INFORMATION ABOUT

Washington health care directives (living wills) and **durable powers of attorney for health care**

Who will decide if you can't?

KAISER PERMANENTE®

1437KPCC-11/11-11 0035 9206

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Like many people, you value your independence and ability to make decisions for yourself. No one ever wants to think he or she may someday be unable to make his or her own decisions — especially when it comes to health care. But sometimes medical situations arise that prevent people from communicating their wishes about medical intervention and/or life-prolonging care.

This brochure has been prepared to assist you in making end-of-life decisions. Your decisions can be communicated in written documents called advance directives. Your chosen decision-maker on your advance directive can speak for you if you are ever unable to communicate your medical wishes.

Please review this brochure. We encourage you to talk with your physician about these issues. While advance directives don't require an attorney's involvement, you may want to discuss any legal questions you have with your personal attorney.

Advance planning reduces uncertainty about how you want to be cared for at the end of life. We hope you will discuss your decisions with those closest to you and put your wishes in writing. By making choices in advance, many patients find peace of mind and assurance knowing their desires will be carried out in the event of a medical crisis. Family and friends appreciate the guidance your decisions provide.

Learn more

This is a brief summary of advance directives. If you would like more details, please contact Membership Services or call to speak with a Kaiser Permanente health coach at 503-286-6816 or 1-866-301-3866 (toll free) and select option 2. Health coaches are available to answer your questions about advance directives Monday through Friday, 8 a.m. to 5 p.m.

Health Education Services also offers a two-hour class, "Your Life, Your Choices," free to Kaiser Permanente members and one guest. The class talks about how you can make your wishes known to your family and health care providers when you cannot speak for yourself. To register, call Health Education Services at 503-286-6816 in the Portland area or 1-866-301-3866 (toll free) from all other areas. Representatives are available Monday through Friday, 8 a.m. to 5 p.m.

Washington members are encouraged to also complete the Oregon advance directive in the event that end-of-life care occurs in Oregon.

Important decisions

In Washington state, you have the right to make your own health care decisions. Under the principle of informed consent, your medical care must be explained so you understand it and can make informed decisions. Treatment without consent, however, is allowed and will generally be provided in an emergency unless you indicate otherwise.

It is important to let your physician and loved ones know your wishes for treatment should you ever be near death and unable to express them. Most health facilities assume you want all available medical treatment, including life-sustaining care, unless you direct otherwise. Under Washington state law, a health care directive (also known as a

1437KPCC-11/11-11 0035 9206

living will or directive to physicians) and a durable power of attorney for health care can help convey your wishes for future medical care, including non-treatment. You may choose to use both. If you travel, you may want to take copies of your documents with you, as other states may honor these forms.

If you have a serious health condition, you need to make decisions about life-sustaining treatment. A POLST form (see below) can be used to represent your wishes as clear and specific medical orders. Your physician may use the POLST form to write orders that indicate what types of life-sustaining treatment you want or do not want at the end of life.

Physician orders for life-sustaining treatment (POLST)

The POLST form is intended for any adult, age 18 or older, with serious health conditions.

The POLST form asks for information about:

- Your preferences for resuscitation.
- Medical conditions.
- The use of antibiotics.
- Artificially administered fluids and nutrition.

The POLST form is voluntary and is intended to help you and your physician discuss and develop plans to reflect your wishes; assist physicians, nurses, health care facilities, and emergency personnel in honoring your wishes for life-sustaining treatment; and direct appropriate treatment by emergency medical services personnel. The POLST form will translate your wishes as expressed in your health care directive and/or durable power of attorney into clear and specific medical orders. You can get a POLST form at your physician's office.

Health care directives (living will)

If you had a terminal condition, would you want your life artificially prolonged? A health care directive is a legal document allowing you to answer this question in writing. This directive is used if you have a terminal condition, as certified by your physician, where life-sustaining treatment would only artificially prolong the process of dying. It is also used when two physicians certify that you are in an irreversible coma or other permanent unconscious condition with no reasonable hope of recovery. In either situation, the directive allows treatment to be withheld or withdrawn so that you may die naturally.

You may also direct whether you would want artificially provided nutrition (food) and hydration (water) stopped under these circumstances. In the directive, you can also give further instructions regarding your care. The health care directive must be signed by you and two witnesses who are not related to you and who will not inherit anything from you. You can change or revoke this directive at any time.

The health care directive allows people who clearly do not want their lives artificially prolonged under the stated conditions to make their wishes known.

Membership Services

8 a.m. to 6 p.m.
Monday through Friday

Portland area
503-813-2000

All other areas
1-800-813-2000

TTY
1-800-833-6388

Language
interpretation services
1-800-324-8010

Durable power of attorney for health care

Who would you want making your health care decisions if you were unable? The durable power of attorney for health care is a legal document allowing you to name a person as your health care agent — someone who is authorized to consent to, stop, or refuse most medical treatment for you if a physician determines you cannot make these decisions yourself. The person you choose should be a trusted family member or friend with whom you have discussed your values and medical treatment choices.

Washington state does not require this directive to be notarized or witnessed. Some states do require it to be notarized; you may want to do so in the event you travel out of state. You can change or cancel this directive at any time.

Who can make decisions for me?

If you lose the ability to communicate and make decisions, Washington state law enables the following people, in order of priority, to make health care decisions for you, including withdrawing or withholding care:

1. A guardian with health care decision-making authority, if one has been appointed.
2. The person named in the durable power of attorney with health care decision-making authority.
3. Your spouse.
4. Your adult children.
5. Your parents.
6. Your adult brothers and sisters.

When there is more than one person, such as children, parents, or brothers and sisters, all must agree on the health care decision.

What to do with these forms

The health care directive and durable power of attorney for health care forms included in this brochure become legal documents once they are completely filled out and signed.

Signed copies of the completed directives should be included in your medical record and given to any person to whom you give your durable power of attorney — including any alternates you have named — and to your personal attorney. Originals should be kept by someone you trust and who can obtain them in an emergency.

For further information

You are encouraged to discuss the directives with your physician. An attorney can answer any legal questions you may have about the use and effect of these directives.

For general information about health care directives, call a Kaiser Permanente health coach at 503-286-6816 or 1-866-301-3866 (toll free) and select option 2. Health coaches are available to answer your questions about advance directives Monday through Friday, 8 a.m. to 5 p.m.

1437KPCC-11/11-11 0035 9206

Name ______________________________

Health record number ______________

Health care directive

Directive made this ________ day of ______________, ________.

I, ______________, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

A. If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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 "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.

B. If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

C. If I am diagnosed to be in a terminal or permanent unconscious condition,

   I want ☐ do not want ☐ (*choose one*)

   artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

D. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians, and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

E. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

F. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

G. I make the following additional directives regarding my care:

____

____

____

____

____

____

____

____

Signed ____

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not the attending physician, an employee of the attending physician or health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the directive.

Witness ____

Witness ____

KAISER PERMANENTE®

©2011 Kaiser Foundation Health Plan of the Northwest

Name ____

Health record number ____________________

Durable power of attorney for health care

Notice to person executing this document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your health care agent the power to make MOST health care decisions for you if you lose the capability to make informed health decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific information in this document on the authority of the health care agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the health care agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions for yourself, if you had the capacity to do so. The authority of the health care agent to make health care decisions for you will GENERALLY include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You can limit that right in this document if you choose.
- A health care agent can only act under state law.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the health care agent will have to act consistent with your wishes or, if they are unknown, in your best interest. You may make your wishes known to the health care agent by including them in this document or by making them known in another manner.
- When acting under this document, the health care agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

Creation of durable power of attorney for health care

I intend to create a power of attorney (health care agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious or if I am otherwise temporarily or permanently incapable of making health care decisions. The health care agent's power shall cease if and when I regain my capacity to make health care decisions.

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.
©2011 Kaiser Foundation Health Plan of the Northwest

Designation of health care agent and alternate agents

If my attending physician or his or her designee determines that I am not capable of giving informed

consent to health care, I, ____, designate and appoint:

Name ____

Address ____

City ______________________ State _______ ZIP ____________ Phone ________________________

as my attorney-in-fact (health care agent) by granting him or her the durable power of attorney for health care recognized in RCW 11.94.010 and authorize him or her to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that ____ is unable or unwilling to serve, I grant these powers to:

Name ____

Address ____

City ______________________ State _______ ZIP ____________ Phone ________________________

In the event that both ____________________________ and ____________________________ are unable or unwilling to serve, I grant these powers to:

Name ____

Address ____

City ______________________ State _______ ZIP ____________ Phone ________________________

Your name (print) ____

General statement of authority granted

My health care agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes, but is not limited to, consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any health care directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the health care agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The preceding authorization to make health care decisions does not include the following absent a court order:

1. Therapy or other procedure given for the purpose of inducing convulsion.
2. Surgery solely for the purpose of psychosurgery.
3. Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW.
4. Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

Special provisions

____

____

____

____

____

Dated this ____________ day of ____________, ________.
(year)

GRANTOR (signature) ____________________________

STATE OF WASHINGTON

(COUNTY OF __________________)

I certify that I know or have satisfactory evidence that the GRANTOR, ________________,

signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated this ____________ day of ____________, ________.
(year)

____________________________.

(optional, not required) NOTARY PUBLIC in and for the state of Washington,

residing at ________________________.

My commission expires ____________________.

When you have completed your forms, please mail a copy to
Kaiser Permanente Process Center, Medical Records Department,
Health Care Directive, 10220 SE Sunnyside Road, Clackamas, OR 97015-9734.

Notes

KAISER PERMANENTE®

1437KPCC-11/11-11 0035 9206

©2011 Kaiser Foundation Health Plan of the Northwest