PATIENT INFORMATION ON NEVADA STATE LAW CONCERNING ADVANCED DIRECTIVES

TODAY'S HEALTHCARE CHOICES

Years ago, we didn't have the choices in medical care that we have today. Seriously ill people, old and young, were more likely to die quickly of natural causes than they are today. Now, medical technology can extend the life of seriously ill people for longer periods of time. It can even keep permanently unconscious people alive for many years. This has created choices that just a few years ago wouldn't have seemed possible.

Sometimes, the new technology seems truly miraculous in its ability to restore health to someone who is seriously ill. At other times, it only seems to prolong suffering and the dying process.

MEDICAL TREATMENTS

There are three kinds of life-prolonging care to consider; cardiopulmonary resuscitation (CPR); artificial provision of nutrition and fluids (tube-feeding); and active treatment to fight disease.

1. CARDIOPULMONARY RESUSCITATION (CPR)

Cardiopulmonary resuscitation is the act of reviving someone whose heart and/or breathing have stopped. CPR (sometimes called a "code") can include basic and advanced measures.

The basic measures are:

- Cardiac compression (repeatedly pressing on the chest to squeeze the heart so that blood begins to circulate again);
- Mouth-to-mouth breathing, to push air into the lungs.

The advanced measures are:

- Intubation (putting a tube through the mouth or nose into the windpipe) and attaching a machine or device to do artificial breathing;
- Defibrillation (powerful electrical shocks to the chest to start the heart beating again);
- Strong medications.

The success of CPR depends on the individual's previous health and on how soon the procedure is started. The best results occur in a generally healthy person whose heart stops unexpectedly, and when CPR is started promptly. The chance of restarting the heart is much less likely when it has stopped as the result of many chronic problems.

Prompt CPR can save a person's life and prevent damage to the body's tissue and organs. On the other hand, brain damage is likely if more than about four minutes have elapsed before the procedure is started. Other risks include injuries to the chest and liver as a result of the force applied during chest compression.

Modern hospitals and nursing homes automatically attempt CPR on anyone whose heart and/or breathing stops, unless there is a Do Not Resuscitate - or "DNR" order - on file for the patient. A DNR order (also called a "no code") can only be written by a doctor with the permission of the patient, his or her health care agent or the family. (Note: A DNR order is not the same thing as an advance directive. If you want to limit CPR, your doctor must write a separate DNR order.)

2. ARTIFICIAL PROVISION OF NUTRITION AND FLUIDS

Artificial provision of nutrition and fluids, also called "tube-feeding," is used either temporarily or permanently when patients are unable to swallow. There are three ways to provide artificial nutrition and fluids;

- the nasogastric tube, which is inserted through the nose into the stomach;
- the gastrostomy tube, which is inserted surgically through the stomach walls;
- intravenous tubes, placed into veins in the arms or chest.

Nevada law permits individuals to refuse tube-feeding, just as patients may refuse other medical treatments. However, some doctors are reluctant to withhold or withdraw tube-feeding from an unconscious patient unless the patient has left specific instructions to do so.

Death usually occurs within two to 14 days after tube-feeding is withheld or withdrawn. Many people worry that the lack of food and water will mean a painful death. Tube-feeding is most commonly withheld or withdrawn when people are unconscious or on the verge of death. By this stage, most patients have lost the desire for nourishment and the sensation of thirst or pain. As a precaution against discomfort, however, comfort care is routinely provided in the interim before death.

3. ACTIVE TREATMENT TO FIGHT DISEASE

Active treatment to fight disease includes intensive treatment (the kind of high-technology care usually provided in hospitals' intensive care units) and non-intensive treatment.

Intensive Treatment:

- Ventilators, commonly called respirators, are machines that can breathe for a patient if lung function is inadequate. This is done through a tube inserted into the windpipe via the nose or mouth or through a tracheostomy, a hole cut in the windpipe at the front of the neck.

Of the two procedures, passing a tube through the nose or mouth is the least comfortable because it prevents the patient from speaking and eating, and it triggers the gag reflex. The tracheostomy, on the other hand, requires anesthesia and surgery, but eventually allows the patient to take food by mouth and to talk for short periods off the ventilator.

A ventilator is particularly helpful in getting a patient through a short-term crisis. It also has risks and can cause complications.

- Kidney dialysis involves the use of a machine to clean the blood when the kidneys no longer function properly. Dialysis takes several hours several times a week, and can be quite uncomfortable.

Dialysis can be used on a temporary basis while a patient recovers from an acute illness or awaits a kidney transplant, or on a permanent basis in the case of more serious kidney problems. Complete kidney failure is a common part of the dying process.

- Invasive monitoring involves the use of intravenous lines (to administer drugs or fluids and to take blood samples) and catheters (to monitor heart and kidney function).
- Electrical pacemakers and other devices can be used to support the failing heart.
- Major surgery can be used to restore function or relieve pain.

Non-Intensive Treatment

- Antibiotics (available in pill form or by injection) to treat infections.
- Blood transfusions.
- Chemotherapy (a drug treatment) and radiation (such as X-ray therapy) to fight cancer.

The following is a Statement of Patient Rights with respect to Treatment and a Description of Advance Directives under Nevada State Law:

QUESTIONS & ANSWERS

DO I HAVE THE RIGHT TO MAKE DECISIONS ABOUT MY MEDICAL CARE?

YES. NRS 449.680 provides that a patient retains the right to make decisions regarding the use of life-sustaining treatment, so long as he is able to do so. NRS 449.720 provides that a patient has a right to refuse treatment to the extent permitted by laws and to be informed of the consequences of that refusal.

DO I HAVE A RIGHT TO REFUSE TREATMENT?

YES. NRS 449.720 provides that you have the right to refuse treatment if you are able to make that decision and to be informed of the consequences of that refusal. A qualified patient may also forego life-sustaining treatment if he is able to do so. Sometimes a patient is so ill that he cannot refuse treatment. Therefore, it is very important to have an advance directive if you wish to refuse life-sustaining treatment during a terminal illness.

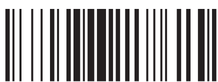
WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directives are:

- “Living Will,” or “Declaration;” and

- a “Durable Power of Attorney for Health Care.”

An advance directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive can enable you to make decisions about your future medical treatment. You can say “yes” to treatment you want, or say “no” to treatment you don’t want.



WHAT IS A LIVING WILL OR DECLARATION?

A Living Will or Declaration generally states the kind of medical care you want (or do not want) if you become unable to make your own decision. It is called a "living will" because it takes effect while you are still living. The Nevada Legislature has used the word "Declaration" as its preferred type of advanced directive. Nevada's form of Declarations are found in NRS 449.535 et seq.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS?

A "Durable Power of Attorney for Health Care" is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend as your "agent" or "proxy" to make medical decisions for you if you should be unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid, such as surgery or artificial feeding. The statutes regarding a Durable Power of Attorney for Health Care are found in NRS 449.800 et seq.

DO I HAVE TO WRITE AN ADVANCE DIRECTIVE UNDER THE LAW?

NO. It is entirely up to you.

CAN I CHANGE MY MIND AFTER I WRITE A DECLARATION OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS?

YES. You may change or cancel these documents at any time in accordance with state law. Any change or cancellation should be written, signed and dated in accordance with state law, and copies should be given to your family doctor, or to others to whom you may have given copies of the original.

If you wish to cancel an advance directive while you are in the hospital, you should notify your doctor, your family, and others who may need to know.

Even without a change in writing, your wishes stated in person directly to your doctor generally carry more weight than a Declaration or Durable Power of Attorney for Health Care Decisions, as long as you can decide for yourself and can communicate your wishes. But, be sure to state your wishes clearly and be sure that they are understood.

IF I AM IN A TERMINAL CONDITION (I AM DYING AND THERE IS NO HOPE OF A CURE) AND I AM NO LONGER ABLE TO MAKE DECISIONS REGARDING ADMINISTRATION OF LIFE-SUSTAINING TREATMENT AND HAVE NO ADVANCE DIRECTIVE, CAN LIFE-SUSTAINING TREATMENT BE WITHHELD OR WITHDRAWN?

YES. If your spouse, an adult child or if more than one child, a majority of the adult children who are reasonably available for consultation, your parents, an adult brother or sister or, if there is more than one sibling (brother or sister) a majority of the adult siblings who are reasonably available for consultation, or the nearest other adult relative by blood or adoption who is reasonably available for consultation, in that order of priority, may in good faith and for your best interest, consent in writing attested by two witnesses to the withholding or withdrawal of treatment.

WHO DECIDES WHETHER I AM UNABLE TO MAKE A DECISION REGARDING TREATMENT?

Your attending physician.

MAY I MAKE AN ORAL ADVANCE DIRECTIVE?

NO. An Advance Directive must be a formal writing and must be signed by two witnesses. However, you may orally revoke an existing Advance Directive.

IS IT ADVISABLE TO HAVE A COMBINED DIRECTIVE (Declaration and Durable Power of Attorney for Health Care Decisions in one document)?

Nevada law does not specifically provide for a combined directive nor does it prohibit one. If possible, you should have a Declaration and a Durable Power of Attorney for Health Care Decisions, either combined or separately, so that your desires have the strongest basis for legal enforcement.

IS IT ADVISABLE TO DISCUSS MY ADVANCE DIRECTIVE WITH MY HEALTH CARE PROVIDER?

YES. Unless your wishes are known by those involved in your health care, your wishes cannot be honored. It is advisable to provide a copy of the Advance Directive to your healthcare provider.

SHOULD I DISCUSS MY PLAN TO EXECUTE OR NOT EXECUTE AN ADVANCE DIRECTIVE WITH MY LAWYER?

YES. Your lawyer can explain the function and advisability of having an Advance Directive to you.

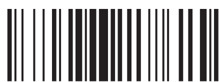
SHOULD I DISCUSS MY ADVANCE DIRECTIVE WITH MY FAMILY OR LOVED ONE?

YES. It is advisable that those dear to you be aware of your wishes and where your original Advance Directive is so that your wishes can be carried out.

MUST AN INSTITUTION WHERE I AM BEING CARED FOR ASCERTAIN WHETHER I HAVE EXECUTED AN ADVANCE DIRECTIVE?

YES. Federal law requires that the provider or organization must “document” in the individual’s medical record whether or not the individual has executed an Advance Directive.

You should not wait until you are old or facing a serious illness to think about these issues. Thinking about them while you are in good health gives you and your loved ones the opportunity to prepare for the sort of medical crisis that could happen to anyone at any time.



The following is the form of a "Declaration," provided for under Nevada Statutes:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration. . . . . [________]

Signed this ______________________ day of _____________, 20 ________.

Signature: _____________________________________

Address: _____________________________________

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The declarant voluntarily signed this writing in my presence.

Witness: _____________________________________

Address: _____________________________________

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Witness: _____________________________________

Address: _____________________________________

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THE PATIENT SELF DETERMINATION ACT, WHICH INCLUDES ADVANCE DIRECTIVES, REQUIRES NORTHERN NEVADA MEDICAL CENTER TO INFORM YOU OF YOUR RIGHTS AS A PATIENT AND OF OUR POLICIES:

1. You have the right to make decisions concerning your medical care.

2. You have the right to accept or refuse medical or surgical treatment, including the right to formulate advance directives (declarations and/or durable powers of attorney for health care decisions).

3. You have the right to be given information concerning Advance Directives within 24 hours of your admission to this hospital.

4. Upon admission, you will be asked if you have an advance directive.

5. It will be documented in your medical record whether or not you have an advance directive.

6. If you have an advance directive you should furnish a copy to the hospital, so it can be placed in and made a part of your medical record/chart, so hospital personnel are made aware of your medical treatment desires.

7. If you have an advance directive it will be honored by the hospital (NRS 449.628 does permit an attending physician or provider of health care who is unwilling to comply with a patient's advance directive, to transfer care to another physician or provider of health care who will).

8. The hospital will not condition the provision of care or otherwise discriminate against you based on whether or not you have formulated an advance directive.

9. For further information regarding advance directives, or to obtain advance directives forms, please contact your Nurse or Social Services at this hospital.

10. For further information in the community you may contact an attorney.

11. Complaints or grievance concerning hospital advance directives noncompliance may be addressed to:

North (includes rural Nevada)

Nevada State Health Division
Bureau of Licensure and Certification
1550 East College Parkway, Suite 158
Carson City, NV 89706
(702) 687-4475

South

Nevada State Health Division
Bureau of Licensure and Certification
4220 South Maryland Parkway
Building D, Suite 810
Las Vegas, NV 89119
(702) 486-6515

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for HealthCare. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

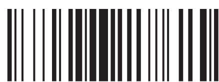
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for HealthCare.

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



1. DESIGNATION OF HEALTHCARE AGENT

I, ______________________________________ (insert your name) do hereby designate and appoint:

Name: ____

Address: ____

Telephone Number: ____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for HealthCare, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date: ______________________________

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that are in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures . . . . [________]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed . . . . [________]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed) . . . . [________]

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld . . . . [________]

5. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life . . . . [________]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires: ____

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7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to serve in the order listed below:

A. First Alternative Attorney-in-Fact

Name: ____

Address: ____

____

Telephone Number: ____

B. Second Alternative Attorney-in-Fact

Name: ____

Address: ____

____

Telephone Number: ____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for HealthCare:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for HealthCare on ____________________ (date)

at ________________________________ (city), ______________________________ (state).

____
(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of statement of witnesses.)

State of Nevada)
: ss:
County of _________________)

On this _____________ day of ____________________, in the year ________, before me, __________

____ (here insert name of notary public) personally appeared ____ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

____

(Signature of Notary Pubic)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: ______________________________

Print Name: ______________________________

Residence Address: ______________________________

Date: ______________________

Signature: ______________________________

Print Name: ______________________________

Residence Address: ______________________________

Date: ______________________

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: ______________________________

Signature: ______________________________

Names: ______________________ Address: ______________________

Print Name: ______________________ ______________________

Date: ______________________ ______________________

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The Power of Attorney should be available so a copy may be given to your providers of health care. Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

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