Advance Directive Questions and Answers

What is an Advance Directive?
An Advance Directive is a written document that expresses your wishes regarding medical care and identifies who you would want to speak for you if you could not speak for yourself. An Advance Directive is a combination of two legal documents, called:

- Durable Power of Attorney for Health Care
- Health Care Directive

What is a Durable Power of Attorney for Health Care?
The Durable Power of Attorney for Health Care lets you name a health care agent. A health care agent is someone who can make decisions about your care, including decisions about life support, if you can no longer speak for yourself.

What is a Health Care Directive?
This form expresses your wishes in writing regarding your medical care, including decisions about life support if you cannot speak for yourself – for instance, if you are in a coma. Having written instructions can help reduce confusion or disagreement among your loved ones or health care providers. Your loved ones and doctors are required by law to follow the instructions in your health care directive.

What if I need help with preparing my advance directive?
Consider filling out the Values Worksheet form located in this document. It may help to gather your thoughts and clarify your values about your medical choices. If you feel that it helps to explain your beliefs about your end-of-life wishes, you may choose to include it with your signed advance directive. If you have questions or need guidance in preparing your advance directive, please call our Supportive Care Services at 206-606-1076 and a staff member will be glad to assist you.

How should I choose a Health Care Agent?
Be sure your health care agent understands your wishes and agrees to follow them. This person will take responsibility for making your medical decisions, even if others challenge your wishes.

The person you name to be your health care agent:

- Must be at least 18 years old and mentally competent.
- May be a family member or close friend you trust to make serious decisions.
- Does not have to be your spouse, partner, or a member of your biological family.
- Does not need to be in Washington but needs to be available in a medical emergency.

The person you appoint as your health care agent cannot be:

- Your physician or an employee of your physician.
- An owner, operator, administrator, employee, or a volunteer of a health care facility where you are currently a patient.

What happens if I do not choose a Health Care Agent?
Choosing a health care agent is recommended. If you do not choose a health care agent, Washington law will assign one for you. An agent will be chosen from the list below in the following order:

- A guardian with health decision-making authority, if one has been appointed by a court;
- Your spouse or registered domestic partner (even if you are separated but not legally divorced);
- Your adult children;
- Your parents;
- Your adult siblings;
- Your adult grandchildren who are familiar with you;
- Your adult nieces and nephews who are familiar you;
- Your adult aunts and uncles who are familiar you; and
- Under certain circumstances, an adult who is a close friend*

* To qualify as a surrogate decision maker, an adult who is a close friend of the patient must have exhibited special care and concern for the patient, be familiar with the patient's values, be reasonably available to make health care decisions, and sign a declaration under penalty of perjury.

When there is more than one person given authority, such as your children, parents, or siblings, **all** must agree. If you worry that they may not all agree, you may want to complete a Durable Power of Attorney for Healthcare form to indicate specifically who should make decisions for you.

What if I have a same sex-spouse or registered domestic partner?
Your domestic partner or spouse may not have the right to make your health care decisions or even have access to you in an emergency medical situation outside of Washington. List your domestic partner or spouse as your health care agent on this form if you travel outside of Washington and want him/her to make health care decisions for you.

What is "temporary life sustaining treatment" and when might I want it?
Temporary life sustaining treatment might include for example ventilation or using a breathing machine. You might want life sustaining treatments if there is a good chance of recovery. For example, if you have a lung infection that might get better. On the other hand, some people would prefer not to have their lives prolonged using machines whether or not the condition is reversible.

I am concerned that comfort care and pain medication might be harmful. Is it true that pain medicine may cause my death to happen faster?
When someone is dying, pain medication is only increased if the person is still in pain. Pain medication almost never causes death to happen sooner when used at end of life. However, pain medication may slow your breathing or cause sedation if you have not used pain medication before (or only in small quantities). That is why it is important to always use pain medications safely and under the direction of your medical team. Drug dependency in a dying person is not an ethical or legal concern. Developing a tolerance to pain medication is not addiction.

Can a health care institution refuse to honor my wishes?
Some health care institutions follow certain religious directives or moral teachings. Because of this, they may not honor your Advance Directive if it conflicts with their institutional values. If you are terminally ill or death is likely, these institutions will usually honor your choices to stop or not start life-sustaining treatment. However, in situations involving pregnancy or persistent vegetative state, they may refuse to honor your wishes. In that case, you have the right to move to a different facility to receive the care you prefer. Give your health care directive to the health care institutions and doctors caring for you to ensure they know your preferences.

Does my Advance Directive remain in effect after death?
Washington law does not explicitly allow health care directives to remain in effect after death. You can state your intention that the document remains in effect to carry out your wishes regarding experimental treatments, organ/tissue donation, autopsy, and medical research or education, on your Advance Directive form.

What if I choose to revoke or cancel my Advance Directive?
You may revoke your Advance Directive at any time by writing and dating "REVOKED" on the form. Notify your health care agent, your family, and your physician(s) in writing of your intent to revoke your advance directive. We strongly recommend that you create an updated Advance Directive as soon as possible and give copies to your health care agent, family and your physicians.

However, you do not need to revoke or cancel your advance directive if you just need to update addresses or phone numbers. You can make those changes on your current form. Updates should be initialed and dated. Be sure to review your Advance Directive occasionally to be sure it reflects your current preferences and values. Initial and date it whenever you review it, and don't forget to share the updated form with your health care agent, family and your physicians.

Where should I keep my Advance Directive?
Keep the original in a secure but accessible place. Remember to tell your health care agent(s) and loved ones where to find your document. Do not give the original to your attorney or put it in a security box (like a safe deposit box), so that it is accessible in the event of an emergency. You may want to carry copies in your wallet/purse, car, or in a suitcase.

Who should have a copy?
Once your form is completed, give copies to your health care agent(s), physician(s), lawyer, family, close friends, clergy, designated agent(s) for funeral arrangements, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have copies of your documents placed in your medical records. Copies of your Advance Directive are just as valid as the original.

How do I tell important people my wishes?
It is important to discuss your Advance Directive with people close to you. Discuss your wishes concerning medical treatment with your health care agent(s), physician(s), clergy, family, and friends often, particularly if your medical condition changes. Make clear to other family members that your health care agent(s) will have final authority to act on your behalf.

Will my physician honor my wishes?
When you present your Advance Directive to your physician, ask if he or she will honor it. If not, find a physician who will.

What happens if I am offered other health care directive forms when admitted to a health care facility or enrolled in a home-based health care program?
Give admissions staff a copy of your completed Advance Directive and ask them to clarify why they think you should complete their forms.

Will my Advance Directive be effective in a medical emergency?
No, your Advance Directive will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) and other life-sustaining treatments unless a valid Physician Orders for Life-Sustaining Treatment (POLST) form is present.

What if I travel to other states?
If you travel, you may want to take copies of your Advance Directive with you, as other states may honor it. Washington State registered domestic partners should be diligent about carrying their Advance Directives when traveling outside of Washington.

Do I need to have my Advance Directive witnessed or notarized?
Beginning July 28, 2019, The Advance Directive must be either witnessed by 2 people or notarized in order to be legally binding.

The witnesses cannot be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate through the operation of law or through any will.
- A person who has a claim against your estate.
- Your physician or an employee of your physician.
- An owner, operator, administrator, employee, or volunteer of a health care facility in which you are a patient at the time you sign your Advance Directive.

Advance Directive completed prior to July 28, 2019, will remain legally valid as long as its version complied with the Washington State law at the time of its completion.

VALUES WORKSHEET

Name _____ Date _____

If applicable, name of the person who helped you to fill out this document _____

The following are questions you may want to consider as you make decisions and prepare documents concerning the kind of health care you want to receive now and in the future. You may want to write down your answers and provide copies to your family members and health care providers, or simply use the questions for discussion. How important are the following items?

	VERY IMPORTANT			NOT IMPORTANT	
Letting nature take its course.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Preserving quality of life.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Staying true to my spiritual beliefs/traditions.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Living as long as possible, regardless of quality of life.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being independent.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being comfortable and as pain free as possible.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Leaving good memories for my family and friends.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Making a contribution to medical research or teaching.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being able to relate to family and friends.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being free of physical limitations.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being mentally alert and competent.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Being able to leave money to family, friends, or charity.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Dying in a short while rather than lingering.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
Avoiding expensive care.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

What will be important to you when you are dying (e.g. physical comfort, no pain, family members present, etc.)?

How do you feel about the use of life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness, such as Alzheimer's disease?

Do you have strong feelings about particular medical procedures? Some procedures to think about include mechanical breathing (respirator), cardiopulmonary resuscitation (CPR), artificial nutrition and hydration, hospital intensive care, pain relief medication, chemo or radiation therapy, and surgery.

What limitations to your physical and mental health would affect the health care decisions you would make?

Would you want to have financial matters taken into account when treatment decisions are made?

Would you want to be placed in a nursing home if your condition warranted?

Would you prefer Hospice care, with the goal of keeping you comfortable in your home during the final period of your life, as an alternative to hospitalization?

In general, do you wish to participate or share in making decisions about your health care and treatment?

Would you always want to know the truth about your condition, treatment options, and the change of success of treatments?

Fred Hutch Cancer Center

Health Care Directive and Durable Power of Attorney For Health Care

of: _____

{print your name here}

This document states my choices about life-sustaining medical treatment and comfort care. It is meant to inform and guide my agent/guardian and clinicians who will make health care decisions for me if I become unable to speak for myself. I understand that before I sign this directive and durable power of attorney for health care, I can add to, delete from or otherwise change the wording of this directive. I may add to or delete from this directive and durable power of attorney for health care at any time and acknowledge that these changes must be consistent with Washington State law or federal constitutional law to be legally valid. I want this form to replace and cancel all health care powers of attorney and health care directives signed by me in the past.

1. When I Want This Document To Apply

I want this document to apply if I become unable to make my own health care decision(s) due to disability or incapacity. I understand that such inability may be temporary. I also understand that if I become unable to make certain decisions, I may still be able to make others. When I can make my own health care decisions, I want to do so. Each section filled out below will cancel and replace any health care directive and durable health care power of attorney signed by me in the past.

Durable Power of Attorney for Health Care

2. My Health Care Agent

I appoint as my agent:

Name _____

Relationship _____

Address _____

_____

Telephone _____

My alternate agent (optional):

Name _____

Relationship _____

Address _____

_____

Telephone _____

I have previously completed *{initial all that apply}:*

Health Care Directive (i.e. living will, advance directive) _____ Yes _____ No

Physician Order for Life-Sustaining Treatment (POLST) _____ Yes _____ No

3. The Authority I Give My Health Care Agent

I grant my agent complete power to make all decisions about my health care. This includes, but is not limited to:

- Consenting to, or refusing/withdrawing consent, for medical treatment recommended by my physician, including life-sustaining treatments;
- Asking for particular medical treatments;
- Accessing my medical records and information;
- Employing and dismissing health care providers;

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- Changing my health care insurers;
- Making a Physician Order for Life-Sustaining Treatment (POLST) form for me; and
- Removing me from any health care facility to another facility, a private home, or other place; and Requesting hospice or comfort care.

This release authority additionally applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 as hereafter amended.

4. How To Make My Health Care Decisions

I want whoever makes my health care decisions to follow the choices I state in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on:

- my values,
- the contents of this document, and
- medical information provided by my health care providers.

Health Care Directive

I make this health care directive to provide clear and convincing proof of my choices and instructions about my treatment.

5. When I Do Not Want Life-Sustaining Treatment

If I am in the following condition(s), I would want to be allowed to die: *{initial all that apply}*

_____ (a) If I am unable to think or communicate due to any medical condition (including coma) and this condition is probably permanent.

_____ (b) If I am totally dependent on others for my care because of my physical condition, which is probably permanent.

_____ (c) If I experience pain which cannot be controlled, or can be eliminated only by sedating me so heavily that I cannot communicate.

_____ (d) If I have Dementia such as Alzheimer's Disease.

_____ (e) Other circumstances in which I would not want life-sustaining treatment (optional):

If this space is not sufficient, write: "See attached page." Any attached page should be signed and either witnessed, or notarized. If you have a potentially life-threatening, chronic condition, discuss specific instructions with your physician.

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6. Temporary Use Of Life-Sustaining Treatment

I understand temporary life sustaining treatment might be an option when my physician thinks that my quality of life or condition might improve. If so, then: *{initial one}*

_____ I want life-sustaining treatment for as long as my doctor thinks it is still appropriate to try.

_____ I want life-sustaining treatment for up to _____ week(s). *After that time, if I have not gotten better, I would want to be allowed to die.*

_____ I still do not want life-sustaining treatment.

7. Life-Sustaining Treatment I do not want

If I experience a condition I initialed in section 5 above or if I experience a quality of life my agent believes I would consider unacceptable, I do not want these life-sustaining treatments started. If already in use, I want them stopped (except for temporary use if I authorized that in section 6): *{initial all that you do not want}*

_____ Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.

_____ Cardiopulmonary resuscitation (CPR) measures to try to restart my heart or breathing, if those stop.

_____ Blood dialysis or filtration to clean life-threatening substances from my blood, if my kidneys do not work normally.

_____ Transfusion of blood, plasma, blood products, or other fluids to replace lost of diseased blood.

Furthermore, if I have a POLST completed, use it to learn about my other preferences.

8. My Wishes Concerning Comfort Care And Pain Medication

If I appear to be in pain, experiencing breathlessness, or otherwise uncomfortable, I want vigorous treatment to relieve my pain and symptoms. I want to be comfortable, even if my physicians or other medical providers believe this might make me unconscious: *{initial one}*

_____ Yes _____ No

9. Regarding A Health Care Institution Refusing To Honor My Wishes

If I am a patient in a health care institution whose policies or religious beliefs are in conflict with this Advance Directive, my admission does not give implied consent to procedures or courses of treatment in conflict with this Advance Directive. Furthermore, if the health care institution in which I am a patient does not follow my wishes as stated in the Advance Directive, I want to be transferred in a timely manner to a hospital, nursing home, or other institution which will agree to honor the instructions set forth in this advance directive.

10. My Wishes Concerning Other Matters

I want this directive to remain in effect after my death for autopsy, organ donation, use of my body for research, and for my agent to make arrangements for my remains if I authorize it below. *{initial all that apply}*

	YES	NO
a. I consent to medical treatments that are experimental.	_____	_____
b. I want to donate organs/tissues.	_____	_____

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c. I consent to an autopsy. _____ _____

d. I consent to use of all or part of my body for medical education or research. _____ _____

I have named the following individual as my designated agent for funeral arrangements: *{initial one}*
If you do not use this section, cross it out.

_____ My Health Care Agent (listed in section 2 of this document) is also authorized to make funeral arrangements

_____ I have named an alternate agent for funeral arrangements

My alternate agent for funeral arrangements:

Name _____

Relationship _____

Address _____

Telephone _____

I want my remains to be disposed of as follows:
If you have left instructions in a property will or have made arrangements with a funeral home or People's Memorial Association, there is no need to complete this part. If you do not use this section cross it out.

11. If A Court Appoints A Guardian For Me

If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

12. How This Document Can Be Revoked Or Canceled

This health care directive and durable power of attorney for health care can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document.

13. Summary And Signature *{sign only in the presence of two witnesses, if witnessing, OR notary, if notarizing}*

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective even if I become incompetent.

NOTE: You must complete either section 14 (Statement of Witnesses) or section 15 (Notarization) in order for this document to be legally binding.

_____ _____

Signature Date

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14. Statement Of Witnesses *{print your name - not the names of your witnesses – on the line below}*

_____ is personally known to me, and I believe him/her to be capable of making health care decisions. I affirm I am at least 18 years old, not related to him/her by blood, marriage, or adoption, and not his/her health care agent named in this document. As far as I know I am not a beneficiary of his/her will or any addition to his/her will, and I have no claim against his/her estate. I am not directly involved in his/her health care, and I am not an employee of his/her physician or a health care facility where the person making this document may reside.

WITNESS 1

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

WITNESS 2

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

15. Notarization

State of Washington, County of _____

I certify that I know or have satisfactory evidence that _____ signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this document.

Dated this _____ day of _____, 20 _____

_____
NOTARY PUBLIC in and for the State of Washington

Residing at _____

My commission expires _____

Note: Some states do require advance directives to be notarized. Fred Hutchinson Cancer Center provides complimentary notarization of advance directives in our Patient and Family Resource Center located on the 3rd floor of the clinic often same day, and always by appointment (206-606-2081).

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