

Your Life, Your Decisions
Advance Directives



This document is also available in Russian, Spanish, Vietnamese, Korean and Chinese.

Данная брошюра имеется также в переводе на испанский, вьетнамский, китайский, русский и корейский языки.

Este documento también está disponible en español, vietnamita, cantonés, ruso y coreano.

Tài liệu này cũng có sẵn bằng tiếng Tây Ban Nha, Việt Nam, Quảng Đông, Nga và Đại Hàn.

본 책자는 스페인어, 베트남어, 광둥어, 러시아어, 한국어로도 나와 있습니다.

本文件亦提供西班牙文、越南文、粵語、俄文和韓文版本。

Information About Advance Directives

Have you thought about what kind of health care you would want to receive if you became very ill or hurt? If you were no longer able to express your wishes, would your doctor and family know what you would want?

This booklet was designed to help you think about these questions.

Washington state law supports your right to make decisions about your health care. You can express your decisions about the kind of care you wish to receive through Advance Directives.



What are Advance Directives?

Formal Advance Directives are papers written before a serious illness that state your choices for health care (Health-Care Directive), or name someone to make those choices (Durable Power of Attorney for Health Care), if you become unable to make decisions. Through Advance Directives, you can make legally valid decisions about your future medical care.

Another important way to make your wishes known is to talk to your family and your physician about what you want.

Directive to Physicians

What is a Health-Care Directive?

A Health-Care Directive (Living Will) is a document in which you can tell your doctor when to stop life-sustaining treatments and let you die naturally. A Health-Care Directive is used when you can no longer make your own decisions, when you are terminally ill with no hope of recovery, and when the use of life-sustaining treatments would only prolong the process of dying. Health-Care Directives are authorized by Washington state law.

How do I prepare a Health-Care Directive?

1. Review a Health-Care Directive form (located in the back of this booklet). If you have any questions, discuss them with your family, doctor, clergy or lawyer. Think about any special instructions that you wish to include. Write or type these instructions and attach them to the form.
2. Sign the Health-Care Directive in front of two witnesses who are not related to you and are not potential heirs. Your doctor, the doctor's employees and employees of your hospital or nursing home cannot be witnesses.
3. Make copies of your Health-Care Directive for yourself, close family members and your lawyer, if you have one. Give your original Health-Care Directive to your doctor. The directive needs to be in the medical record kept by your doctor to make sure your wishes are followed.



Organ and Tissue Donation

If you wish to be an organ and/or tissue donor, you can state this desire in your health-care directive. You can register with the region's federally-designated organ donation organization, LifeCenter Northwest Organ Donation Network, at www.lcnw.org or 1-877-275-5269. You can also register as a donor at the Department of Motor Vehicles when you apply for or renew your driver's license. A symbol of your donor status will appear on your license. Registration means you have chosen to have the organs and tissues you designate made available for transplant, research or both, to help others at the time of your death. If you are registered as a donor, no further consent is needed to move forward with donation.

Whether or not you are a donor, it is important to talk to your family about your decision. With no directive or registry record, your family may be asked to make a decision on your behalf. To ensure your wishes are carried out, it is important to clearly share your decision with your family, so they can support it at the time of death.

Durable Power of Attorney for Health Care

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a paper in which you name another person to make medical decisions for you anytime you are unable to make them for yourself. You can include instructions about any treatment you want or do not want, such as surgery, artificial nutrition and hydration (such as fluids or medicine). You can draw up a Durable Power of Attorney for Health Care with or without the advice of a lawyer. Your representative should understand and respect your health-care wishes.

How do I prepare a Durable Power of Attorney for Health Care?

1. Review a Durable Power of Attorney for Health Care form (located in the back of this booklet). Think about whether you wish to change the form. Think about any special instructions you wish to include to limit or guide your representative. Write or type these instructions and attach them to the form.
2. Select the person who you want to act as your representative. Obtain his or her consent to be your Durable Power of Attorney for Health Care. Tell him or her as directly as possible the kinds of decisions you want made on your behalf.
3. Sign and date the form.
4. Make copies of your Durable Power of Attorney for Health Care for yourself, your representative, close family members and your lawyer, if you have one. Give your original Durable Power of Attorney for Health Care to your doctor. The Durable Power of Attorney for Health Care needs to be in the medical record kept by your doctor to ensure your wishes are followed.

What if I don't have an Advance Directive?

The decision to have written directives is a very personal one. The best way to make your wishes known is to put them in writing. Some people find it comforting to have written directives. They feel it eases the load of decision making for family and friends.

Who makes health-care decisions for me if I can't?

Washington state law sets the following order of priority for people to make decisions on your behalf if you cannot make decisions for yourself:

1. Your guardian, if one has been appointed
2. The person named in your Durable Power of Attorney for Health Care
3. Your spouse/registered domestic partner
4. Your adult children
5. Your parents
6. Your adult brothers and/or sisters

The person chosen to make decisions on your behalf is responsible by state law to follow your wishes as stated in your directives.

Can I change my Advance Directives?

Yes, you may change or cancel a Health-Care Directive or Durable Power of Attorney for Health Care at any time. You may do this by destroying the document, putting your change in writing, or telling your doctor, nurse and family about the change. If you change your directive, you should give new copies to your family, doctor, lawyer, or others who may be involved. Your doctor must know about the change or it will not be effective.

What if there is a disagreement about my Advance Directives?

Your doctor and the hospital will honor Advance Directives that meet the requirements of Washington state law and standards of medical ethics. If a hospital or doctor cannot honor an Advance Directive, they are required by law to make an effort to transfer you to a doctor or hospital that will.

What are life-sustaining treatments?

There are several life-sustaining treatments and medical interventions that can lengthen a person's life, delaying the moment of death. We would like you to consider these and discuss your choices with your family, friends and doctor. It is important your wishes be known in case you are unable to speak for yourself.

Life-sustaining treatments do not include procedures or medicine given to relieve pain. A decision to forego life-sustaining treatment will in no way affect the care you are given to provide comfort and reduce pain. *Supportive care given for comfort and pain relief will always be provided.*

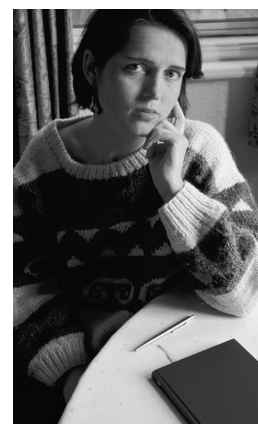
The following are some life-sustaining treatments:

- *Cardiopulmonary Resuscitation (CPR)*

CPR is used when a person's heart or lungs have suddenly stopped working. It usually involves chest compressions, the use of drugs and/or electric shock to restore the heartbeat, and the placement of a tube in the windpipe to maintain breathing. CPR may not be appropriate for certain patients (such as those in the process of dying due to terminal illness, those in a persistent vegetative state, or those with an incurable illness) as its use would only lengthen the process of dying.

- *Respirator/Ventilator*

A respirator/ventilator is a machine that, by moving air into the lungs, breathes for a person who is unable to breathe naturally. Ventilators are sometimes used after a person has had surgery or when a person has an illness. The ventilator helps the person to breathe until he or she is able to do so on their own. A ventilator may not be appropriate for a patient with a terminal illness, however, because the use of a ventilator may only prolong the process of dying.



- *Artificial Nutrition and Hydration*

Artificial nutrition and hydration are ways to provide food or fluids to a person who is unable to eat or drink. Food and/or fluids can be given directly or indirectly into the stomach (also called “tube feeding”) or through an intravenous line. These methods are commonly used when there is a temporary loss of eating or digestive function. When death is certain or there is no hope for recovery, the use of artificial food and fluids may only prolong the process of dying.



Swedish Medical Center's policies for Advance Directives

- We respect the rights and responsibilities of patients to make choices about their health care, including decisions regarding withholding or withdrawing life-sustaining treatment.
- We are committed to providing you with health-care treatment information and listening to your treatment choices. You have the right to accept or refuse any medical treatment.
- We will not discriminate against anyone based on whether or not the person has written an Advance Directive.
- We will honor treatment decisions stated in your Advance Directives, except where we believe it is not medically indicated or unethical to do so. If the medical center or doctor cannot honor your Advance Directive based on the above policies, we will make every effort to transfer you to a facility that will.

What's the medical center procedure on Advance Directives?

When you are admitted as a patient or come for a pre-admission visit prior to surgery, you will be asked if you have completed a Health-Care Directive, Durable Power of Attorney for Health Care, or if you want to be an organ donor.

If you are admitted to a hospital, bring copies of your written directives. They will be placed in your medical record.

What is a Mental Health Advance Directive?

A Mental Health Advance Directive is a document that allows you to write down how you would like your mental health treatment handled in the future. It is much like a Living Will. It goes into effect only in the event you become “incapacitated” – unable to make sound choices due to the occurrence of mental illness. You can create a directive that gives someone else the legal authority to make mental-health decisions for you, and you can write down instructions about the treatments you do or do not want to receive. Mental Health Advance Directives are authorized by Washington state law.

How do I prepare a Mental Health Advance Directive?

You can prepare a Mental Health Advance Directive in the same way that you would prepare a Health-Care Directive.

1. Review a Mental Health Advance Directive form (located in the Admitting Department at any of the Swedish campuses or at the Behavioral Health Unit nursing station). If you have any questions, discuss them with your family, doctor, clergy or lawyer. Think about any special instructions and include them on the form.
2. Sign the Mental Health Advance Directive in front of two witnesses who are not related to you and are not potential heirs. Your doctor, the doctor’s employees and employees of your hospital or nursing home cannot be witnesses.
3. Keep your original Mental Health Advance Directive in a safe place. Make copies of it for yourself, close family members and your lawyer. Copies should also be given to your doctor, anyone you have appointed as a representative to make decisions for you, and hospital admission personnel if you are being admitted to the hospital. A copy of the Mental Health Advance Directive needs to be in your medical record and/or hospital chart to make sure your wishes are followed.

Where do I get more information?

- Talk to your nurse or doctor.

Swedish Medical Center/Ballard

- Call the Spiritual Care chaplain at **206-782-2700**, extension **35615**.
- Contact Ethics Resource Committee members through the nursing supervisor. The nursing supervisor can be reached through the operator at **206-782-2700**.

Swedish Medical Center/Cherry Hill

- Call the Pastoral Care chaplain at **206-320-2288**.

Swedish Medical Center/First Hill

- Call the Pre-Admission Center at **206-386-2997** to talk with a nurse.
- While in the medical center, watch the video on Advance Directives on Channel 22 at 8:45 a.m. called “On Your Behalf”
- Call the Spiritual Care chaplain at **206-386-2082**.
- Contact the clinical nurse specialists, and/or Ethics Committee members through the operator at **206-386-6000**.

Health-Care Directive (Living Will)

I, _____, living in the city of _____, in the county of _____, in the state of _____, make this Health-Care Directive this _____ day of _____, 20____:

Being of sound mind, I willfully and by choice make known my wish that my life shall not be artificially prolonged as outlined below and hereby declare that:

1. If at any time I should be diagnosed in writing to be in a *terminal condition* by my attending doctor, or in a *permanent unconscious condition* by two doctors, and where the use of life-sustaining treatment would serve only to artificially lengthen the process of dying, I ask that such treatment be withheld or withdrawn and I be allowed 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 use of life-sustaining treatment would serve only to lengthen 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 chance of recovery from an irreversible coma or a persistent vegetative state.

2. If I am unable to give directions regarding the use of such life-sustaining procedures, it is my intention this Health-Care Directive be honored by my family and doctors as the final expression of my legal right to refuse medical or surgical treatment, and I accept what may happen because of my refusal. If another person is appointed to make these decisions for me, whether a Durable Power of Attorney or otherwise, I request the person to follow this Health-Care Directive and any other clear stated desires.
3. If I have been diagnosed as pregnant and the pregnancy is known to my physician, this Health-Care Directive shall have no force or effect during the course of my pregnancy.
4. In the event I suffer from a *terminal condition* or in a *permanent unconscious condition* explained in #1 above, I request no active steps be taken, including CPR.

Initial: _____ I want artificial administration of food and fluids.

_____ I do not want artificial administration of food and fluids.

5. This Health-Care Directive is to remain in effect as written unless changed by me, and any request I make concerning action to be taken or withheld in connection with this Health-Care Directive will be made without further discussion.

6. I have confidence in the good faith of my doctors and make this Directive to prove to them I do not wish to be subjected to further decline, pain or indignity for the sake of continuing my life under the conditions stated in #1 above. I therefore ask that medicines be given to me to lessen pain and suffering. I ask and authorize the doctors in charge of my case to know and understand what my wishes would be in any given situation. This request is made after careful consideration. Although I know this request appears to place a heavy responsibility upon the doctors in charge of my case, it is my wish to remove them of such responsibility and place it on myself in keeping with my strong beliefs.
7. It is my intent this Health-Care Directive be viewed as the written instrument provided for under the *Natural Death Act*, Chapter 70.122 RCW, as corrected. Additionally, it is my wish that this Health-Care Directive be interpreted as my desire, to the extent permitted by law, that I be allowed to die naturally and my life not be lengthened artificially through use of life-sustaining procedures, if my doctor determines I am in a *terminal condition* or two physicians determine I am in a *permanent unconscious condition*.
8. I understand the full importance of this Health-Care Directive, and I am emotionally and mentally fit to make this Health-Care Directive.

SIGNATURE OF DECLARER

_____, the declarer who signed the above Directive, is personally known to me, and I believe said declarer to be of sound mind. I agree that I am not related to the declarer by blood or marriage, that the declarer has stated I am not mentioned in the declarer's will, that I have no claim against the declarer, and that I am not an attending doctor or an employee of an attending doctor of the declarer or an employee of the health-care facility (if any) in which the declarer is a patient.

WITNESS DATE PLACE

PRINT NAME RESIDENCE ADDRESS

WITNESS DATE PLACE

PRINT NAME RESIDENCE ADDRESS

Important Note: This Health-Care Directive should be made a part of the Medical Record kept by your attending doctor. Keep a copy for yourself and provide a copy to close family members and your lawyer, if you have one.

(This document is provided as a community service by Swedish Medical Center, Seattle, Wash., which recommends you discuss questions about this document with a lawyer.)

Durable Power of Attorney for Health Care

I, _____, living in the city of _____, in the county of _____, in the state of _____, designate _____ as my *Attorney-in-Fact*, to act for me if I become unable to communicate for myself. I hereby cancel all health-care powers of attorney previously granted by me.

1. **Alternate Attorney-in-Fact.** If for any reason _____ fails to act, or is not able to act, I designate _____, *Alternate Attorney-in-Fact*, to serve in the order named. An attorney-in-fact may resign by (giving) written notice to that effect, in recordable form, to an alternate, successor, or co-attorney-in-fact. In this Power of Attorney, the “attorney-in-fact” means the then-acting attorney-in-fact.
2. **Power to Make Health-Care Decisions.** My agent for health-care decisions shall have the following powers:
 - To make health-care decisions on my behalf if I am unable to do so, including giving informed consent to health-care providers. Included in this power is the authority to make decisions about life-prolonging medical procedures, such as (but not limited to) a respirator, placement or removal of tubes to provide nutrition or hydration, antibiotics, and cardiopulmonary resuscitation.
 - I intend my agent to have the authority to consent to giving, withholding or stopping my health-care treatment, service or diagnostic procedure. All of this is to be in keeping with my instructions below or in my Health-Care Directive to Physicians (Living Will).

Instruction: _____

3. **Effectiveness.** This Power of Attorney shall become effective upon my incapacity. Incapacity includes the failure to make health-care decisions effectively for reasons such as mental illness, mental deficiency, incompetency, physical illness or disability, advanced age, chronic use of drugs, or chronic use of alcohol. Incapacity may be determined by: (a) a court order, or (b) a written statement by a qualified, regularly attending doctor, who shall be certain of my incapacity. Any person dealing with the attorney-in-fact may use this statement without question.
4. **Duration.** This Power of Attorney becomes effective as provided in Section #1 above, and shall remain in effect to the fullest extent permitted by Chapter 11.94, RCW, or until canceled or removed as provided in Sections #5 or #6 on the next page.

5. **Cancellation.** The Power of Attorney may be canceled, suspended, or removed by written notice from me to the designated attorney-in-fact and, if this power has been recorded, by recording this notice in the office where deeds are recorded for real estate located in _____ County, Washington.
6. **Termination.** If appointed, my guardian may, with court approval, cancel, suspend, or remove this Power of Attorney.
7. **Trust.** Any person dealing with the assigned attorney-in-fact shall be entitled to trust this Power of Attorney to carry out my wishes for health care. No one shall deal with this Power of Attorney if they know or have written notice of any cancellation, suspension or removal of the Power of Attorney. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my relatives or inheritors of my estate.
8. **Indemnity.** My estate shall hold harmless and indemnify the attorney-in-fact from all liability for acts done in good faith.
9. **Applicable Law.** The internal law of the State of Washington shall govern this Power of Attorney.
10. **Optional.** I understand this document only authorizes the above-named person to make decisions for me based on my health-care needs. Therefore, if at some time, I should require a Guardian or Limited Guardian to make other decisions for me regarding my estate or person, I nominate _____, or in the alternative, _____.
11. **Execution.** This Power of Attorney is signed on the _____ day of _____, 2_____, to be effective as provided in Section 3 above.
12. **Certification.** I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

SIGNATURE

DATE

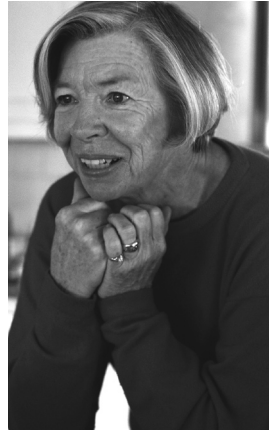
PLACE

Important Note: This Durable Power of Attorney for Health Care should be made a part of the Medical Record retained by your attending doctor. Keep a copy for yourself and provide a copy to your attorney-in-fact, close family members, and your lawyer, if you have one.

(This document is provided as a community service by Swedish Medical Center, Seattle, Wash., which recommends independent legal counsel be sought for any specific legal ramifications of this document.)

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Notes





SWEDISH

SWEDISH MEDICAL CENTER

747 Broadway
Seattle, WA 98122-4307
T 206-386-6000
TTD 206-386-2022

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1-800-SWEDISH (1-800-793-3474)
www.swedish.org

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