This booklet is designed to help you better understand:

A brief history of the legal issues surrounding health care decisions

The kinds of life-support systems currently being used

Your options in determining an appropriate level of care

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This booklet was patterned after the pamphlet Personal Choices distributed by Baylor University Medical Center.
It is the policy of Avera facilities to provide high quality medical care to all patients with the objective of saving and sustaining life. However, this commitment involves recognition that beginning and/or continuing treatment may not be in the patient’s best interest when the burdens of such treatment outweigh the benefits. At these times, the objective is to allow as peaceful a death as possible.

There may come a time when you or a member of your family is seriously injured or becomes gravely ill. In the midst of your stress and grief, you may be asked to make difficult decisions about medical care, such as whether or not life-support systems should be used or withdrawn. While advances in medical technology have saved thousands of lives, sometimes this technology raises more questions than it gives answers and makes decisions about choices of medical care much more difficult. Because of this, it is important that you and your family members learn about the available choices of medical care and discuss the kinds of treatment you would feel comfortable with before the need for such care and treatment arises.

While making these decisions can be difficult, many people can help you. In addition to your doctor, our nurses, pastoral care staff and social service workers are ready to help any person or family with the emotional, moral and ethical concerns that accompany such a decision. We urge you to talk freely to any of these people.
A federal law, The Patient Self-Determination Act of 1990, requires health care providers to advise individuals, as they are admitted to a health care institution or program, of their right to accept or reject medical treatment and their right to make advance directives or written instructions about their choices of treatment in case they should become incapacitated.

In summary, decisions to accept or reject life-sustaining treatments must be made voluntarily by a competent and informed patient, or, if the patient is incapacitated, by another appropriately informed individual acting on the patient’s behalf. This individual could be a family member, legal guardian or a person who has been granted power of attorney by the patient.

It is an excellent idea to tell your family and doctor(s) about your wishes for life-sustaining treatments and choices of care. You also may wish to complete an advance directive, such as a durable power of attorney for health care and/or a living will. The “Ethical and Religious Directives for Catholic Health Care Services” (ERDs), published by the United States Conference of Catholic Bishops, give guidance to Catholic health care providers and facilities in the administration of medical treatment for the benefit and dignity of the patient in keeping with the teachings of the Catholic faith. Information in this pamphlet is consistent with the “Ethical and Religious Directives.” The full text can be found at Avera.org.
What is life-sustaining treatment?
Life-sustaining treatment maintains life when an organ or body system has ceased to function at a level adequate for survival. Life-sustaining technologies include antibiotics and other medications, IVs, machines or medical procedures that can keep a person alive.

An explanation of the most common forms of life-sustaining treatment, how they are used and what they do is included in the glossary at the end of this booklet.

What about pain and suffering?
Regardless of any decision about choice of care or termination of any life-sustaining treatment, the person will continue to receive appropriate medical and nursing care aimed at easing pain and suffering.

What are choices of care?
This is simply a determination of how much the medical team should do to prolong life, in light of expected outcomes. Determining what care to give involves balancing the burdens of a particular therapy against the benefits of that therapy to the patient. For example, if a terminally ill person’s heart should stop (cardiac arrest), should medical personnel attempt to restart it with cardiopulmonary resuscitation (CPR)? When may a critically ill person who is unlikely to recover decide to forgo further aggressive medical care and choose to be kept comfortable?

A competent, informed person working closely with a physician should make these personal choices, or, if the person is incapacitated, by another appropriately informed individual working on the person’s behalf.
What about hydration and nutrition?
Life can be sustained by food and water given through medically assisted methods. In principle, there is a general moral obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This general obligation is based on the fundamental human dignity of all persons, including those in a persistent vegetative state. However, this obligation ceases, and measures become morally optional, when they cannot reasonably be expected to prolong the patient’s life, become excessively burdensome for the patient, or cause significant physical discomfort (for example, medical complications resulting from the use of medically administered nutrition and hydration). For dying patients, medically administered nutrition and hydration may not be of benefit and may, in fact, impose significant burdens.

In such cases, medically administered nutrition and hydration may be withheld or withdrawn.

What is a “No Code” or “Do Not Resuscitate” (DNR) order?
Every person admitted to this facility will receive life-sustaining treatment, including CPR, unless a decision not to code (not to revive from apparent death) has been made. Generally, a “no code” or “DNR” order is made after thoughtful discussion between the physician, a competent person and any others involved in the decision-making process.

If a decision is made that one should not receive life-sustaining treatment and the physician authorizes a “no code” or “DNR” order, it does not mean that all medical and nursing care will be withheld. Supportive care will continue to be provided.
Can someone else make treatment choices for me?

You may select another individual to make health care decisions for you if you are unable to speak for yourself. This designation is made by signing an advance directive, such as a durable power of attorney for health care.

When does care become more of a burden than a benefit?

This is a very complicated question, and it is suggested that a person communicate with physicians, spiritual advisors and others in order to answer it. Each person’s situation must be individually assessed. Issues such as pain, the possibility of success of treatment, financial expense and many others are considered when weighing benefits and burdens.

What is a durable power of attorney for health care?

A durable power of attorney for health care document authorizes another person to make health care decisions for an individual who, temporarily or permanently, can no longer make or communicate such decisions. The term “durable” means that the individual appointed is authorized to make health care decisions on behalf of the person who becomes incapacitated — for example, a person who is in a coma after a car accident.

Without a durable power of attorney for health care, the family member or close friend making the health care decision for you may not be the individual you would select.

For what period of time is a durable power of attorney for health care effective?

A durable power of attorney for health care is effective until revoked or death occurs. At least every two years, the document should be reviewed to ensure that the individual appointed and the health care decisions expressed are still appropriate.
What is a living will?

A living will is a document that specifies a person’s choices of life-sustaining treatment to be received should the need arise.

Unlike a durable power of attorney for health care, a living will normally does not allow for the appointment of an individual to make health care decisions.

Who should be appointed to make your health care decisions?

Think carefully about who will best be able to speak for you on health care matters. For many, this will be a spouse or adult child, but anyone may be appointed, including a friend. Evaluate whether the individual could be available when health care decisions need to be made.

Will this facility always follow directions either specifically stated in the living will or as authorized to be made by the appointed individual under my durable power of attorney for health care?

This facility is a member of Avera, a Catholic health care organization, and has adopted and operates in compliance with the “Ethical and Religious Directives for Catholic Health Care Services” approved by the United States Conference of Catholic Bishops. These directives prohibit certain actions or omissions which are not in keeping with Catholic doctrine. If your request — or that of the individual appointed under a durable power of attorney for health care — would violate one of these directives, then the request would be declined and treatment alternatives discussed. Examples of prohibited interventions include, but are not limited to, euthanasia, abortion and non-medically necessary sterilization. Facilities managed by Avera also comply with the “Ethical and Religious Directives.”
Can the individual appointed make a decision contrary to your express wishes or against medical practice?

No. The individual must follow your express wishes stated in your advance directive and must consider the physician’s recommendations. The decision by the appointed individual must be in accordance with accepted medical practice, and in this facility, with the “Ethical and Religious Directives for Catholic Health Care Services.”

What if I don’t have an advance directive?

If you do not have an advance directive and you become unable to make decisions about your health care, your physician or health care provider will ask your spouse or closest available relative for consent. This informal traditional practice has been enacted into law in some states so that health care providers have specific guidance on which relatives to contact and in what order to contact them.

If relatives are not available to give consent for treatment, such laws normally protect the physician or health care provider in the event treatment is provided. In most non-emergency cases, and all emergency cases, this facility and its medical staff will act with the intention of supporting life.

Conclusion

It is difficult for people to make decisions when under pressure or emotional strain, particularly in areas where sometimes there are no clear-cut answers, such as the use of life-sustaining treatments and determining choices of health care. These issues require a great deal of discussion and careful thought. The information in this booklet has been presented in the hope that you will discuss it with your physician and others and make decisions that are right for you and those you love.
Artificial Ventilation is the mechanical technique of breathing for patients unable to breathe on their own. This requires a tube to be inserted through the nose or the mouth into the trachea (windpipe). The patient will be unable to speak, eat or drink. If artificial ventilation is necessary for more than two weeks, a tracheostomy often is required. A tracheostomy is an incision through the neck into the trachea through which a tube is inserted.

The tube can be used for both artificial ventilation and to suction fluids that might interfere with breathing.

Brain Death is the absence of all brain activity. When this occurs, the patient cannot recover and is considered legally dead, even though other vital organs may continue to function through the use of technology.

Cardiopulmonary Resuscitation (CPR): If a person’s heart stopped beating (cardiac arrest), he or she would die within a few minutes unless immediate action was taken. CPR was developed to help the heart begin to function again. It generally consists of chest compression, artificial ventilation, medication and electrical shocks to the heart.

Hydration and Nutrition:
If a person is unable to take liquid or food by mouth, or unable to digest food properly, he or she may receive fluids and/or nutrition by one or more of the following techniques:

- **Intravenous (IV):** IV solutions are used to provide fluid, vitamins, salts, minerals and medication. A small tube is inserted into a vein in a patient’s arm or hand. The number of calories that a person can receive through this method is not enough to sustain life for long periods of time.

- **Total Parenteral Nutrition (TPN):** TPN is a special IV solution containing enough vitamins, salts, minerals and adequate calories to sustain life. This technique requires a special IV line, different from that described above, and is generally used in situations when a patient is unable to take food by mouth or digest it properly.
• **Tube Feeding**: Liquid food can be given through a variety of tubes inserted into the stomach of a patient capable of digesting food. A nasogastric or feeding tube may be inserted through the patient’s nose into the stomach. If a patient needs to be fed artificially for a long time, a special tube may be surgically inserted into the stomach.

**No Code – Do Not Resuscitate** (DNR) is an order written and signed by the physician instructing staff not to begin CPR or another life-sustaining treatment if the person’s heart or respirations have stopped (cardiac or respiratory arrest). This order is usually written when someone is terminally ill or near death. Only a physician can authorize a no code or DNR order. Before a physician authorizes such an order, he or she will discuss with the patient and/or family the situation and the patient’s condition.

**Supportive Care** takes the form of palliative medicine, hospice care or a combination of both. These services provide comfort in the form of pain and symptom management and support in developing goals and decision-making.

• **Palliative Medicine** is specialized medical care for people with serious, acute or chronic progressive illness that focuses on providing patients with relief from symptoms, pain and stress — whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is often provided by a team of doctors, nurses, social workers, chaplains and/or other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious or chronic illness and can be provided along with curative treatment. Palliative care teams enhance communication, help manage pain and other symptoms, help navigate the health care system, provide guidance with complex treatment choices, offer emotional and spiritual support and assist with the development of advance directives. Palliative medicine is offered in the acute hospital setting or in the outpatient clinic.
• The focus of Hospice Care is on symptom relief and support for patients and their families with a shorter life expectancy due to an acute or chronic disease process. Hospice care offers appropriate medical and nursing care to provide comfort and dignity at the end of life. The use of medications eases pain and other symptoms as well as prolongs life in many cases. Hospice care involves a team-oriented approach to expert medical care, pain management and emotional and spiritual support. The emphasis is on caring, not curing. Hospice care is provided to patients and their families in their homes or in freestanding hospice facilities, hospitals, nursing homes and other long-term-care facilities.

Terminal Illness is the end stage of a disease process, injury or illness that is incurable, irreversible and will result in death within a foreseeable, but uncertain, time period.

A Ventilator is a machine that artificially controls or assists respirations (breathing) when patients are unable to breathe adequately on their own.
Avera, the health ministry of the Benedictine and Presentation Sisters, is a regional partnership of health professionals who share support services to maintain excellent care. Avera owns and manages hospitals, nursing homes, assisted living centers and senior apartment complexes in South Dakota and surrounding areas of Iowa, Minnesota, Nebraska and North Dakota. The Avera Central Office is in Sioux Falls, S.D.

Mission

Avera is a health ministry rooted in the Gospel. Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Vision

Working with its partners, Avera Health shall provide a quality, cost-effective health ministry which reflects Gospel values. We shall improve the health care of the people we serve through a regionally integrated network of persons and institutions.
Today I have life, how long will it last?
The days go so quickly, the months pass so fast.

My death I don’t fear, but how will I die?
Will I recognize loved ones as they bid me good-bye?

Please, let us talk now and make plans that are real, put them in writing so you’ll know how I feel. It’s my life, you know, and I want to make sure if my last illness is serious and there is no cure,

You’ll carry out my wishes, and know in your heart, that I am at peace, and with dignity depart.