Advance Directives

Living Will and Durable Power of Attorney for Health Care

PROVIDENCE
Health Care

Health Care Directive

Providence Health Care respects the right of individuals to make their wishes known concerning health care. We believe it is important for individuals to discuss their wishes with their physicians, families, close friends, pastors, attorneys or other professionals important to them.

Providence hospitals and care facilities provide high quality health care to all, with respect for the values and dignity of each person. Providence is guided by Catholic ethical principles which call us to respect the sacredness of life and provide compassionate care for the physical, spiritual and emotional needs of the whole person.

Planning Ahead

To make sure your wishes are followed if you become incapacitated, you must plan ahead. This also eases the burden of decision-making that could fall upon your family.

Begin by learning about health care decisions you may face and by clarifying your own thoughts and feelings.

Then decide what kind of care you would want if incapacitated. Under what circumstances would you—or would you not—want your life prolonged? Are there procedures you would want to receive or refuse? Who would you want to make decisions for you? What should they consider in making these choices?

After you decide about treatment, there are several ways to make your preferences known in case you are unable to state them. The most important thing you can do is talk with people who may be making decisions for you. You can state your wishes in writing by creating advance directives such as the Living Will, Durable Power of Attorney for Health Care, an Organ Donor Card and by working with your doctor to complete a Physician Orders for Life-Sustaining Treatment form (POLST).

What are Advance Directives?

Advance Directives are documents that allow you to specify the kind of medical care you wish to receive at the end of your life.

The first type of Advance Directive is called a *Health Care Directive* but is commonly known as a *Living Will*.

The second type of Advance Directive is called a *Durable Power of Attorney for Health Care*.

Your wishes do not necessarily need to be documented in an Advance Directive form. They may be documented by your physician in the medical record.

Health Care Directive (Living Will)

What is a Health Care Directive (Living Will)?

A Health Care Directive (Living Will) is a form you use to explain what you want and/or do not want concerning your medical care. This Directive becomes effective if you have a terminal condition (diagnosed in writing by your attending physician) or are in a permanent unconscious condition (diagnosed in writing by two physicians) and are unable to communicate.

What does "terminal condition" mean?

A terminal condition is an incurable or irreversible condition caused by disease, injury or illness whereby life-sustaining medical procedures would only artificially postpone the moment of death.

If you become incapacitated, your doctor will talk with your family or others, or refer to written instructions you have prepared, to find out what treatment you would want or would be in your best interest.

Does the Health Care Directive (Living Will) need to be notarized?

No. However, to be valid, the document must be signed and dated in the presence of two witnesses who must also sign the document.

Can anyone witness the Health Care Directive (Living Will)?

No. The two witnesses must **not** be:

- related to you by blood, marriage or adoption.
- your physician or an employee of your physician.
- entitled to inherit your property or money if you die.
- an employee of the health care facility where you are a patient or a resident.
- people to whom you owe money.

Is it difficult to make a Health Care Directive (Living Will)?

No. A free copy is provided in this packet. In order to fill out this form, you must be 18 years old or older and be mentally competent. You must also sign this form in the presence of two witnesses. This form gives you a good opportunity to discuss with members of the medical community, your family and friends what you want and do not want when your life nears its end.

I made out a Living Will some time ago in another state. Is it still valid?

Yes. As long as it complies with Washington state law, it remains effective. Make sure you have a copy.

Can I change my mind after I have filled out a Health Care Directive (Living Will)?

Yes. A Health Care Directive (Living Will) can be changed by you at any time. To cancel the Directive, you must inform your attending physician of your intention. In addition to informing your attending physician, you may also cancel the Directive by destroying it or having someone else destroy it in your presence or signing and dating a written cancellation.

Can anyone force me to fill out a Health Care Directive (Living Will)?

No.

Where should I keep my Health Care Directive (Living Will)?

Make several copies of your Health Care Directive (Living Will). Keep one with you at home and distribute a copy to each of the following:

- your physician.
- your health care provider (hospital/nursing home).
- your power of attorney for health care.
- family members and/or trusted friends.

Durable Power of Attorney

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a form you use to name a person (called an agent) who will make medical decisions for you if you become unable to do so. In this document, you also state what type of medical decisions you desire.

Does the Durable Power of Attorney for Health Care need to be notarized?

No. By law, the Durable Power of Attorney for Health Care does not need to be notarized; however, it is strongly recommended.

Is it difficult to make a Durable Power of Attorney for Health Care?

No. A free copy is provided in this packet. In order to fill out this form, you must be 18 years old or older and be mentally competent. It is strongly recommended that you have this document notarized. This form gives you a good opportunity to discuss with members of the medical community, your family and friends what it is that you want and do not want when your life nears its end.

Can I change my mind after I have filled out a Durable Power of Attorney for Health Care?

Yes. A Durable Power of Attorney for Health Care can be changed by you at any time if you are able to do so. To cancel your form, you must notify your attending physician of your intention. Also, you need to notify the person you chose as your agent.

I made out a Durable Power of Attorney for Health Care some time ago in another state. Is it still valid?

Yes. As long as it complies with Washington state law, it remains effective.

Can anyone force me to fill out a Durable Power of Attorney for Health Care?

No.

Where should I keep my Durable Power of Attorney for Health Care?

Make several copies of your Durable Power of Attorney for Health Care. Keep one copy with you at home and distribute a copy to each of the following:

- your physician.
- your health care provider (hospital/nursing home).
- your lawyer (if any).
- your agent and alternate agents for medical care (people you choose to make decisions for you).
- family members and/or trusted friends.

What should I remember when making a Durable Power of Attorney for Health Care?

Choose someone you trust as your agent. You may also wish to choose alternate agents if your primary agent is not available. Make sure to tell that trusted person exactly what you want and do not want concerning your medical care.

Who can be my agent in a Durable Power of Attorney for Health Care?

Your agent must be 18 years old or older and can be a family member, other relative, close friend or some other trusted person.

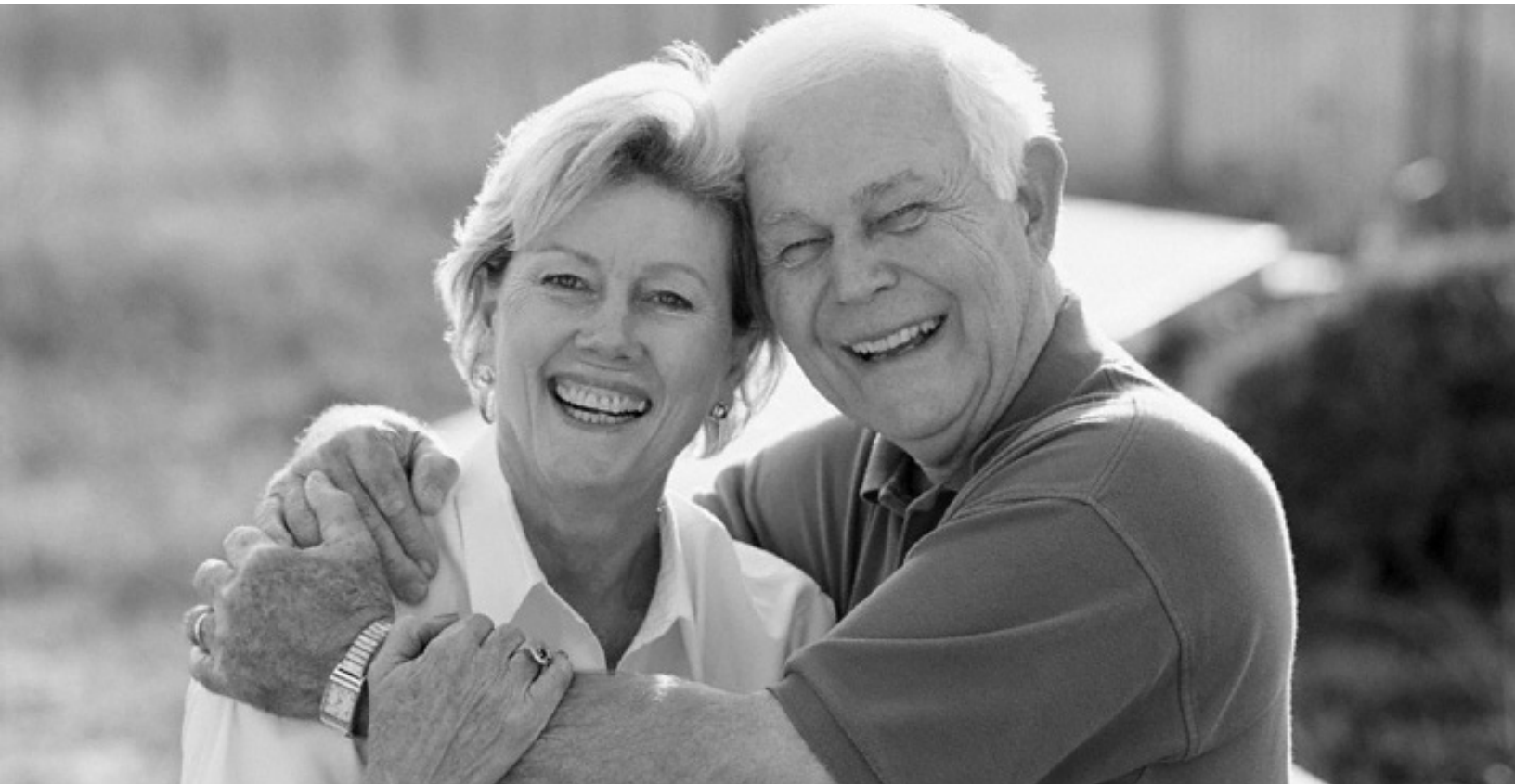
Who can't be my agent in a Durable Power of Attorney for Health Care?

- Your physician or an employee of your physician.
- An administrator, owner or employee of the health care facility where you are a patient or resident. (However, if any of these people are your spouse, adult child, parent, brother or sister, then they may be your agent.)

In the State of Washington is there an order of priority for decision making for an incapacitated patient/resident?

Yes. According to Washington state law on informed consent, the descending order of priority for decision makers for incapacitated patients/residents is:

- a court-appointed guardian of the patient (if any).
- the person (if any) to whom the patient/resident has given Durable Power of Attorney for Health Care.
- the patient's/resident's spouse or legal domestic partner.
- children (at least 18 years old) of the patient/resident, if all agree on a decision.
- parents of the patient/resident, if all agree on a decision.
- adult brothers and sisters of the patient/resident, if all agree on a decision.



Registering for Organ Donation

If you would like to be an organ, eye and tissue donor, it is important to register your decision. In addition, you should also discuss your decision with your family and friends so that they are aware of your decision.

Who can be an organ donor?

People of all ages should consider themselves potential organ and tissue donors. The condition of your organs is more important than age. Doctors will examine your organs and determine whether they are suitable for donation if the situation arises. If you are under 18, you will need the permission of a parent or guardian to donate.

What can be donated?

Organs that can be donated for transplantation include the heart, lungs, kidneys, liver, pancreas and intestine. Tissue that can be donated includes corneas, bone, tendon, skin, veins and heart valves.

How do I register as an organ, eye and tissue donor?

Residents of Washington state can register as an organ, eye and tissue donor by visiting www.lcnw.org and clicking on the Register Now button.

Alternatively you may make your decision known by:

- Saying yes to donation while receiving or renewing your driver's license or state ID card
- Talking to your family and loved one's about your decision to be a donor.

(People who wish to donate their whole body for teaching or research purposes, rather than organ donation and transplantation, must make arrangements in advance with the University of Washington Medical Center. For details call 206-543-1860.)

Physician Orders for Life-Sustaining Treatment (POLST) Form

If you have a serious health condition or expect to receive treatment in a health care facility or nursing home, you need to make decisions about life-sustaining treatment. Your physician can use the POLST form to represent your wishes as clear and specific medical orders.

You and your physician can use the POLST form to help you discuss and develop plans regarding your preference for CPR (cardiopulmonary resuscitation), treatment of certain specific medical conditions, the use of antibiotics and artificially administered fluids and nutrition. You and your physician can complete all of the POLST or only the CPR portion of the form if you prefer.

The POLST form is designed to remain with you whether you are at home, in the ambulance or in a hospital or long-term care facility.

The POLST form must be signed by your physician to be valid. You also sign the form. If you are the designated health care representative for someone who can no longer make their wishes known, the physician can complete the POLST form based on your understanding of your loved one's wishes.

The POLST is not an advance directive and is not used to name an agent to speak for you if you cannot speak for yourself. You will still need an advance directive (Durable Power of Attorney for Health Care) document to name an agent.

The POLST form is designed for those with advanced life-limiting diseases who, in their current condition, know they want or do not want a specific life-prolonging treatment the next time they have a medical emergency.

Values Worksheet

The following are questions to think about as you make decisions and prepare documents for your health care wishes. You may want to write down your answers and give copies to your family and health care providers, or just use the questions for thought and discussion.

(a) How important to you are the following items?	**Very Important →**				**Not Important**
Letting nature take its course	4	3	2	1	0
Preserving my quality of life	4	3	2	1	0
Staying true to my spiritual beliefs and traditions	4	3	2	1	0
Living as long as possible, regardless of quality of life	4	3	2	1	0
Being independent	4	3	2	1	0
Being comfortable and as pain-free as possible	4	3	2	1	0
Leaving good memories for family and friends	4	3	2	1	0
Making a contribution to medical research or teaching	4	3	2	1	0
Being able to relate to family and friends	4	3	2	1	0
Being free of physical limitations	4	3	2	1	0
Being mentally alert and competent	4	3	2	1	0
Being able to leave money to family, friends, charity	4	3	2	1	0
Dying in a short time rather than lingering	4	3	2	1	0
Avoiding expensive care	4	3	2	1	0

(b) What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

(c) How do you feel about using life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness or disability (e.g., Alzheimer's disease)?

Continued on reverse

(d) Do you always want to know the truth about your condition?

(e) Do you have strong feelings about certain medical treatments? Some treatments you might want to decide about include: mechanical breathing (respirator), cardiopulmonary resuscitation (CPR), artificial nutrition and hydration (nutrition and fluid given through a tube in the veins, nose or stomach), antibiotics, kidney dialysis, hospital intensive care, pain-relief drugs, chemo or radiation therapy and surgery.

(f) Would your feelings about these treatments change depending on your health condition and prognosis? Would you want to avoid certain treatments only when death was certain, or also when you would probably be left incapacitated? Would you want to avoid certain treatments if they were used only to prolong the dying process, but accept them if they would help you recover or be more comfortable?

(g) What limitations to your physical and mental health would affect the health care decisions you would make?

(h) Do you want to have finances taken into account when treatment decisions are made?

(i) Do you want to be placed in a nursing home?

(j) Do you want hospice care, with the goal of keeping you comfortable in your home during the end of life, instead of hospitalization?

(k) Do you want to take part in making decisions about your health care and treatment?

(l) Do you want to be an organ donor at the time of your death?

Health Care Directive

Directive made this _____day of _____, in the year 20____ .

I, _____, having the capacity to make health care decisions willfully and voluntarily, make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below. I do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand that a terminal condition means an incurable and irreversible condition caused by injury, disease or illness, that would (within reasonable medical judgment) cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this Health Care Directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a Durable Power of Attorney for Health Care or otherwise, I request that the person be guided by this Health Care Directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

_____ I DO want to have artificially provided nutrition and hydration. _____ Initial

_____ I DO NOT want to have artificially provided nutrition and hydration. _____ Initial

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this Health Care Directive shall have no force or effect during the course of my pregnancy.

(e) I understand the full import of this Health Care Directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

Continued on reverse

(f) I understand that before I sign this Health Care Directive, I can add to or delete from or otherwise change the wording of this Health Care Directive and that I may add to or delete from this Health Care Directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this Health Care Directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of my Health Care Directive be implemented.

Signed: _____

_____

Address

_____

City, County and State of Residence

To Be Read By Witness Before Signing

I am not the attending physician, an employee of the attending physician or health facility in which the declarer is a patient, not related by blood or marriage, or a person who has a claim against any portion of the estate of the declarer upon the declarer's death, at the time of the execution of the directive.

1. Witness: (Print your name)	(Sign your name)
2. Witness: (Print your name)	(Sign your name)

Additional comments, if any:

Durable Power of Attorney for Health Care

Section 1

I,_____of
(address)_____, do hereby designate and appoint
(name)_____ of
(address)_____
(telephone number) (_____)_____ as my attorney-in-fact for health care decisions (hereafter, Agent). I authorize this Agent to make all health care decisions for me as described in this document. By "health care decisions," I intend my Agent to have the authority to consent to giving, withholding or stopping any health care, treatment, service or diagnostic procedure.

Further, my Agent may consent to my admission to a medical, nursing, residential or similar facility and may enter into agreements for my care. My Agent also has the authority to talk with health care personnel, request, receive and review any information, verbal or written, regarding my personal affairs or my personal and mental health, including medical and hospital records, and sign forms necessary to carry out health care decisions.

Section 2

If the person designated as my Agent in Section 1 is unwilling or unable to act as my Agent, or if I revoke that person's authority to act as my Agent, I then designate and appoint, in the order listed below, the following persons to serve as my Agent to make health care decisions for me.
My first alternate Agent is: (name) _____ of
(address) _____
(telephone number) (_____) _____
My second alternate Agent is: (name)_____ of
(address) _____
(telephone number) (_____) _____

Section 3

My Agent shall make decisions consistent with my desires as expressed here.
I confirm the terms of the Health Care Directive that I executed on _____ , 20___ , which records my wish regarding the use of life-sustaining procedures. It is my intent and direction that this Durable Power of Attorney for Health Care be read and implemented in conjunction with the Health Care Directive.

[Please initial any of the following statements that reflect your desires.]

[ ] I want my life to be prolonged and I want life-prolonging treatment to be provided unless, in my Agent's judgment, the pain, discomfort or probable outcomes of the treatment outweigh any benefit the treatment may have for me. _____ Initial

[ ] If I should be in an incurable or irreversible physical condition with no hope of recovery, I do not want any treatment that will merely prolong my dying. Thus, I want my treatment limited to medical and nursing measures that are intended to keep me comfortable, to relieve pain and to maintain my dignity. _____ Initial

[ ] If I am in a coma or vegetative state which my doctors reasonably believe to be permanent, I do not want any life-prolonging treatment to be provided or continued, including but not limited to the placement of a tube to artificially provide food and water to me or the continuation of that treatment if it has already begun.
_____ Initial

By completing this document, I intend to create a Durable Power of Attorney for Health Care under chapter 11.94 of the Revised Code of Washington. It shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity to the extent permitted by law or until I revoke it.

By signing this document, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Health Care.

Dated this _____day of _____ , 20___ .

_____ _____

(Print your name) (Sign your name)

Option #1

NOTARY PUBLIC (preferred but not required):

The laws of the State of Washington shall govern this Power of Attorney.

Dated this _____ day of _____, in the year _____.

On this day personally appeared before me, _____, to me known to be the individual described in and who executed the within and foregoing instrument and acknowledged that he/she signed the same as his/her free and voluntary act and deed for the uses and purposes therein mentioned.

Given under my hand and official seal this _____ day of _____ in the year 20___ .

_____

Notary Public in and for the State of Washington
Residing in Spokane County

My appointment expires: _____

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Additional copies available
online at: www.shmc.org