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Advance Health Care Directives and Health Care Decision-making for Incompetent Patients

*A guide to Act 169 of 2006 for physicians
and other health care providers*



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General background

This guide summarizes Act 169 of 2006, which provides a comprehensive statutory framework governing advance health care directives and health care decision-making for incompetent patients. This new law takes effect on January 29, 2007.

Major components of Act 169

Act 169 provides for health care decisions to be made for an adult incompetent patient through:

- Instructions from the patient in a living will,
- Directions from a health care agent appointed by the patient in a health care power of attorney, or
- Directions from a close family member or other health care representative designated by the patient or authorized by default under the law.

The Act also provides for out-of-hospital do-not-resuscitate (DNR) orders, which direct emergency medical services providers to withhold cardio-pulmonary resuscitation (CPR) from the patient in the event of cardiac or respiratory arrest.

What's new in the law as of January 29, 2007?

The living will and out-of-hospital DNR order provisions largely mirror existing statutory law. The health care power of attorney and health care representative provisions are new.

Physicians always have relied on health care agents and close family to make decisions for incompetent patients. The consensus was that this generally was authorized under prior judicial decisions, constitutional principles, a surrogate appointment provision in the prior living will law, or the general power of attorney statute.

However, the applicable standards and procedures were not clearly defined. As a result, physicians sometimes were faced with the untenable dilemma of either

This guide is intended to help medical staff leaders develop policies and procedures to promote compliance with Act 169. The Medical Society also has available less detailed information to provide physicians with a quick overview of the Act. (See "Additional resources" box on the back inside cover or go to www.pamedsoc.org/advancedirectives.)

The guide provides general legal information. It is not intended as legal advice. Physicians should consult their personal attorney if they are in need of legal guidance on a specific situation. Nothing in this guide should be construed as defining a standard of care.

ignoring patient autonomy or risking adverse legal ramifications.

The Act's explicit statutory authority provides both greater clarity and protections for patients and physicians.

POLST – Strengthening continuity between health care settings

Another major benefit of Act 169 is that it requires the Department of Health, in consultation with an advisory committee, to consider adoption of a standardized physician-order-for-life-sustaining-treatment (POLST) form.

POLST orders provide for continuity of DNR and other life-sustaining treatment orders from one setting to another, such as when a patient is transferred from a nursing facility to a hospital or vice versa.

Under a POLST program, the POLST order is required by regulation to be transferred with patients when they move from one setting to another and recognized in the new setting.

This assures that each patient's difficult decisions regarding end-of-life care are honored and are not dishonored by misplaced or delayed paperwork.

The Medical Society has been advocating for a POLST program for a number of years and views the advisory committee mandate to be a substantial step forward.

What are the basic requirements for advance health care directives?

Types of advance directives

There are three types of advance health care directives:

- **Living will** — The patient states his or her personal desires regarding life-sustaining treatment and other end-of-life care.
- **Health care power of attorney** — The patient appoints a person, known as the patient's health care agent, to make health care decisions for the patient.
- **Combination document** — Incorporates features of both a living will and a health care power of attorney.

Requirements for valid advance directives

Only adults of sound mind may make an advance health care directive.

For purposes of Act 169, an adult includes an individual who is 18 years of age or older, has graduated from high school, has married, or is an emancipated minor.

An advance health care directive must be:

- Made in a written document that is dated and signed by the patient or, if the patient is unable to sign, by an individual acting at the patient's direction, and
- Witnessed by two individuals who are at least 18 years of age.

An individual who signs for the patient may not also be a witness. Health care providers and their agents, including physicians and their office staff, may not sign an advance health care directive on behalf of a patient that they are treating.

An advance health care directive does not have to be notarized to be recognized in Pennsylvania. However, some other states do impose such a requirement, and notarization will help the directive to be recognized in those other states.

The Act includes an example advance health care directive that is a combined living will and health care power of attorney. Patients are not required to use the Act's example form. (See "Patient brochure" on p. 12 for information regarding the Medical Society's form.)

An advance health care directive remains in effect for as long as the patient lives, unless it is revoked or it states a time of termination. Advance directives executed under the prior law remain valid.

Advance directives made under the laws of another state are valid in Pennsylvania, except to the extent that the directive allows directions inconsistent with Pennsylvania law, e.g., the restrictions for pregnant women.

Amending advance directives

A patient may amend an advance health care directive only if the patient is of sound mind. An amendment must conform to the requirements for executing an advance health care directive.

In the case of multiple conflicting advance health care directives, the latest directive prevails, unless the directives expressly provide otherwise.

Revoking advance directives

The requirements for revoking an advance health care directive differ for living wills and health care powers of attorney.

A patient may revoke a living will at any time and in any manner, regardless of the mental or physical condition of the patient, i.e., even if the patient is not of sound mind.

In contrast, a patient must be of sound mind to revoke a health care power of attorney.

A revocation of a living will is effective when it is communicated to the attending physician or other health care provider by either the patient or a witness to the revocation.

In contrast, to revoke a health care power of attorney, a patient must either do so in a writing conforming to the requirements for a health care power of attorney, or personally communicate the revocation to the patient's attending physician, health care provider, or health care agent.

Health care provider documentation obligations

When presented with an advance health care directive, health care providers must place a copy in the patient's medical record.

Health care providers who are notified that a patient has amended or revoked an advance health care directive must likewise document the amendment or revocation in the patient's medical record.

When and what decisions can be made by living wills and health care agents and representatives?

Living wills

Living wills focus on life-sustaining treatment and other end-of-life care.

A living will is not operative (i.e., in effect) unless:

- The patient is incompetent, and
- The patient is permanently unconscious or has an end-stage medical condition.

(See right for definitions.)

Health care agents

A health care power of attorney may give a health care agent authority as broad as the patient would

have if competent. In contrast to living wills, health care agents are not restricted to end-of-life decision-making.

Although health care agents usually are given authority only when the patient is incompetent, a health care power of attorney may vest an agent with authority even when the patient is competent.

Key definitions

End-stage medical condition — An incurable and irreversible medical condition in an advanced state caused by injury, disease or physical illness that will, to a reasonable degree of medical certainty, result in death, despite the introduction or continuation of medical treatment. The term is defined similarly to “terminal condition” in the prior living will law and replaces that term. In the Medical Society's view, it better describes the qualifying conditions.

Incompetent — Not able to understand, make, and communicate health care decisions, even when provided appropriate information and aids. A patient may be competent to make some simple health care decisions, but incompetent to make other more complex decisions.

Life-sustaining treatment — Generally means any medical procedure or intervention that, when administered to a patient who has an end-stage medical condition or is permanently unconscious, will serve only to prolong the process of dying or maintain the patient in a state of permanent unconsciousness.

Examples of care that may—depending upon the circumstances—be considered life-sustaining include: CPR, mechanical respiration, kidney dialysis, surgery, radiation therapy, chemotherapy, and antibiotics.

There are circumstances in which artificial nutrition and hydration satisfies the criteria for the general rule. However, under Act 169, use of the term “life-sustaining treatment” in an advance health care directive does not include artificial nutrition and hydration unless the directive specifically states that this care is included. (See also pp. 10-11.)

Permanently unconscious — A medical condition in which the patient has total and irreversible loss of consciousness and capacity for interaction with the environment, such as an irreversible vegetative state or an irreversible coma. A diagnosis that a patient is permanently unconscious must be made in accordance with currently accepted medical standards and to a reasonable degree of medical certainty.

A health care agent, when duly authorized, generally may direct health care providers to provide, continue, withhold, or withdraw all forms of medical care from the patient. There are some limited restrictions in the case of pregnant women and disabled patients. (See p. 11.)

Act 169 does not impose a requirement that the patient be permanently unconscious or have an end-stage medical condition for a health care agent to direct the withholding or withdrawing of health care necessary to preserve the patient's life.

However, in the absence of the patient having one of those conditions, physicians should take special care to determine that the health care power of attorney does not impose such a restriction and that the agent is following the prescribed decision-making process.

Health care representatives

Generally speaking, a health care representative may make health care decisions for an incompetent adult patient who has no controlling living will, health care agent, or guardian of the person.

Like a health care agent, a health care representative generally may direct health care providers to provide, continue, withhold, or withdraw all forms of medical care, with limited restrictions in the case of pregnant women and disabled patients.

However, in contrast to a health care agent, a health care representative may direct the withholding or withdrawal of care necessary to preserve life only when the patient is permanently unconscious or has an end-stage medical condition. (See p. 10.)

Patient countermands

A patient of sound mind may countermand (i.e., reverse) the decision of a health care agent or representative at any time, by personally informing the attending physician or health care provider.

In addition, regardless of the patient's mental or physical capacity, a patient may countermand the decision of a health agent or representative that would

withhold or withdraw life-sustaining treatment, by personally informing the attending physician.

A countermand is different from a revocation of a health care power of attorney and the disqualification of a representative. It applies only to a specific health care decision and does not affect the authority of the agent or representative to make other health care decisions.

Required physician determinations

Determinations regarding a patient's competence and whether a patient is permanently unconscious or has an end-stage medical condition must be made by the patient's attending physician.

Under the prior living will law, determinations that a patient had a terminal condition or was permanently unconscious had to be confirmed with a second opinion.

Act 169 does not require determinations of any triggering event to be confirmed with a second opinion. However, the patient's advance directive may require a confirming second opinion.

For example, the Five Wishes Advance Directive model form requires determinations that the patient is incompetent to be made by the patient's attending physician and confirmed by another health care professional.

In addition, living wills executed under the prior law sometimes require a second confirming opinion that the patient is permanently unconscious or has a terminal condition.

In any event, a second opinion or consultation with an ethics committee may be helpful when there is a question as to whether the patient meets the criteria.

Physician documentation and notification requirements

When a patient's attending physician determines that the patient is incompetent, or has regained competence, the physician must document that

finding in the patient's medical record and, to the extent possible, notify the patient and the patient's health care agent.

When the patient's attending physician determines that the patient is permanently unconscious or has an end-stage medical condition, the physician must certify that finding in the patient's medical record and, to the extent possible, notify the patient and the patient's health care agent.

How are health care agents and representatives designated?

Appointment of health care agents

As noted, health care agents are appointed by the patient in a health care power of attorney.

A patient may appoint one or more successor agents. Successor agents serve in the order designated in the power of attorney, unless the power of attorney expressly directs otherwise.

A patient also may appoint multiple agents of equal priority. Joint agents must act together (i.e., must agree on the course of action), unless the power of attorney expressly states otherwise.

Determination of health care representatives

A patient's health care representative is designated by the patient or authorized by default under the law.

A patient of sound mind may designate a health care representative, either in a signed written document or by personally informing the health care provider.

This process is less formal than the appointment of a health care agent in a health care power of attorney. However, if the patient has a specific decision-maker in mind, it generally is best for the patient to formally appoint that person as a health care agent in a health care power of attorney.

The patient can direct and restrict a health care agent via provisions in a health care power of attorney. Health care agents also may be given broader authority than health care representatives have under the law. (See pp. 3-4.)

If the patient has not designated a health care representative (and has no controlling living will, health care agent, or guardian of the person), Act 169 provides for the default designation of a health care representative.

The patient's default health care representative generally is determined by a priority list in the law. (See below for default priority list.)

Default priority list for health care representatives

Act 169 generally gives priority to the following classes, in the order listed:

- Spouse and adult child who is not the child of the spouse,
- Adult child,
- Parent,
- Adult sibling,
- Adult grandchild, and
- Close friend (i.e., individual who is knowledgeable of the patient's preferences and values).

A patient may have multiple representatives in the same priority class. The Act provides for resolution of disputes among multiple representatives of the same priority. (See pp. 7-8.)

Patient over-ride options for default priority list

A patient of sound mind may modify the default rules for designation of a health care representative.

- The patient may, by a signed writing or by personally informing the patient's health care provider, disqualify one or more individuals from serving as a health care representative.
- The patient may, by a health care power of attorney or other signed writing, provide for a different order of priority.

Judicial over-ride of default health care representatives

If any member of a default health care representative class petitions the court, a judge may disqualify one or more otherwise eligible individuals from serving as a health care representative in appropriate circumstances.

For example, a court could disqualify a higher priority individual in favor of a lower priority individual who is substantially more familiar with the patient's preferences and values.

Automatically disqualified individuals

Generally, a patient may designate any individual as a health care agent or representative.

However, the designation of a spouse as a patient's health care agent is deemed revoked if either the spouse or the patient files for divorce, unless the power of attorney clearly provides otherwise.

A patient's spouse also loses priority as the patient's health care representative if either the spouse or the patient files for divorce.

In addition, unless related to the patient by blood, marriage, or adoption, neither the patient's attending physician nor an owner, operator, or employee of a health care provider in which the patient is receiving care may serve as a health care agent or representative for the patient.

Verification of authority

Upon assuming authority, a health care representative is required to promptly inform the other members of

the patient's family who fall within any of the default classes and can be readily contacted.

A health care provider may require an individual claiming the right to act as the patient's health care representative to provide a written declaration, made under penalty of perjury, stating facts and circumstances reasonably sufficient to establish the claimed authority.

While obtaining such a declaration is not required, it generally is prudent to have the representative at least sign a document stating the representative's relationship to the patient and verifying, to the best of the representative's knowledge, that there is no other person of higher authority who is readily available and willing to act for the patient.

What decision-making process must be followed by health care agents and representatives?

Step 1: Collect information

Before making a health care decision on behalf of a patient, a health care agent or representative is required to gather information on the patient's prognosis and acceptable medical alternatives regarding diagnosis, treatments, and supportive care.

Typically, the patient's attending physician and other members of the health care team will need to provide this information. (See p. 8 for privacy issues.)

In the case of procedures for which informed consent is mandated under the Mcare Act (e.g., surgery), the collected information is to include the information required to be disclosed under the Mcare Act.

In the case of health care decisions regarding the end of life of a patient with an end-stage medical condition, the collected information is to distinguish between:

- Curative alternatives, palliative alternatives, and alternatives that will merely serve to prolong the process of dying.
- The patient's end-stage medical condition and any other concurrent disease, illness or physical, mental, cognitive or intellectual condition that predated the patient's end-stage medical condition.

This information requirement is one of several safeguards incorporated to protect disabled patients.

Step 2: Follow prescribed criteria

Health care agents and representatives generally are required to make decisions for patients based upon the following criteria, in the order listed:

- Any clearly expressed instructions (oral or verbal) of the patient while competent,
- The patient's preferences and values (including religious and moral beliefs), and
- The best interests of the patient.

When evaluating a patient's best interests, health care agents and representatives are required to take into account the following goals and considerations: the preservation of life, the relief from suffering, and the preservation or restoration of functioning.

In addition, when considering whether the care under consideration will restore or preserve the patient's functioning, health care agents and representatives must take into account any pre-existing disability of the patient, i.e., the benchmark is the patient's level of functioning with the pre-existing disability.

This last criterion is another key safeguard incorporated to protect disabled patients.

Modified rules apply in the case of withholding or withdrawing of artificial nutrition or hydration. (See pp. 10-11.)

Facility policies and procedures to promote compliance

Act 169 requires the Department of Health to ensure, via the licensure process, that hospitals, nursing homes, and other facilities under its jurisdiction have policies and procedures to implement the mandated decision-making process.

Medical staffs should work with the hospital administration to develop appropriate policies and procedures for their institution.

Although not required by Act 169, consideration should be given to the beneficial role that ethics committee and mediation processes can play in facilitating appropriate decision-making by agents and representatives.

Additional decision-making issues and requirements for health care providers

Highest priority decision-maker is unavailable

The highest priority decision-maker for the patient may not be reasonably available, i.e., readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs.

For example, a patient's parent may have the highest priority, but not be reasonably available because he or she is on vacation and unreachable, declines to serve, or is incompetent.

In such cases, the individual or class with the next highest priority may serve in the interim.

Resolution of disputes

A patient may have joint agents of equal priority or multiple representatives in the highest priority class. For example, a widowed patient may have several

children who step forward to serve as the patient's health care representative.

Usually the members of the class will agree on a course of action after consultation with the patient's health care team and application of the prescribed decision-making process. However, in some cases, there will be disagreement among the class.

Although not required by Act 169, in such cases, whenever feasible, consideration should be given to use of an ethics committee or mediation process to facilitate the class reaching a unified position.

In the case of joint agents with equal priority, no decision can be made unless they agree.

In contrast, if agreement cannot be reached among representatives of equal priority, Act 169 allows the attending physician to rely on the decision of the majority.

But, if the representatives are evenly divided, the Act does not allow the class to make a decision; nor does it allow an individual having lower priority to break the tie or serve as the patient's health care representative.

In any event, the lack of agreement does not preclude the administration of medical treatment in accordance with accepted standards of medical practice in the meantime. For example, if it is medically appropriate to maintain the patient on a respirator, this may be continued until a dispute regarding its withdrawal is resolved.

Privacy issues

Disclosures to health care agents and representatives generally will not violate the various state and federal privacy requirements.

For example, such disclosures will not violate the HIPAA privacy regulations, as the agent or representative "stands in the shoes" of the patient and has the same right to access information as the patient.

However, health care providers subject to federal drug and alcohol treatment privacy protections are subject

to more stringent restrictions and arguably need a patient authorization if the patient has not been determined by a court to be incompetent.

Documentation of disclosed information

A prior version of the bill required health care providers to document all the information provided to the patient's health care agent or representative in the patient's medical record. The Medical Society succeeded in having this problematic requirement removed.

However, physicians should document discussions, disclosures, and consents involving a health care agent or representative to the same extent that that physician would document such matters involving a competent patient in accordance with good medical practice.

Communication of decisions

Before implementing a health care decision made by a health care agent or representative, a health care provider must, whenever possible, promptly communicate the decision to the patient and disclose the identity of the person making the decision.

In the event that a patient countermands the decision of a health care agent or representative, a health care provider must make reasonable efforts to promptly inform the agent or representative of the countermand.

What are the rules governing compliance by health care providers?

General obligation to comply

Act 169 generally requires health care providers to comply with instructions regarding life-sustaining treatment in a living will.

In addition, it generally requires health care providers to honor directions from a duly authorized health care agent or representative to the same extent as if the directions were issued by the patient.

Immunity protections for health care providers

Act 169 provides extensive immunity protections for health care providers to encourage their compliance with living wills and directions from health care agents and representatives.

An immunity provision allows health care providers to assume that an advance directive presented to them was valid when made and has not been amended or revoked, unless they have reason to believe otherwise.

Health care providers also are provided immunity protection when they initiate, continue, withhold, or withdraw medical treatment from an incompetent patient if they believe in good faith that they are acting in accordance with the terms of the patient's living will or the directions of a duly authorized health care agent or representative.

Religious and moral objections

Health care providers may be faced with situations in which they are unwilling in good conscience to comply with directions to withhold or withdraw life-sustaining treatment or their policies and procedures preclude compliance with such directions.

In such situations, the Act allows health care providers to decline to withhold or withdraw the treatment, provided that they:

- Inform the patient if the patient is competent or the patient's health care agent or representative if the patient is incompetent, and
- Make every reasonable effort to assist in the transfer of the patient to another physician or health care provider who will comply.

Futile and other medically inappropriate care

The Medical Society does not interpret Act 169 as requiring health care providers to provide medical treatment that is futile or otherwise is medically

inappropriate, i.e., has no medical basis in addressing any medical need or condition of the patient, to a reasonable degree of medical certainty.

Act 169 also provides a specific immunity protection for these situations.

However, health care providers declining to provide care on the basis that it is medically futile or otherwise medically inappropriate generally should:

- Inform the patient if the patient is competent or the patient's health care agent or representative if the patient is incompetent,
- Cooperate with efforts to transfer the patient to another physician or health care provider who will comply, and
- Follow applicable ethical standards.

Physicians also should keep in mind that refusal to provide futile care is a very sensitive issue, especially in the case of do-not-resuscitate (DNR) orders.

It generally will not be prudent to issue a DNR order on the basis that CPR will be "futile," in the absence of consent for the order via a living will or a duly authorized health care agent or representative or legal guardian.

Use of an ethics committee or mediation process may be helpful in resolving disagreements with an agent or representative who refuses to consent to a DNR order.

On the other hand, it is the Medical Society's view that once CPR is initiated, the attending physician should make the medical decision as to when to terminate the effort on the basis that continuation would be futile.

Comfort and other beneficial care

A determination that a patient has an end-stage medical condition does not preclude health care providers from rendering comfort or other beneficial care, unless the patient has specifically directed otherwise in an advance health care directive.

Abuse and other concerns

Health care agents and representatives almost always will protect the interests of the patient and act in accordance with Act 169, in particular its requirements for health care decision-making. However, on rare occasions, health care providers may have concerns.

For example, a physician may be concerned that an agent or representative will not consent to the withholding or withdrawal of life-sustaining treatment even though the physician believes that the patient would not have wanted the care.

A physician also might be concerned that an agent or representative will not consent to comfort or other care that would be beneficial to the patient.

In these situations, an ethics committee or mediation process may be helpful in resolving the disagreement.

Physicians also have some leeway under an immunity protection that applies when the physician ignores the direction of a health care agent or representative due to a good faith belief that the agent or representative is not acting in accordance with the required decision-making process.

However, it generally is prudent to consult legal counsel and the facility's ethics committee before ignoring the direction of a duly authorized health care agent or representative. In some cases, it may be prudent to obtain a court order.

What restrictions apply in special circumstances?

Life-preserving care

As noted, health care representatives may not direct the withholding or withdrawal of care necessary to preserve the patient's life, unless the patient is permanently unconscious or has an end-stage medical condition.

If an incompetent patient neither is permanently unconscious nor has an end-stage medical condition, health care providers must provide life-preserving care, unless the patient refused the care while competent or a duly authorized health care agent refuses the care.

On the other hand, in most situations in which it is appropriate for a health care representative to direct a health care provider to withhold or withdraw life-preserving medical care, the patient will be considered to be permanently unconscious or to have an end-stage medical condition.

For example, consider a patient with Alzheimer's, who develops pneumonia.

- If the patient is in the early stages of the Alzheimer's, the patient may still be competent to decide whether to accept or refuse antibiotics.
- If the patient is not competent to make that decision, the patient's family generally will consent to antibiotics, unless the patient's Alzheimer's is in an advanced stage.
- In the Medical Society's view, advanced Alzheimer's qualifies as an end-stage medical condition, and the patient's physician may follow the directions of a health care representative to withhold or withdraw antibiotics and other life-preserving care when the patient has advanced Alzheimer's.

Note that there is no maximum life-expectancy parameter in the definition of "end-stage medical condition." For example, there is no requirement, as in some states, that the patient be expected to die within six months. The condition need only be in an "advanced" state.

Artificial nutrition and hydration

As noted, Act 169 imposes special rules for nutrition and hydration administered by gastric tube or intravenously or by other artificial or invasive means.

Health care agents and representatives must make decisions regarding artificial nutrition and hydration in accordance with a modified process.

First, it must be assumed as a starting point that the patient would want artificial nutrition and hydration, unless the patient specifically stated otherwise in a written document, such as an advance health care directive.

Second, the presumption in favor of the patient wanting artificial nutrition and hydration may be overcome only if:

- The patient **clearly** expressed wishes to the contrary, or
- It is **clear** from the patient's preferences and values that the patient would not want the artificial nutrition and hydration under the circumstances.

Physicians also should keep in mind that under Act 169, use of the term "life-sustaining treatment" in an advance health care directive does not include artificial nutrition and hydration unless the directive specifically provides that this care is included. (See p. 3 for definition of that term.)

Pregnant women

Act 169 retains provisions in the prior living will law that restrict the withholding and withdrawal of life-sustaining treatment from an incompetent pregnant woman.

It mandates the provision of life-sustaining medical treatment to an incompetent pregnant woman unless the life-sustaining treatment will:

- Not maintain the woman in such a way as to permit the continuing development and live birth of the unborn child,
- Be physically harmful to the woman, or
- Cause pain to the woman that cannot be alleviated by medication.

These determinations must be made to a reasonable degree of medical certainty and certified by the woman's attending physician and an obstetrician who has examined the woman.

The Act requires the state to pay for life-sustaining care provided to a pregnant woman under this provision.

Physicians are not required to perform a pregnancy test, unless the physician has reason to believe that the woman may be pregnant.

Disabled patients

As noted, the prescribed decision-making process incorporates protections for disabled patients.

In addition, the federal Americans with Disabilities Act (ADA) prohibits discrimination against disabled patients by various entities, potentially including hospitals and other health care providers.

The Medical Society believes that compliance with decisions of duly authorized health care agents and representatives, who were directed to follow the Act's prescribed decision-making process, does not constitute discrimination under the ADA.

However, this is an evolving area of the law. Consultation with the facility's ethics committee and legal counsel is prudent when there is a question of potential disability discrimination.

Mental health commitments

Health care agents and representatives (in contrast to mental health agents) cannot consent to a voluntary mental health commitment.

What other decision-makers may make decisions for incompetent patients?

Parents of minor children

Minors generally are considered incompetent to make their own health care decisions and their parents make

their health care decisions. Act 169 does not affect the right of parents to make health care decisions for their minor children who are not emancipated.

Legal guardians

An incompetent patient may have a court-appointed “guardian of the person.” For example, it is not uncommon for a court to appoint the parents of a mentally retarded child as legal guardians when the child reaches majority.

A health care agent appointed by the patient while of sound mind retains authority to make health care decisions for the patient, despite the subsequent appointment of a guardian, unless the appointment is revoked by the guardian or the court.

A guardian of the person has the same authority to revoke or amend the appointment of a health care agent as the patient would have if of sound mind.

However, a guardian of the person may not otherwise revoke or amend instructions in an advance health care directive executed by the patient while of sound mind (e.g., a direction to withhold life-sustaining care when the patient is permanently unconscious or has an end-stage medical condition), unless specifically authorized by the court.

Mental health agents

Another Pennsylvania law provides for the appointment of mental health agents in a mental health power of attorney. The rules regarding the appointment and authority of mental health agents are somewhat different and are outside the scope of this document.

How can physicians help patients understand and use advance health care directives?

Discussions with patients

Physicians should initiate discussions with patients regarding advance health care directives at appropriate times, such as during initial consultations and annual examinations, at diagnosis of a chronic illness, or when a patient transfers from one health care setting to another.

It is especially important for physicians to be available to help patients complete their advance health care directive. Physicians can help explain:

- The meaning of terms such as “end-stage medical condition,” “permanently unconscious,” and “life-sustaining treatment,” and
- The benefits of artificial life support and invasive procedures versus the pain, discomfort, and indignity that they may involve.

Patient brochure

The Pennsylvania Medical Society is in the process of updating our patient advance directive brochure. It will include an explanatory guide and an example advance health care directive.

Patients will be able to download a PDF copy of the Society’s patient advance health care directive brochure at the Society’s patient information Web site, www.myfamilywellness.org.

Additional resources

Pennsylvania Medical Society materials

All educational materials for physicians, plus information available to patients, can be found at www.pamedsoc.org/advancedirectives.

Contents of the law

A copy of Act 169 is available on the General Assembly's Web site as SB 628 (printers no. 2117) at: <http://www2.legis.state.pa.us/WU01/LI/BI/BT/2005/0/SB0628P2117.pdf>.

AMA ethical opinions

E-2.037 Medical Futility in End-of-Life Care

<http://www.ama-assn.org/ama/pub/category/8390.html>

E-2.20 Withdrawing and Withholding Life-Sustaining Medical Treatment

<http://www.ama-assn.org/ama/pub/category/8457.html>

Other Resources Available from the Pennsylvania Medical Society

Practice Transitions: Starting, Stopping and In Between

This publication, available for purchase, covers topics such as qualified retirement plans, estate planning, phasing down and partial retirement, recruiting and hiring a new physician, selling a practice, and the legal, ethical and practical aspects of closing a practice. Included are details on handling patients and medical records along with sample letters.

Medical History Wallet Cards

Help your patients keep track of their medical history by providing them with complimentary medical history wallet cards. By carrying the wallet card with them, patients can easily update their medical history. Medical conditions such as allergies, surgeries, and other facts of their medical history, including medications, can be listed so they have the information readily available for their next check-up or in case of an emergency.

Medical Consent Cards

Recognizing the need to assist parents in preparing for the unpredictable, the Pennsylvania Medical Society has developed a complimentary wallet-sized parental consent card that can be carried easily and accessed by grandparents and other caregivers during an emergency. Parents designate and authorize the child's caregiver to make necessary medical decisions in the event of an emergency during their absence. The card contains an area to complete a medical profile of the child including blood type, allergies, current medications and medical conditions.

HIPAA Resources

As HIPAA implementation evolves, so do our knowledge and services. If you have questions regarding privacy compliance planning, security or assistance with other aspects of HIPAA, the Pennsylvania Medical Society has resources to assist and train staff.

Patient Safety and Risk Management Issues

The Society offers two simple, quick CME newsletters to help physicians communicate better, reduce their liability risk and improve relationships with patients.

*To inquire about any of these services, contact Member Services at (800) 228-7823,
e-mail memberservices@pamedsoc.org, or go to www.pamedsoc.org/store.*

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