



BRIGHAM AND
WOMEN'S HOSPITAL



FAULKNER
HOSPITAL

Patient and Family Guide to Advance Directives

Information on Health Care Proxies and Living Wills

Member of the  PARTNERSSM HealthCare System

Introduction

Advances in modern medical care have not only saved lives, but have also improved the quality of life for many people. However, sometimes these advances may not be helpful, or the burdens of treatment may outweigh any potential benefits that might be gained. Thoughtful decision making is needed when considering the many options available to you. The best medical decisions for you involve both expert advice from doctors, nurses and other clinicians, as well as your personal beliefs and values. Communicating those beliefs and values in a situation when you cannot do that for yourself is the purpose of advance care directives - health care proxies and living wills. This brochure provides you with more information about these important documents.

Important Phone Numbers

BWH Main Number	617-732-5500
Care Coordination	617-732-6469
Admitting Office	617-732-7450

Information About Health Care Proxy and Living Will Declaration

Brigham and Women's Hospital recognizes the right of individuals to make decisions about their treatment. The Brigham and Women's Hospital offers every patient a chance to fill out a health care proxy and living will form during their stay. These forms can help insure that your wishes are carried out in the event that you are unable to make or communicate those decisions for yourself. We also provide assistance to patients and families who wish to discuss treatment options at the end of life. Patients and families have told us they have appreciated this opportunity.

There are two forms that insure that your wishes can be carried out if you become unable to make decisions. Ideally, you should complete both forms.

- 1) One is a legal document called a **Health Care Proxy**. In Massachusetts, a Health Care Proxy allows you to appoint someone you trust to make health care decisions for you if you become unable to make or communicate those decisions for yourself. You may complete this document if you are 18 years of age or older.
- 2) The second is a **Living Will Declaration**. This is a written advance directive that allows you to specify your preferences regarding the type of medical care you would want if you become terminally ill or you are not expected to recover from physical or mental disability or disease. It may give general guidelines, such as requesting no life-support if you are terminally ill or specific instructions, such as no breathing tubes. Massachusetts does not have a "living will law" as some states, so a living will may only provide guidance for your agent and health care team under certain circumstances. If you only choose to complete one form, the Health Care Proxy should be chosen.

If you already have a Health Care Proxy or another form of advance directive, make sure to provide copies of these documents to your health care providers. If you do not have these forms completed, we recommend that you do so and discuss your wishes with your doctor and your proxy. You may also wish to appoint an alternate should the first person you choose be unavailable. Be assured that if you choose not to fill out one or both of these forms, BWH's staff is committed to providing all appropriate medical care, pain relief and comfort.

You may revoke or change these documents at any time by filling out another form. We recommend that you talk with your doctor and your health care proxies to be sure they are aware of any changes you want to make. The hospital shall keep these documents in your medical record for future reference.

If you have any questions about any of these documents, bring them to the attention of your doctor or nurse. You can also obtain assistance with these documents from the staff in the Care Coordination Department at 617-732-6469.

Questions and Answers

Why is a Health Care Proxy Necessary?

Health care delivery today is in part directed by choices and values you make as a patient. When you are not able to speak for yourself, your voice in the conversation must be preserved. Appointing a health care proxy (known as your "healthcare agent" under Mass law) to speak for you is the best way to assure that your wishes for treatment choices are maintained.

Who can be a Health Care Proxy?

Your health care proxy should be someone you trust, who knows you well enough to know what treatment decisions you would make for yourself, such as a spouse, family member or friend. You should discuss your wishes with your proxy in advance. (The only restriction is that your proxy cannot be an employee of the health care facility where you are a patient unless that person is a relative.)

What authority does a Health Care Proxy have?

Your health care proxy may act for you only if your doctor determines that you are unable to make or communicate your own health care decisions. Subject to any limitations that you may put in your health care proxy form, your proxy can make any and all health care decisions that you could make. Your agent should make those decisions based on his/her understanding of your wishes (or, if your wishes are not known, on his/her assessment of your best interests.)

When should I complete a Health Care Proxy form?

The best time to think about your wishes and choose a health care proxy is before you become ill, when you can carefully consider your choices. If you have not completed a Health Care Proxy form and you become unable to make or communicate your health care decisions, your family may be asked to make those decisions for you. If you have no family, or if there is disagreement about what treatment you would want, a court may be asked to appoint a guardian to make those decisions on your behalf.

How do I complete a Health Care Proxy?

The process consists of three simple steps:

1. Choose a trusted person to be your proxy.
 2. Talk to him or her about your health care wishes.
 3. Fill out a health care proxy form and give copies to all of your health care providers.
- In completing the form, name the agent you have chosen and have two witnesses sign the form. Anyone may serve as a witness except your health care proxy. You do not need a lawyer to complete the form.

What should I discuss with my Health Care Proxy?

The decisions your health care proxy would want your guidance in making are ones that involve use of resuscitation (CPR), long-term dependence on technology, such as a ventilator (breathing machine), or permanent tubes for feeding, particularly if there is little or no expectation of your recovery.

What do I do with the Health Care Proxy once it is completed?

Make copies of the completed form and give them to your health care proxy, your physician and other health care providers, as well as others who may be involved in making medical decisions for you if you become unable to make those decisions. This may include family members, your clergy or your lawyer. The original document should be kept with your other important papers.

What if I change my mind?

If you decide that you do not want a health care proxy or would like someone else to be your proxy, you may revoke the proxy form by destroying it, signing a new one and notifying all those who have copies. You may also notify orally any health care provider of your decision to revoke your proxy. If your proxy is your spouse and you become legally separated or divorced, your proxy will be automatically revoked unless you indicate otherwise.

How can I get more information?

Additional information can be obtained from the Care Coordination Department at (617) 732-6469, Health Care Proxy forms are available through the Admitting Office at Brigham & Women's Hospital, telephone number (617) 732-7455 or the Care Coordination Department.

Instructions

Please sign the Health Care Proxy form in the presence of two witnesses (persons 18 years of age or older who are not designated as your agent). You do not need a lawyer to fill out these forms. You should keep the original documents with your important, personal papers. Make copies of the form for your doctor, your proxy, and any other close family members or friends as needed.



HEALTH CARE PROXY

I, _____, residing at _____, appoint _____, residing at _____, telephone _____, as my health care agent with the authority to make all health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself. My health care agent shall have the same authority as I would to make these decisions. EXCEPT (LIST THE LIMITATIONS IF ANY, YOU WISH TO PLACE ON THIS AUTHORITY):

I direct my health care agent to make decisions based on his/her assessment of my personal wishes, including those expressed in the living will declaration I have signed. Should my wishes be unknown, my agent shall make decisions based on his/her assessment of my best interests. Photocopies of this proxy form shall have the same force and effect as the original.

If the person I have named is unavailable, unwilling or not competent to serve, I designate the following person as my alternate:

NAME: _____ ADDRESS: _____
 _____ TELEPHONE: _____

Note: Generally, you may not choose as your health care agent an employee or member of the medical staff of Brigham and Women's Hospital, unless you are related to that person by blood, marriage or adoption.

 Patient's Signature

 Date

WITNESS STATEMENT

This form requires two witnesses 18 years of age or older:

We, the undersigned witnesses, each declare that we have witnessed the signing of this document and that the person appears to be at least 18 years of age, of sound mind and under no constraints or undue influence. Neither of us is named as the health care agent or alternate.

Witness One:
 Name (print) _____
 Address: _____
 Date: _____

Witness Two:
 Name (print) _____
 Address: _____
 Date: _____

 (signed)

 (signed)



LIVING WILL DECLARATION

To My Family, Doctors, and All those Concerned with My Care:

I, _____, residing at _____
_____, make this statement to express my wishes
regarding the withholding or withdrawal of life support should a time come when, as determined
by my doctor, I am unable to participate in decisions regarding my health care.

Should a time come when there is no expectation of my recovery from physical or mental dis-
ability or disease, I direct that I be allowed to die with dignity, and that my doctor withhold or
withdraw treatment that merely prolongs life and is unlikely to offer a cure or remission of the
disease. I direct that my treatment be limited to measures that will keep me comfortable and re-
lieve pain.

These directions are made after careful consideration and in accordance with my strong convic-
tions and beliefs. I expect my family, doctor, and others concerned with my care to abide by my
wishes and in doing so, to be free of any legal or moral liability.

Additional

Instructions/ comments: _____

Signature: _____

Date: _____