Your Rights To Make Health Care Decisions

A Summary of Connecticut Law

prepared by the Office of the Attorney General
for the Department of Social Services and
Department of Public Health
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Your Rights to Make Health Care Decisions

You have the right to make health care decisions about the medical care you receive. If you do not want certain treatments, you have the right to tell your physician you do not want them and have your wishes followed.

You also have the right to receive information from your physician to assist you in reaching a decision about what medical care is to be provided to you.

There may come a time when you are unable to actively participate in determining your treatment due to serious illness, injury or other disability.

This booklet discusses the options available in Connecticut to help you to provide written instructions to guide your physician, family and others as to what treatment choices you desire to be made if you can not express your wishes. It also shows you how to appoint someone to make decisions on your behalf.

Frequently Asked Questions

Do I have the right to make health care decisions?

Yes. Adult patients in Connecticut have the right to determine what, if any, medical treatment they will receive. If you can understand the nature and consequences of the health care decisions that you are being asked to make, you may agree to treatment that may help you or you may refuse treatment even if the treatment might keep you alive longer.

Do I have the right to information needed to make a health care decision?

Yes. Physicians have the responsibility to provide patients with information that can help them to make a decision. Your physician will explain:

- what treatments may help you;
- how each treatment may affect you, that is, how it can help you and what, if any, serious problems or side effects the treatment is likely to cause;
- what may happen if you decide not to receive treatment.

Your physician may also recommend what, if any, treatment is medically appropriate, but the final decision is yours to make. All of this information is provided so you can exercise your right to decide your treatment wisely.

What is an advance directive?

An advance directive is a legal document through which you may provide your directions or express your preferences concerning your medical care and/or to appoint someone to act on your behalf. Physicians and others use them when you are unable to make or communicate your decisions about your medical treatment.

Advance directives are prepared before any condition or circumstance occurs that causes you to be unable to actively make a decision about your medical care.

In Connecticut, there are two types of advance directives:

- the living will or health care instructions
- the appointment of a health care representative

Must I have an advance directive?

No. You do not have to make a living will or other type of advance directive to receive medical care or to be admitted to a hospital, nursing home or other health care facility. No person can be denied medical care or admission based on whether they have signed a living will or other type of advance directive.

If someone refuses to provide you medical care or admit you unless you sign a living will or other type of advance directive, contact the Department of Public Health in Hartford, Connecticut at 860-509-7400.

What is a living will?

A living will is a document that states your wishes regarding any kind of health care you may receive. Should you be in a terminal condition or permanently unconscious, the living will can also tell your physician whether you want "life support systems" to keep you alive or whether you do not want to receive such treatment, even if the result is your death. A living will goes into effect only when you are unable to make or communicate your decisions about your medical care.

What does terminal condition and permanently unconscious mean?

A patient is in a "terminal condition" when the physician finds that the patient has a condition which is (1) incurable or irreversible and (2) will result in death within a relatively short time if life support systems are not provided. "Permanently unconscious" means a permanent coma or persistent vegetative state where the patient is not aware of himself or his surroundings and is unresponsive.

What is a life support system?

A "life support system" is a form of treatment that only delays the time of your death or maintains you in a state of permanent unconsciousness. Life support systems may include among other things:

- devices such as respirators and dialysis;
- cardiopulmonary resuscitation (CPR);
- food and fluids supplied by artificial means, such as feeding tubes and intravenous fluids.

It does not include

- normal means of eating and drinking, such as eating with assistance of another person or through a straw;
- medications that help manage pain;

Will I receive medication for pain if I have a living will?

Yes. A living will does not affect the requirement that your doctor provide you with pain medication or care designed solely to maintain your physical comfort (for example, care designed to maintain your circulation or the health of your skin and muscles). This type of care must be provided whenever appropriate.

What is a health care representative?

A health care representative is a person whom you authorize in writing to make any and all health care decisions on your behalf including the decision whether to withhold or withdraw life support systems. A health care representative does not act unless you are unable to make or communicate your decisions about your medical care. The health care representative will make decisions on your behalf based on your wishes, as stated in a living will or as otherwise known to your health care representative. In the event your wishes are not clear or a situation arises that you did not anticipate, your health care representative will make a decision in your best interests, based upon what is known of your wishes.

What kind of treatment decisions can be made by a health care representative?

A health care representative can make any and all health care decisions for you, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat any physical or mental condition. The health care representative can also make the decision to provide, withhold or withdraw life support systems. The health care representative cannot make decisions for certain specific treatments which by law have special requirements.

How will my health care representative know when to get involved in making decisions for me?

At any time after you appoint your health care representative, your health care representative can ask your attending physician to provide written notice if your physician finds that you are unable to make or communicate your decisions about your medical care. Even if your health care representative does not do so, your health care providers will usually seek out your health care representative once they determine that you are unable to make or communicate your decisions about your medical care.

What is a conservator?

A "conservator of the person" is someone appointed by the Probate Court when the Court finds that a person is incapable of caring for himself/herself including the inability to make decisions about his or her medical care. A person who is conserved by a court is known as a “ward”.

The conservator of the person is responsible for making sure that the ward’s health and safety needs are taken care of and generally also has the power to give consent for the ward’s medical care, treatment and services.

You can name in advance the person you want the Court to appoint as your conservator if you become incapable of making your own decisions. If you have a conservator, he or she will be consulted in all medical care decisions. If you have a living will, however, the conservator's consent is not required to carry out your wishes as expressed in the living will.

If a conservator is later appointed for you, he or she must follow your health care instructions, either as expressed in a living will, or as otherwise known to your conservator made while you were able to make and communicate health care decisions. Further, a conservator cannot revoke your advance directives without a probate court order.

How are decisions made if I have both a health care representative and a conservator?

Generally, the decision of a health care representative will be followed if the conservator and health care representative disagree unless the probate court orders otherwise. This rule may not apply when the conservator has been appointed in some particular situations.

What advance directives should I have?

If you want to be sure that your wishes about your medical care are known if you cannot express them yourself, you should have a living will and you should

also appoint a health care representative. Each of these advance directives has a special importance.

If you are unable to make or communicate your preferences as to your medical care, your physician will likely look first to your living will as the source of your wishes. Your health care representative can make decisions on your behalf according to what is stated in your living will. In situations that are not addressed by your living will, your health care representative can make a decision in your best interests consistent with what is known of your wishes.

Who can I name as my health care representative or as my conservator?

If you wish to you can name the same person to be your health care representative and to be your conservator. The following persons cannot be named your health care representative:

- your physician;
- if you are a patient at a hospital or nursing home or if you have applied for admission, the operators, administrators, and employees of the facility;
- an administrator or employee of a government agency responsible for paying for your medical care.

Other than these restrictions, you can name anyone you feel is appropriate to serve as your health care representative. Of course, you should speak to the person whom you intend to name and be sure of his or her willingness to serve and to act on your wishes.

Do I need a lawyer to create an advance directive?

No. You do not need a lawyer to create an advance directive. You can use the forms in this booklet.

Do I need a notary to create an advance directive?

Except for optional forms, the forms do not require the use of a notary. An additional optional form called a witnesses' affidavit that is included among the forms in this booklet requires a notary public or a lawyer to verify the signature of the witnesses. This form is discussed in more detail in the next section. If you have legal questions, you should consult a lawyer.

Do I have to sign my advance directives in front of witnesses?

Yes. You must sign the document in the presence of two witnesses in order for the advance directives to be valid. The witnesses then sign the form.

For the living will and the appointment of health care representative, an optional form is provided in this booklet. It is called a witnesses' affidavit. It is the witnesses' sworn statement that they saw you sign the living will or appointment form, that you were of sound mind and it was your free choice to do so. In the event that there is a dispute regarding your living will or appointment of a health care representative, the witnesses' affidavits support its validity. This affidavit requires the use of an attorney or notary public. No other form requires the use of a notary or an attorney.

Who can witness my signature on an advance directive?

In general, Connecticut law does not state who may or may not be a witness to your advance directive. An important exception is that the person who you appoint to be your health care representative or as your conservator cannot be a witness to your signature of the appointment form.

Once I complete an advance directive what should I do?

You should tell the following persons that you have completed an advance directive and give them copies of the directives you have made:

- your physician;
- the person(s) you have named as a health care representative;
- anyone who will make the existence of your advance directives known if you cannot do so yourself, such as family members, close friends, your clergy or lawyer.

You should also bring copies with you when you are admitted to a hospital, nursing home or other health care facility. The copies will be made part of your medical record.

After I complete an advance directive, can I revoke it?

Yes. You can revoke your living will or appointment of a health care representative at any time. A living will can be revoked either orally or in writing. If you sign a new living will, it may revoke any prior living will you made.

However, to revoke your appointment of a health care representative, you must do so in writing that is observed and signed by two witnesses in order for the revocation to be valid.

Remember whenever you revoke an advance directive to tell your physician and others who have copies of your advance directive.

To revoke your designation of a conservator, you can do so either in writing or by making a new designation which states that earlier designations are revoked. It is advisable to put any revocation in writing. However, once a court has appointed a conservator, it cannot be revoked without a court order.

If I already have a living will or appointed someone to make health care decisions, do I need a new one?

No. Connecticut's living will statutes were revised effective October 1, 2006. If your living will and other advance directives, such as a health care agent or power of attorney for health care, were completed prior to this date, they are still valid, although they are slightly different than the new advance directives.

On October 1, 2006, the health care representative replaced the appointment of a health care agent and power of attorney for health care. The health care representative is, in effect, a combination of these two types of advance directives. The new living will makes clear that the living will can be used to provide your instructions regarding any type of health care, not just life support systems.

If I don't have an advance directive, how will my wishes be considered if I am unable to speak for myself?

If you are unable to make and communicate your decision concerning your medical care and you do not have a living will, your physician can consult with other persons to determine what your wishes are regarding the withholding or withdrawal of life support systems. If you have discussed your wishes with your physician, he or she will, of course, know your stated wishes. Your physician may also ask your health care representative, your next of kin or close relatives and your conservator, if one has been appointed, what you have told them about your wishes regarding withholding or withdrawing life support systems. If your wishes are unknown, then decisions will be made based upon what is in your best interests.

It is not recommended that you rely on oral instructions to these individuals to make your wishes known. If there is no living will, such instructions are required to be specific and may need to be proven in a court. You are better advised to complete a living will or appoint a health care representative if you want to be sure that your wishes will be understood and known in the event you are unable to state them yourself.

What is a document of anatomical gift?

It is a document in which you make a gift of all or any part of your body to take effect upon death. Any adult may make an anatomical gift in writing, including through a will, a donor card or by a statement imprinted or attached to a motor

vehicle operator's license. An anatomical gift may be made for the purpose of transplants, therapy, research, medical or dental education, or the advancement of medical or dental science. If you do not limit the gift's purpose to one or some of these uses, the gift can be used for any of these purposes. You may select who receives the gift - a hospital, physician, college, or an organ procurement group. You may also specify that the gift be used for transplant or therapy for a particular person. If no one is named to receive the gift, any hospital may do so.

Can I revoke an anatomical gift?

Yes. An anatomical gift may be revoked or changed only by (1) a signed statement; (2) an oral statement in the presence of two witnesses; (3) or by informing your physician if you are in a terminal condition. An anatomical gift may not be revoked after the donor's death.

What if I have more questions?

If you have additional questions about advance directives, discuss them with your physician and family. A social worker, patient representative or chaplain may be able to assist you, but they cannot provide legal advice. If you have legal questions, you should speak with a lawyer.

ADVANCE DIRECTIVE FORMS

Three sets of forms are contained in this booklet.

1. A **combined advance directive** form includes all of the advance directives- appointment of health care representative, living will, appointment of conservator and organ donation into one form. In the combined form, there is a place where you can choose to not make or use each kind of directive by signing your initials.
2. An **appointment of health care representative** form if you wish to only appoint a health care representative.
3. A **living will or health care instructions** if you wish to only make your wishes known but not appoint anyone to act on your behalf.

Each form includes the optional witness affidavit form.

COMBINED ADVANCE DIRECTIVES

FORM

ADVANCE DIRECTIVES OF _____

To Any Physician Who Is Treating Me, this document contains the following:

1. My Appointment of A Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of Anatomical Gift
4. The Designation of My Conservator Of The Person For My Future Incapacity

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

I choose not to appoint a health care representative, please go to the next page. ____ (Initial here)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

I choose not to provide Health Care Instructions, please go to the next page. _____ (Initial here)

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		_____
Artificial Respiration (including a respirator)		_____
Artificial means of providing nutrition and hydration		_____
_____		_____
_____		_____

Other specific requests: _____
_____
_____
_____
_____
_____
_____
_____
_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

DOCUMENT OF ANATOMICAL GIFT

I make no anatomical gift at this time. _____ (Initial here)

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death _____ (Initial here)

I give: (check one) ____ (1) any needed organs or parts
____ (2) only the following organs or parts:

_____
_____

to be donated for: (check one)
___ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes
___ (2) these limited purposes _____.

DESIGNATION OF A CONSERVATOR OF THE PERSON

I choose not to designate a person to be appointed as my conservator. _____ (Initial here)

If a conservator of my person should need to be appointed, I designate _____, be appointed my conservator.
If this person is unwilling or unable to serve as my conservator of my person, I designate _____ be appointed my conservator.
No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

x_____L.S. Date _____, 20____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____	x_____
(Witness)	(Witness)
x_____	x_____
(Number and Street)	(Number and Street)
x_____	x_____
(City, State and Zip Code)	(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
__
(City, State and Zip Code)
x_____
__

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE FORM

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

LIVING WILL OR HEALTH CARE INSTRUCTIONS FORM

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		_____
Artificial Respiration (including a respirator)		_____
Artificial means of providing nutrition and hydration		_____
_____		_____
_____		_____

Other specific requests: _____
_____
_____
_____
_____
_____
_____
_____
_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this living will or health care instructions by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____