



# Starting Points:

*Your Guide to Advance Directives*

- Values Statements
- Healthcare Directives
- Durable Power of Attorney for Healthcare







Advances in medicine are helping people to live longer than ever before. Medical care can also ask for patients and families to make complicated decisions. Your family members often do not know what medical care you want when facing serious illness or the end of life. One way you can start the discussion is by using a document – a Values Statement, a Healthcare Directive or a Durable Power of Attorney for Healthcare – as a ...

# Starting Point

This booklet can help you think about your choices and find ways to express your wishes to your loved ones and your doctors.

## **The Law and Your Rights as a Patient**

Federal law (the Patient Self-Determination Act) requires Overlake Medical Center to inform patients of their rights in making healthcare decisions. As a patient, you have the right to:

- receive or refuse care
- document these wishes as Healthcare Directives

Your healthcare team needs to know your wishes about your care. If you are not able to communicate, or if you are not capable of making decisions, you will need someone to make those decisions for you. According to Washington State's Informed Consent Law, doctors must turn to the following people, in this order:

1. Your guardian with healthcare authority; if none, then
2. Your Durable Power of Attorney for Healthcare; if none, then
3. Your spouse or Registered Domestic Partner; if none, then
4. Your adult children, all in agreement; if none, then
5. Your parents, both in agreement; if none, then
6. Your adult siblings, all in agreement; if none, a guardian may be necessary.

# Advance Directives

Advance Directives are records that document your wishes about your healthcare. They also name the person who will make your healthcare decisions if you cannot.

- A Values Statement is a guide for discussion of medical treatment and end-of-life decisions.
- A Healthcare Directive is a document that indicates your treatment preferences should you become unable to communicate.
- A Durable Power of Attorney for Healthcare is a legally enforceable statement of your wishes.

You are not required to create an advance directive. However, these documents can help the healthcare team and the person making the decisions for your healthcare understand your wishes. When your doctor and loved ones know and understand your wishes clearly, you can feel comfortable that they will be carried out.

The most important thing you can do is appoint a durable power of attorney for healthcare. Choose someone who understands and will honor your wishes. If you cannot make decisions for yourself, the legal decision maker (appointed by you or according to the Washington State Informed Consent Law) will decide for you.

## Values Statement

A Values Statement describes your views on healthcare and end-of-life issues. If you cannot speak for yourself, the Values Statement helps others know your wishes.

Values Statements are not legal documents. People often attach a Values Statement to their Healthcare Directive to provide a more complete picture of their wishes. Some of the issues in the Values Statement may be important to you, while others may not. Either way, share your thoughts with your loved ones either aloud or in writing to help them understand your choices.

*A Values Statement is a guide for discussion of medical treatment and end-of-life decisions.*

## Healthcare Directive

In the state of Washington, a Healthcare Directive tells your doctor what your wishes are regarding the care you receive at the end of life. This directive is only used if you have a serious condition where treatment would only prolong the process of dying, or if you are permanently unconscious with no reasonable hope of recovery.

Your Healthcare Directive must be completed and signed by you while you are mentally capable of making healthcare decisions. You may alter or withdraw it verbally or in writing at any time.

A Healthcare Directive that is valid in the state of Washington is in the back of this booklet. Once you have filled out a Healthcare Directive, give copies to your loved ones and doctor for their records. Let them know if you change or withdraw your Healthcare Directive.



***A Healthcare Directive is a document that indicates your treatment preferences should you become unable to communicate.***

## Durable Power of Attorney for Healthcare

A Durable Power of Attorney for Healthcare goes further than a Healthcare Directive. It allows you to name someone (an “agent”) to make healthcare decisions for you when you are not capable of making them for yourself.

It covers a broader range of healthcare issues, not just those that arise if you have a terminal condition or are permanently unconscious. For example, it could be used if you were temporarily disabled due to a stroke. A Durable Power of Attorney for Healthcare applies only to healthcare decisions and cannot be used to deal with your financial affairs or other matters. For financial or other areas, you need to talk with an estate-planning attorney.

You may use a Durable Power of Attorney for Healthcare instead of, or in addition to, a Healthcare Directive. You may find it especially useful if you 1) have no living relatives, 2) you want someone other than your family members to make your important healthcare decisions or 3) think your relatives may disagree about the kind of care you should receive.

***A Power of Attorney for Healthcare designates an agent who can make healthcare decisions for you when you can no longer express yourself.***

***Bring copies of your Healthcare Directives any time you are hospitalized.***

*If your ability to communicate returns, your verbal instructions always supersede your written instructions or any decisions made by your “agent.”*

The Durable Power of Attorney for Healthcare is a recognized legal document. You may alter or withdraw it verbally or in writing at any time. Let your appointed agent know if you make changes.

Make sure that the agent you choose understands and is comfortable with your choices. It is a good idea to list one or two other decision-makers in case your primary agent is unavailable when needed. The state of Washington does not have a specific Healthcare Power of Attorney form. We have included a sample form for you in this booklet. Overlake Medical Center conforms to the Washington State Natural Death Act. For more information, ask to speak to a social worker.

## **POLST Form**

### **Physician Orders for Life-Sustaining Treatment (POLST)**

Your physician (doctor) can use the POLST form to translate your wishes into specific physician orders indicating what types of life-sustaining treatment you want or do not want.

The POLST form is voluntary and is intended to:

- help you and your doctor talk about and make a plan to reflect your wishes;
- help doctors, nurses, healthcare facilities and emergency personnel to honor your wishes for life-sustaining treatment;
- be moveable from one care setting to another;
- guide treatment by Emergency Medical Services personnel.

The POLST form is intended for any adult, 18 years or older, with serious health conditions, or who may expect to receive healthcare outside of the hospital.

### **How do I obtain a copy of the POLST form?**

Ask your doctor. If your doctor is not aware of a POLST, or needs more information, have them contact the Washington State Medical Association at 206-441-9762 or toll free at 800-552-0612 or e-mail: [gfs@wsma.org](mailto:gfs@wsma.org). A doctor must sign the bright green form as a physician order so it can be understood and followed by other healthcare professionals.

*The POLST form enables you to state what type of life-sustaining treatments you want - or don't want - at the end of life.*

# Organ and Tissue Donation

Organ transplants save lives, but there are far more people who need transplants than there are organs available. Organ and tissue donation is a deeply personal issue. No matter what you and your family decide, the hospital staff supports your decision.

You may register your desire to be a tissue or organ donor through the Living Legacy Registry. This registry was created through legislation in 2003, to enable the public to make informed choices about donation, as well as to record your personal decision.

For further information about organ and tissue donation, call Life Center Northwest at 1-877-275-5269.

## What if I change my mind?

You can cancel (revoke) your Healthcare Directive by:

- destroying it or having someone destroy it in your presence; or
- signing and dating a written statement that you are canceling the Healthcare Directive; or
- verbally telling your doctor, or instructing someone to tell your doctor, that you are canceling it.

**You, or someone you have instructed, must tell your attending doctor before cancellation is effective.**

## What if I get better?

If your ability to communicate returns, your verbal instructions always take the place of your written instructions or any decisions made by your “agent.”





# Durable Power of Attorney for Healthcare

## Notice to the 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 Healthcare Agent the power to make MOST healthcare decisions for you if you lose the capacity to make informed healthcare decisions for yourself. This power is effective only when you lose the capacity to make informed healthcare decisions for yourself. As long as you have the capacity to make informed healthcare decisions for yourself, you retain the right to make all medical and other healthcare decisions.*
- You may include specific limitations in this document on the authority of the Healthcare Agent to make your healthcare 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 healthcare matter, the Healthcare Agent GENERALLY will be authorized by this document to make healthcare decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Healthcare Agent to make healthcare decisions for you GENERALLY will 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.*
- When exercising his or her authority to make healthcare decisions for you, the Healthcare Agent will have to act consistently with your express desires or, if they are unknown, in your best interest. You may express your desires to the Healthcare Agent by including them in this document or by making them known in another manner.*
- When acting under this document, the Healthcare Agent GENERALLY will have the same rights that you have to receive information about proposed healthcare, to review healthcare records and to consent to the disclosure of healthcare records. You can limit that right in this document, if you choose.*

I, \_\_\_\_\_, the undersigned individual, herein referred to as Principal, a resident of the state of Washington, hereby designated and appoint \_\_\_\_\_, hereinafter referred to as Healthcare Agent, as my attorney in fact for healthcare decisions as authorized by the laws of the state of Washington.

## 1. Creation of Durable Power of Attorney for Healthcare

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

## 2. Designation of Healthcare Agent and Alternate Agents

As attorney-in-fact (Healthcare Agent) by granting him or her the Durable Power of Attorney for Healthcare 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.

If my attending physician or his or her designee determines that I am incapable of giving informed consent to healthcare, I designate and appoint:

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

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

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

### Authority Granted to Healthcare Agent

While this Power of Attorney is in effect, my Healthcare Agent may consent to healthcare treatment for me. This includes, but may not be limited to, decisions to begin, continue, discontinue or forego medical treatment, including artificially supplied nutrition and hydration.

## Limitations on Authority of Healthcare Agent

- A. If I have provided instructions or stated my desires regarding medical treatment, my Healthcare Agent shall follow and interpret my instructions and stated desires. This includes any instructions or stated desires regarding the provision, withholding or withdrawing of life-sustaining treatment contained in this document, in a Healthcare Directive or elsewhere. If my Healthcare Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making healthcare decisions.
- B. My Healthcare Agent may not consent to the following treatment without a court order:
1. Therapy or other procedures 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 RCW Chapter 71.05
  4. Sterilization
  5. Special Provisions \_\_\_\_\_
- \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_

GRANTOR \_\_\_\_\_ State of Washington, County of \_\_\_\_\_

**Note: 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.**

I certify that I know or have satisfactory evidence that GRANTOR, \_\_\_\_\_, signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in this instrument. Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_.

I have personally known the declarer and I believe him or her to be capable of making healthcare decisions.

Witness _____	Witness _____
Address _____	Address _____
City _____	City _____
State _____	State _____
Zip _____	Zip _____



# Healthcare Directive

*According to Washington State law, a healthcare directive may be in the following form, but in addition, may include other specific directions.*

Directive made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

I, \_\_\_\_\_, having the capacity to make healthcare 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 that by using this form, 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 a reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

- B. In absence of my ability to give directions regarding the use of such life-sustaining treatment, 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 and 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.

☐ **I DO** want hydration but **I DO NOT WANT** artificially provided nutrition.

☐ Other: \_\_\_\_\_



- 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 healthcare 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 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.

Signature X \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_, Washington

**Note: Washington state does not require this directive to be notarized. 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.**

I have personally known the declarer and I believe him or her to be capable of making healthcare decisions.

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

# Values Statement

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Think about the issues listed below. Answer the questions that are important to you. Make copies of your responses to give your family members, close friends, physicians, and others who may need to know.

## Your Health

- How do you feel about your current health? \_\_\_\_\_
- If you have any medical problems, do they affect your ability to function? \_\_\_\_\_
- If yes, how? \_\_\_\_\_

## Your Independence

- Do you consider yourself an independent person? \_\_\_\_\_
- If you became less independent than you currently are, how would that affect how you look at your life? \_\_\_\_\_
- Do you like to make your own decisions? \_\_\_\_\_
- If you couldn't make your own decisions, would you let others make them for you? \_\_\_\_\_
- How would you feel about a permanent stay in a long-term facility? \_\_\_\_\_

## Your Life

- What activities do you enjoy (for example, hobbies, sports, reading, etc.)? \_\_\_\_\_
- Are you happy to be alive? \_\_\_\_\_
- What makes you laugh? \_\_\_\_\_
- What makes you cry? \_\_\_\_\_
- What do you fear most? \_\_\_\_\_
- What upsets you? \_\_\_\_\_
- What goals do you have for the future? \_\_\_\_\_

## Your Finances

- Is leaving a financial legacy something you feel strongly about? \_\_\_\_\_
- Is there someone assigned to handle your finances if you become unable to make decisions? \_\_\_\_\_ If so, who? \_\_\_\_\_

## Illness, Death and Dying

- Has anyone close to you died? \_\_\_\_\_
- What does death mean to you? \_\_\_\_\_
- What would you fear the most about a terminal illness (an illness where death is certain)? \_\_\_\_\_

- If you were to die very soon, are there any important unresolved matters you would want to resolve today? \_\_\_\_ If yes, what are they? \_\_\_\_\_
- How do you feel about using life-sustaining treatment in the face of: terminal illness? Permanent coma? Irreversible progressive chronic illness (Alzheimer's Disease, for example) \_\_\_\_\_
- What will be important to you when you are dying (physical comfort, having family there, and so on)? \_\_\_\_\_

### People Involved in Decision Making

- Name family or friends you have discussed your feelings about death and dying with:  
 Name \_\_\_\_\_ Name \_\_\_\_\_  
 Phone \_\_\_\_\_ Phone \_\_\_\_\_  
 Relationship \_\_\_\_\_ Relationship \_\_\_\_\_
- Would you always want to know the truth about your condition? \_\_\_\_\_
- Do you wish to participate in making decisions about healthcare and treatment? \_\_\_\_\_

Have you made arrangements for family or friends to make medical decisions on your behalf, i.e., Durable Power of Attorney for Healthcare? \_\_\_\_ If so, who has agreed to make decisions for you and under what circumstances? \_\_\_\_\_

First Choice: **Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City/State/Zip Code** \_\_\_\_\_  
**Phone** \_\_\_\_\_

If the above person is unable, unavailable, or unwilling to serve, I designate:

Second Choice: **Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
**Address** \_\_\_\_\_  
**City/State/Zip Code** \_\_\_\_\_  
**Phone** \_\_\_\_\_

Where are your Healthcare Directives kept? \_\_\_\_\_

Who else has a copy of your documents?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

# TERMINOLOGY

## ***Artificial Nutrition and Hydration***

Supplying food and fluids through a tube or intravenous catheter, where the patient is not required to chew or swallow voluntarily. Artificial nutrition and hydration does not include assisted feeding such as spoon- or bottle-feeding.

## ***Care Management***

Care Management is available to inpatients.

- Social Workers are available to assist you with post-hospital transitions to skilled nursing facilities, home health agencies, hospice or other services.
- Case Managers work with your health insurance provider to assure medically necessary care is covered.

## ***CPR (Cardiopulmonary Resuscitation)***

A process that keeps blood circulating and puts oxygen in the lungs by manually compressing the chest and using mouth-to-mouth or bag mask respirations when the heart has stopped and a person is no longer breathing. This is a temporary intervention until more advanced procedures are available. The survival rate of this varies based on the reason the heart stopped and other chronic illness the person may have.

## ***Palliative Care***

Palliative care is specialized medical care for people with serious illnesses. Care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

## ***Pastoral Care***

Pastoral Care attends to and cares for that which gives a person meaning, value, purpose and worth in life. This includes but is not limited to religious belief systems. Hospital chaplains are available to meet with patients and families of any tradition or moral code.

## LET US HELP

If you have questions or concerns, consult your physician or a member of your healthcare team.

**For More Information:** Care Management: **425.688.5261**  
Chaplain: **425.688.5127**

**Additional Resources:** Washington State Medical Association at **800.552.0612** or [wsma.org/advance-directives](http://wsma.org/advance-directives)  
Coalition for Compassionate Care of California, [prepareforyourcare.org](http://prepareforyourcare.org)  
The Conversation Project, [theconversationproject.org](http://theconversationproject.org)

# Notes



***For more information,  
talk to your doctor or nurse.***

# Starting Points



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