decisions for me. There is language in there about the kind of care I want if I cannot make decisions for myself. I hope this document will give you some guidance.

The main principle to follow is to weigh the benefit of a proposed treatment with the burdens of that treatment (to me, the patient) when making decisions. Please give me food and water unless it's truly burdensome to me and/or my body cannot assimilate it. Everyone needs food and water to live, even if it's administered "artificially" (i.e. orally, intravenously, by tube, or other means, etc.)

I strongly believe in pro-life principles and do not want anything done to hasten my death, but I also understand that some pain medications might have the *unintended* effect of shortening my life. Again, please take a look at my *Advance Directive and Health Care Power of Attorney* for more information to help you make decisions.

If it looks like I am at the end of my earthly life, please do your best to ensure that I receive the appropriate care from my minister or an appropriate chaplain. Read to me from Sacred Scripture and pray with and for me. Helping me with my spiritual needs is probably the most important thing you can do for me!

I have attached some additional resources and people you can contact to assist you if you need help making decisions.

Pray for the Holy Spirit to guide you. Ask God to grant me a peaceful death and thank you for all your love and care for me.

# MY SPIRITUAL/RELIGIOUS NEEDS

If I am in a terminal condition or death is imminent, I ask that I be told of this so that I might prepare myself for death, and I ask for the following if possible *(please initial all those that apply):*

*Initial below*

| | |
|---|---|
| | Please call my Church:_____<br>or minister: _____ |
| | I would like this prayer, service, or blessing: _____ |
| | Please read to me from my Bible or appropriate sermons (_____) |
| | I would like all reasonable steps to be taken to allow me to see my family. |
| | If possible, I would like to die at home, or at least in a hospice that has the appearance of a home setting. |
| | Additional Request: |
| | Additional Request: |

My favorite prayers are:

My favorite readings are:

# OTHER INSTRUCTIONS

*(please initial all those that apply):*

*Initial below*

| | |
|---|---|
| | My church affiliation is *(insert name and phone #):* |
| | I want my funeral to include a specific type of service at my church. (*Note: It is wise to do funeral planning with your church to ensure that you will receive this. Not all traditions have a set rite.)* |
| | I have already made arrangements for my funeral with: *(Name funeral home and/or Church)***:** |
| | The funeral home I wish to care for my arrangements is *(Name funeral home)***:** |
| | I wish to be buried |
| | If burial, what cemetery? *(Name cemetery):*<br><br>I own a burial plot at that cemetery *(Mark your response):*<br>☐ Yes ☐ No |
| | I would like my body to be cremated with burial to follow. |
| | I would like an open casket if it is possible. |
| | I do not want an open casket. |

Other wishes/special instructions:

_____
_____
_____
_____
_____
_____

The name, address and phone number of the attorney who has a copy of my Last Will and Testament is:

_____
_____
_____

Optional – I have a will and the executor of my estate is: _____

# RESOURCES AND PEOPLE TO CALL

If you need help on making a good prudential judgment on how to care for me, these are the people/places I would go to if I was facing end of life decisions for a loved one:

*Consider pro-life doctors that you know and trust that could be consulted. List their name and contact information.*

_____

_____

_____

_____

_____

_____

*Consider your pastor or other ministers that you know who could assist you when needed. List their name and contact information.*

_____

_____

_____

_____

_____

_____

*(More resources are on the next page.)*

# RESOURCES

1. **Christian Medical and Dental Associations: https://cmda.org/**

2. **The National Catholic Bioethics Center:** www.ncbcenter.org
   Note: you may not be Catholic, but the NCBC has created documents that are used by many faith based organizations in determining bioethical standards for medical care at the end of life. The NCBC offers free consultation service by a credentialed bioethicist who can share with you the Catholic principles for addressing an ethical dilemma involving health care or the life sciences. If you have a specific time-sensitive question that cannot wait until their regular business hours, please call: **877-2660**, **24 hours/day, 7 days/week.**

   Follow the prompts to leave a message and an ethicist will be paged and respond to your call as soon as possible. If your question is not related to an emergency situation, please call during regular business hours (9am - 5pm Eastern Time) or use their Consultation Request Form.

3. **Patients Rights Council:** www.patientsrightscouncil.org

   The Patients Rights Council is the author of the Protective Medical Decisions Document. If you have friends or family in another state that need a Health Care Power of Attorney, this is an organization that can assist them. They can be reached at: 1-800-958-5678 or 740-282-3810.

4. *Other resources (list here)*

*This page intentionally left blank*

# SECTION EIGHT: ADDITIONAL RESOURCES AND REFERENCES FOR FURTHER STUDY

*(Please turn to the next page)*

# FOR FURTHER STUDY

## General Resources

*Neurology: The Official Journal of the American Academy of Neurology,* "Variability of brain death determination guidelines in leading US neurologic institutions," 2008:

> "Major differences exist in brain death guidelines among the leading neurologic hospitals in the United States. Adherence to the American Academy of Neurology guidelines is variable. If the guidelines reflect actual practice at each institution, there are substantial differences in practice which may have consequences for the determination of death and initiation of transplant procedures."

The full study can be purchased at: http://www.neurology.org/content/70/4/284.abstract. Accessed February 13, 2020. Abstract is also available at: http://www.ncbi.nlm.nih.gov/pubmed/18077794. Accessed February 13, 2020.

***Discussing Your Medical Wishes: A Patient's Guide*****,** 3rd Edition by Focus on the Family. Available online at: https://www.focusonthefamily.com/pro-life/discussing-your-medical-wishes-a-patients-guide/

*End of Life Resources: Orthodox Christians:* https://www.oca.org/news/headline-news/orthodox-christian-end-of-life-resources-now-available

Schneiderman, Lawrence J. and Nancy S. Jecker. Wrong Medicine: Doctors, Patients, and Futile Treatment. Baltimore, MD: The Johns Hopkins University Press, 2011.

Tollefsen, Christopher. Artificial Nutrition and Hydration: The New Catholic Debate. Dordrecht, The Netherlands: Springer, 2010.

## POLST Forms

Ethics and Medics: "POLST and Catholic Health Care: are the two compatible?" E. Christian Brugger, Ph.D., Stephen Pavela, MD, William Toffler, MD, and Franklin Smith, MD, January 2012 (Volume 37, Number 1). Contact the National Catholic Bioethics Center at 1-215-877-2660 to order.

# OHIO REVISED CODE SECTIONS

You cannot be required to sign a Living Will, DNR, or Health Care Power of Attorney in order to receive health care or medical services.

## Living Will (Also Known as A "Declaration")

Ohio Revised Code Section 2133.12(B)(4) provides: (4) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX [39] of the Revised Code, health insuring corporation, other health care plan, legal entity that is self-insured and provides benefits to its employees or members, or other person shall require any individual to execute or refrain from executing a declaration, or shall require an individual to revoke or refrain from revoking a declaration, as a condition of being insured or of receiving health care benefits or services.

## DNR

Ohio Revised Code Section 2133.24(B)(4) provides: (4) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX [39] of the Revised Code, health insuring corporation, other health care benefit plan, legal entity that is self-insured and provides benefits to its employees or members, or other person shall require an individual to possess DNR identification, or shall require an individual to revoke or refrain from possessing DNR identification, as a condition of being insured or of receiving health care benefits or services.

## Health Care Power of Attorney

Ohio Revised Code Section 1337.16(A) provides: (A) No physician, health care facility, other health care provider, person authorized to engage in the business of insurance in this state under Title XXXIX [39] of the Revised Code, health insuring corporation, other health care plan, or legal entity that is self-insured and provides benefits to its employees or members shall require an individual to create or refrain from creating a durable power of attorney for health care, or shall require an individual to revoke or refrain from revoking a durable power of attorney for health care, as a condition of being admitted to a health care facility, being provided health care, being insured, or being the recipient of benefits.

## Definition of Death

Ohio Revised Code Section 2108.40 provides: An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

A physician who makes a determination of death in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the physician's acts or the acts of others based on that determination.
Any person who acts in good faith in reliance on a determination of death made by a physician in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the person's actions.

*Notes*

*If we live, we live for the Lord; and if we die, we die for the Lord. So, whether we live or die, we belong to the Lord.* - Romans 14:8

Greater Columbus
Right to Life
Growing a Community of Life