

Making Decisions About Your Health Care

(Information about Durable Power of Attorney for Health Care and Living Wills)



NORTHWEST HOSPITAL
& MEDICAL CENTER

Following guidelines set by federal regulations, we would like to inform you of your right to make personal health care decisions. This may include the right to accept or refuse medical/surgical treatment and the right to formulate advance directives. This booklet has been prepared to help you in this process. If you have already written an Advance Directives Plan, please provide us with a copy to place in your medical chart.

Making Decisions

There are many decisions that you and your family, together with your doctor, must make while you are in the hospital. Some are simple, like choosing your hospital meal, but many are difficult, such as deciding to undergo surgery. Others are even more soul-searching, such as deciding whether or not to receive life-sustaining treatments.

Difficult decisions can arise while you are in the hospital or receiving other health care treatment at home. We hope that this booklet will ensure that your health care is handled in the manner you desire, even if you are unable to communicate at the time the care is required.

Washington State law recognizes the right of all adults to control decisions about their own medical care. By completing “Durable Power of Attorney for Health Care” or “Directive to Physician” forms, you are taking an important step in managing your preferences. These forms are known as Advance Directives.

Asking Questions

It is not unusual to feel uncertain and perhaps frightened when faced with a major illness. You should know as much about your health care as you can. This means asking questions. Your doctor should be the primary source of information since you will be making many of the decisions together. Ask the doctor to explain what you don't understand, or ask the nurses, social workers, therapists and other members of your health care team. They are sources of information about your health care.

What Is Informed Consent?

Upon admission to the hospital, you will be asked to sign an informed consent verifying that you understand and agree to the procedures and/or treatment that is planned for you. The following are some questions you might ask your physician:

1. Why is this necessary?
2. Are there other reasonable alternatives?
3. What should I expect?
4. What are the risks involved?

What Is a Code?

A code (resuscitation) is a set of potentially lifesaving procedures conducted on a person whose heart and/or lungs have suddenly stopped functioning. Current health care practice requires that attempts at resuscitation must be made unless otherwise specified. Calling 911 will activate all resuscitation efforts despite previous decisions, unless you have executed an "Emergency Medical Services--No CPR" form or bracelet. (Contact the State Department of Health at 1-800-458-5281, for more information.)

There are several levels of code status available. There are situations where resuscitation measures may not be appropriate. For example, an individual with a terminal illness may not want a particular procedure performed because it does not enhance his or her quality of life.

These options should be discussed with your physician, other members of the health care team, and your family prior to making a decision.

How Do I Make My Choices Known?

We encourage you to talk with your physician and family about your choices. Open discussion can be an informal way to be certain your wishes are understood. More formally, two documents which can be helpful are:

- A "Durable Power of Attorney for Health Care" which clearly states your wishes and empowers a person of your choice to act on your behalf should you be unable to do so. A simple form of "Durable Power of Attorney for Health Care" has been included in this booklet. Your family attorney can be consulted for more complex forms.
- A "Directive to Physicians," also known as a "living will," will help communicate your wishes and values on this subject and has been included in this booklet. A living will is applicable only when a person is terminally ill.

What Is Hospice?

Hospice is a philosophy of care which helps the terminally ill patient and family live as fully as possible until death. The Hospice Northwest program is comprised of health care professionals and volunteers concerned with helping patients and their families face life-threatening illnesses.

When Are Decisions About Life-Sustaining Measures Needed?

There are situations that occur during a serious illness that may require you or your family to make a decision about continuing life-sustaining measures. In these situations, it is important to review the patient's condition with the physician and other members of the health care team to decide if present therapies will enhance the patient's life.

The laws of Washington State recognize the right of the patient and family to make these choices. Deciding to forego life-sustaining measures does not mean that all health care will stop. All efforts will be made to ensure the patient is comfortable.

What if I Have to Make a Decision for My Loved One?

If you must make a decision for a loved one, the decision should express the patient's own personal ideas or feelings regarding life-sustaining measures. The physician, nurse, social worker, or chaplain can provide you with information and support in making the appropriate decision.

What if I Need Help With Making a Decision?

The physician and other members of the health care team are available to meet with the patient and family to review treatment options and life-sustaining measures. In the event that additional support is necessary in making a decision, the Health Resources Northwest Ethics Committee is available for consultation at (206) 368-1709.

What if I Change My Mind?

It is important to emphasize that a decision may be changed at any time, either verbally or in writing.

What if I Want To Donate Organs?

Some of you may wish to donate organs or tissue at the time of death. In accepting organ and tissue donations, Northwest Hospital considers the patient's personal preferences, religious beliefs, and suitability of the organs or tissue being donated. We encourage you to make your wishes known to your family and caregivers about organ and tissue donation.

DIRECTIVE TO PHYSICIANS/HEALTH CARE DIRECTIVE

(also known as a Living Will)

Adapted from Natural Death Act RCW 70.122.030

Directive made this _____ day of _____, 20_____.

I, _____,

(Print Name)

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, and 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 by using this form 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 in using this form 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 procedures, it is my intention that this 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 or otherwise, I request that the person be guided by this 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.
_____ I DO NOT want to have artificially provided nutrition and hydration.
- (d) 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.
- (e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.
- (f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this 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 directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

THIS DIRECTIVE MUST BE SIGNED IN THE PRESENCE OF TWO QUALIFIED WITNESSES.

(See reverse)

Signed (Declarer) _____

(City, County and State of Residence)

WITNESS* STATEMENT

The Declarer has been personally known to me, and I believe him or her to be capable of making health care decisions. I affirm that the foregoing Directive to Physicians was signed by the Declarer in the presence of two witnesses. I am not related to the Declarer by blood or marriage and would not be entitled to any portion of the estate of the Declarer upon Declarer's decease under any Will of the Declarer or Codicil thereto then existing or, at the time of the Directive, by operation of law then existing. I am not the Declarer's attending physician, an employee of the attending physician or a health facility in which the Declarer is a patient, nor do I have a claim against any portion of the estate of the Declarer upon Declarer's decease at the time of the execution of the Directive.

Witness_____

Witness_____

(Print Name)

(Print Name)

(Address)

(Address)

(City, State, Zip)

(City, State, Zip)

****Witnesses can not be related to the declarer by blood or marriage,
or an employee of the health care team.***

DISTRIBUTION

Suggested distribution of this document:

1. Original in the Declarer's files, easily accessible to others in the event of the Declarer's illness.
2. A copy to the Declarer's physician, to be kept in the Declarer's medical record.
3. A copy to a family member or close friend who would be involved in the event of the Declarer's terminal illness.

REVOCAION

This Directive to Physicians may be revoked at any time by the Declarer by any of the following methods:

- A. By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the Declarer or by some person in Declarer's presence and by Declarer's direction.
- B. By a written revocation of the Declarer expressing Declarer's intent to revoke, signed and dated by the Declarer. Such revocation shall become effective only upon communication to the attending physician by the Declarer or by a person acting on behalf of the Declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.
- C. By a verbal expression by the Declarer of Declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the Declarer or by a person acting on behalf of the Declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____

(Declarer)

a resident of the State of Washington, designate and appoint

(Agent)

as my attorney-in-fact and agent, with powers to act for me in accordance with the terms and conditions of this instrument (hereinafter "My Attorney-in-Fact").

1. Effectiveness; Duration. This power of attorney shall be effective immediately, shall not be affected by any incapacity, disability or incompetence that may befall me or by any uncertainty as to whether I am dead or alive, and shall continue in full force and effect until revoked or terminated by operation of law or in accordance with this instrument. It shall be valid and effective in any jurisdiction in which it is presented. I revoke any prior Power of Attorney for health care.
2. Powers. My Attorney-in-Fact shall have all powers with respect to my person that I would have if alive and fully competent, except as limited by the operation of law or by the terms of this instrument. These powers shall include, without limitation, the power:
 - To make all of my health care decisions to the full extent allowed by the law in effect at the time of the decision; to provide informed consent for all such decisions; to select a hospital, nursing home, and other health care facility or hospice; to decide methods of treatment; to employ and discharge physicians and other health care personnel; to consent or refuse diagnostic or medical treatment for any physical or mental condition; to receive, review and consent to the release of medical information and records; and to authorize the withholding or withdrawal of life-sustaining nutrition, hydration, cardiopulmonary resuscitation and dialysis, to the full extent allowed by the law in effect at the time of the decision.

3. Revocation and Termination. The powers granted in this instrument may be revoked or terminated in whole or in part at any time:
- (a) by me with written notice to my Attorney-in-Fact;
 - (b) by a court-appointed guardian acting under such authority as may be granted under applicable law or by an order of the court;
 - (c) by an order of a court with jurisdiction.

SIGNATURE OF PRINCIPAL

I am fully informed as to all the contents of the Durable Powers of Attorney for Health Care and understand the full import of this grant of power to my agent(s). I further declare that I am emotionally and mentally competent to make this Durable Power of Attorney for Health Care.

DATED this ____ day of _____, 20_____.

(Signature of Principal)

WITNESS* STATEMENT

I declare under penalty of perjury under the laws of the state of Washington that the person who signed this document is personally known to me to be the Principal; that the Principal signed this document in my presence or directed another person to sign this document on his behalf in my presence of the other witness; and/or that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

(Signature)

(Signature)

(Print Name)

(Print Name)

****Witnesses can not be related to the declarer by blood or marriage, or an employee of the health care team.***



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