

HEALTH CARE “ADVANCE DIRECTIVES” IN INDIANA

“Advance directive” is the general label used by hospitals, doctors, and other health care professionals for any of several kinds of documents that a patient signs, in order to state *in advance* what kinds of care should be given or withheld, and who is authorized to issue instructions, if the patient later becomes seriously ill and unable to issue his or her own instructions.

If an individual suddenly collapses, a bystander properly trained in CPR can supply what the stricken individual needs: mouth-to-mouth resuscitation *only* if the individual is not breathing, and chest compressions *only* if the individual has no carotid pulse. In an analogous fashion, an advance directive speaks for a patient *only* if the patient is unable to give his or her own instructions. A patient who is conscious and able to communicate remains in control of his or her medical treatment; the advance directives signed by him or her will become relevant *only* if the patient loses the ability to give informed consent to treatment.

The Medicaid statute and regulations require every hospital that participates in the Medicare or Medicaid programs to ask every patient, upon admission, whether he or she has a “living will” or other advance directive, or (if the patient has no such document) whether he or she wants to sign one. The law also requires such hospitals to keep a copy of each advance directive as a part of the patient’s record.

Under Indiana law, the following kinds of advance directives can be signed and used:

Letters of Guardianship

A court-appointed “guardian of the person” of an incapacitated patient has authority to authorize or refuse health care for the incapacitated patient and to obtain access to the patient’s medical records and “personal health information.” *Letters of guardianship* are issued by the clerk of the court that appointed the guardian, bear the clerk’s seal, and are official evidence of the guardian’s authority. Any restrictions on the authority of the guardian will be stated on the letters of guardianship.

Health Care Representative Appointment (HCRA)

This document appoints one or more Health Care Representatives and authorizes the Representative(s) to issue instructions or consents to treatment on behalf of the signer, if the signer later becomes unable to give his or her own consents or instructions. Indiana’s health care consent statute (Indiana Code 16-36-1) specifies the general content of the HCRA, which must be signed in the presence of and witnessed by one adult other than the named Representative. Indiana’s HCRA is substantially the same as the “health care power of attorney” or “health care proxy” that is common in other states, but the HCRA does not need to be notarized.

If the HCRA includes an extra paragraph stated in the power of attorney statute, the Health Care Representative will be authorized to refuse or to discontinue life-prolonging procedures, if the signer is not able to make and communicate his or her own decision. If the signer adds another optional paragraph to the HCRA, the signer can *prevent* certain relatives (spouse, adult child, parent, etc.) from making health care decisions for the signer, where those relatives would otherwise be authorized under the statute to make such decisions.

The standard form of HCRA under the statute is intended to be effective only when the signer is incapable of directly consenting to health care, and applies to all kinds of medical treatment, not just in serious, end-of-life situations (terminal illness or persistent coma). The standard HCRA can be modified to be effective upon signing. Under the Indiana statute, a doctor or other health care provider has some leeway to refuse to follow instructions given by a Representative appointed in a HCRA. This problem can be minimized by attaching the HCRA to a Durable Power of Attorney (DPOA) that grants “health care powers” authority to the named Representative.

Health Care Power of Attorney

A separate informational handout on “durable powers of attorney” (DPOAs) is available. The DPOA does not need to be notarized, can be made effective immediately or upon the occurrence of some later event (such as the signer becoming unconscious or incapacitated), and can grant authority to the named Agent (attorney-in-fact) with respect to health care and health care powers.

When the Health Care Representative named in a HCRA is also named as an Agent in a DPOA and given health care powers under the DPOA statute, it will be easier to force doctors and other health care providers to follow instructions given by the Representative/Agent, than if no DPOA had been signed.

Because of the unusual way in which the health care consent statute (In Indiana Code Title 16) and the DPOA statute (in Title 30) were separately amended in 1993 and 1994, the language that authorizes the withholding or discontinuation of life-prolonging procedures is stated in the DPOA statute, not in the HCRA statute. Because of such quirks in the two statutes, a common and recommended practice is to *attach* the signed HCRA to the back of the DPOA whenever both documents are being signed and used.

The Living Will

Unlike the HCRA or the health care power of attorney, the “living will” does not name any individual and give him or her authority to make health care decisions. Instead, the “living will declaration” is a written statement of instructions that should be carried out *IF* the signer becomes terminally ill *AND IF* the terminal condition is certified in writing by a physician *AND IF* the signer is not able (because of coma, heavy sedation, etc.) to issue instructions about giving or withholding life-prolonging treatment.

The Indiana “living will” statute contains official forms for two diametrically opposite documents:

- The “life-prolonging treatment declaration,” which instructs health care providers to start and continue life-prolonging treatment at every turn, even if such treatment merely prolongs the dying process and there is no reasonable prospect of recovery (*very few people sign this type of document*); and
- The “living will declaration, which expresses the signer’s desire and firm intention that he or she be allowed to die naturally, without life-prolonging procedures but with any medication or other procedures necessary to provide “comfort care” and to alleviate pain.

Either type of declaration must substantially follow the official format but can include other provisions that are not inconsistent with the official form. For example, many living wills are drafted so that they apply not only when the physician has certified a terminal illness, but also when the physician certifies that the signer is in a persistent vegetative state (coma) that is irreversible. Under the Indiana living will statute, the signer has three choices available with respect to artificial nutrition and hydration (tube feeding): to refuse it, to request it (even if other life-prolonging procedures are refused), or to make no decision and allow tube feeding to be started or stopped according to the decision of family members or the signer’s Health Care Representative. The living will should indicate which choice has been made by the signer regarding tube feeding.

Every living will declaration must be signed by the signer (declarant) or by someone else at his direction and in the presence of two adult witnesses, neither of whom (1) is a spouse, child, or parent of the signer, (2) could inherit any property from the signer, or (3) is directly financially responsible for the signer’s medical care.

Indiana law allows a living will to be orally revoked, and allows a treating physician considerable latitude in refusing to follow instructions in a living will. Many Catholic hospitals will refuse to follow instructions in a living will in some circumstances and will explain their policy to patients upon admission. Usually, a patient’s family or Health Care Representative can arrange to have the patient transferred to another physician or hospital that will agree to obey the living will.

The Health Care Representative Appointment (HCRA) or health care power of attorney can serve as a useful “backup” for a living will, because it will be harder for a physician to ignore a living will if a Health Care Representative is available to confirm the same instructions.

The Out-of-Hospital DNR Order

A little-used 1999 Indiana statute allows a physician to sign a do-not-resuscitate (DNR) order at the request of a patient, following the signing of a “DNR declaration” by that patient or his or her guardian or Health Care Representative, so that if the patient suffers sudden cardiac or pulmonary arrest *outside a hospital or nursing facility*, emergency medical personnel will refrain from attempting to restart the patient’s heart, etc. The patient who obtains an out-of-hospital DNR order and signs a corresponding DNR declaration usually wears a Medic-Alert-type bracelet or necklace, so that emergency medical technicians on the scene will know that there is a DNR declaration and order in effect. Obviously, such a declaration is useful or advisable only for an individual whose doctor has determined that the individual already suffers from a terminal condition and would not respond favorably to resuscitation if he or she suffered cardiac or pulmonary failure.

The Psychiatric Advance Directive

A 2004 Indiana statute allows any *competent* individual to sign a “psychiatric advance directive” that can specify the individual’s consent to and preferences for or against particular types of mental health treatment or treatment settings, including preferred methods of administering medication, counseling, electroconvulsive therapy, etc. The psychiatric advance directive normally would become effective at some future time when the signing individual became incapacitated and unable to give consent or instructions at that time. The signing and witnessing requirements are the same as for the Health Care Representative Appointment

(HCRA), except that the signer’s treating psychiatrist must countersign the directive, and the directive must list the names, addresses, and telephone numbers of the signer’s treating physician and named health care representative. The new statute and this new type of advance directive are not likely to be useful to large numbers of individuals, and will not be useful at all to an individual who has no history of mental health treatment.

The HIPAA Personal Representative Appointment

Most Americans have heard that under a 1996 federal law (the Health Insurance Portability and Accountability Act or HIPAA), a Privacy Rule went into effect in April 2003. The Privacy Rule confirms that individuals have the right to control the disclosure of their personal health information (PHI), including medical records, and restricts the ability of doctors, hospitals, and other health care providers from making various kinds of disclosures of an individual’s PHI without his or her written consent.

The health care “industry” has been training its nurses, medical records custodians, and other personnel to maintain tighter control over patients’ PHI, in order to prevent unauthorized disclosures that would violate the HIPAA Privacy Rule and trigger potential criminal penalties.

It is not surprising that the HIPAA Privacy Rule has an impact on the ability of all Americans to use health care “advance directives.” For example, if a Hoosier signs a Health Care Representative Appointment (HCRA) and later falls into a coma, it may be vital for the named Health Care Representative to have access to the comatose signer’s medical records.

The HIPAA Privacy Rule is stated in federal regulations and includes the concept of a “personal representative,” which is an individual who is authorized by applicable state law to have access to a patient’s PHI and medical records to the same extent as the patient, and to sign authorizations for the further disclosure of the patient’s PHI and medical records. A “personal representative” for HIPAA Privacy Rule purposes could be —

1. A court-appointed guardian of the person of the patient;
2. After the patient’s death, the court-appointed executor or administrator of the patient’s estate;
3. (According to the consensus of most experts) the Agent or attorney-in-fact named in an immediately-effective power of attorney that confers health care powers; or
4. One or more individuals named as a “personal representative” for HIPAA purposes in a stand-alone document by the patient, with specific reference to the HIPAA Privacy Rule.

The language of the HIPAA Privacy Rule confirms that the specific appointment of a “personal representative” should not be combined with or included in another document. If an individual signs a Durable Power of Attorney that is *not* effective immediately plus a regular Health Care Representative Appointment, it is arguably advisable, and certainly does no harm, for him or her to sign a stand-alone appointment of one or more HIPAA “personal representatives.” This should prevent a Catch-22 situation in which a physician refuses to cooperate in making a determination that a comatose signer is incapacitated (in order to trigger effectiveness of the Durable Power of Attorney) because no one is available to authorize disclosure of the signer’s medical records. Although such a situation is possible under the HIPAA Privacy Rule, it remains unlikely that a physician who knows the patient would refuse to cooperate in providing enough medical

information for a determination of incapacity, even if the patient has not signed a separate HIPAA personal representative appointment.

This summary is intended as general information and not as legal advice to any specific individual.

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