

# What Matters Most?

Advance health care directive and  
values exploration workshop



**Led by Redwing Keyssar, RN, BA**

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UCSF MERI Center for Education in Palliative Care  
at Mount Zion



I offer this poem by Jane Kenyon, because this is the reason we must all do advance care planning. We know that one day, things will be different.

- Redwing Keyssar

### OTHERWISE

I got out of bed  
on two strong legs.  
It might have been  
otherwise. I ate  
cereal, sweet  
milk, ripe, flawless  
peach. It might  
have been otherwise.  
I took the dog uphill  
to the birch wood.  
All morning I did  
the work I love.

At noon I lay down  
with my mate. It might  
have been otherwise.  
We ate dinner together  
at a table with silver  
candlesticks. It might  
have been otherwise.  
I slept in a bed  
in a room with paintings  
on the walls, and  
planned another day  
just like this day.  
But one day, I know,  
it will be otherwise.

Jane Kenyon

# **Being a Patient Advocate For Yourself, Family, or a Friend**

## **AT THE DOCTOR'S OFFICE**

- ◆ Do not be afraid to ask questions.
- ◆ Write down questions for the doctor or healthcare practitioner. At the appointment, write down the answers.
- ◆ If you do not understand what a doctor is saying, ask for clarification.
- ◆ Make sure that the patient's goals for treatment or care are the same as the healthcare provider's goals.
- ◆ Ask about side effects of drugs and treatments, and how to manage them.
- ◆ Find out if there are new treatments that should be considered.
- ◆ Ask if there are any lifestyle changes that might better support your loved one's health goals.
- ◆ Find out if there are any products or services that would be helpful.
- ◆ If you use "complementary" or "integrative" healing modalities, let your doctor know about this.
- ◆ If a medication is not working (for pain or symptoms), ask for a different one, or request a consultation.
- ◆ Second opinions are usually covered by insurance.

## **IN THE HOSPITAL**

- ◆ Most hospitals have Palliative Care teams. You need a doctor's referral to access this team. Anyone with a serious illness can get a referral, either as an inpatient or in some cases as an outpatient (UCSF, CPMC, and Kaiser). These teams are incredibly valuable.
- Have a copy of your DPOA/Advance Directive with you in the hospital.
- ◆ If your loved one or friend is in the hospital, it is beneficial to have someone present at most times, who can advocate by asking questions, getting the nurse, make sure the right medications are given at the right time, etc. A squeaky wheel gets the grease! There is no point in being a "good and quiet patient," if it means suffering.

- In the hospital, things fall through cracks easily. You may need to remind someone about a consult or test, or you may need to speak with a doctor.
- If you do not understand what is happening, ask to speak with the charge nurse, doctor, or case manager.
- DO NOT allow for a discharge to home without a solid plan.
- If you believe that the patient has needs that are not being addressed, you must help address them. If you are not the medical power of attorney for healthcare, make sure that whoever is, can be contacted easily.
- Sometimes you must request to see the doctor who is in charge, and not a resident.

## AT HOME

- ◆ If you believe that your friend/loved one is near the end of life, but no one is discussing it, ask. Ask the physician about a hospice referral. That often opens up a different level of conversation.
- ◆ Find out how much your friend does or does not want to know about their illness and treatment.
- ◆ Some hospice teams have an outpatient palliative care department that can assist you.

**IMPORTANT INFO FOR PERSONAL HEALTH BINDER**

USE A 3-RING TYPE BINDER WITH TABS

TABS SHOULD INCLUDE:

- Health history
  - Complete medical history updated regularly
  - Dates of any major diagnoses or surgeries
- Medications
  - Both current and any recently stopped.
  - Any complementary medications/supplements, etc
  - Name of pharmacy
- Doctors
  - List of all doctors with contact info
  - emergency contact information
- Recent visits
  - Summaries of recent MD visits
  - List of upcoming appointments

## **Authorization to Disclose Confidential Information**

I authorize \_\_\_\_\_(health professional)\_\_\_\_to exchange  
confidential information with \_\_\_\_spouse/family member/friend\_\_\_\_\_  
in regard to \_\_(self)\_\_\_\_\_.

This authorization is valid through \_\_\_\_\_.

Signature of Client:\_\_\_\_\_ Date:\_\_\_\_\_

## Durable Power of Attorney for Healthcare Decisions

**■ Take a copy of this with you whenever you go to the hospital or on a trip ■**

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments *you* want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

I, \_\_\_\_\_, SS# \_\_\_\_\_ (optional), appoint the person named in this document to be my agent to **make my** healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care, I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/ tube feeding. My agent is authorized to

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental or emotional well-being;
- Request, receive, review; and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal action, if needed;
- Make decisions about autopsy; tissue and organ donation, and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising *this* power, I expect my agent to be guided *by* my directions as we discussed them prior to this appointment and/or to be guided *by* my Healthcare Directive (*see reverse side*).

*If you DO NOT want the person (agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.*

Agent's name \_\_\_\_\_ Phone \_\_\_\_\_ Email. \_\_\_\_\_

Address \_\_\_\_\_

*If you do not want to name an alternate, write "none."*

Alternate Agent's name \_\_\_\_\_ Phone \_\_\_\_\_ Email. \_\_\_\_\_

Address \_\_\_\_\_

### Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about *my* condition. My agent's authority to make all healthcare and related decisions for me is effective when and only when I cannot make *my* own healthcare decisions.

**SIGN HERE** for the *Durable Power of Attorney* and/or *Healthcare Directive* forms. Many states require notarization. It is recommended for the residents of all states. Please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature \_\_\_\_\_ Date'-----

Witness. \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date ---

### Notarization:

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of \_\_\_\_\_, State of \_\_\_\_\_ on the date written above.

Notary Public \_\_\_\_\_  
 Commission Expires, \_\_\_\_\_

## ADVANCE HEALTH CARE DIRECTIVE

## INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end of life decisions, you need not fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

***You have the right to revoke this advance health care directive or replace this form at any time.***

**PART 1 POWER OF ATTORNEY FOR HEALTH CARE****DESIGNATION OF AGENT:**

I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

(*home phone*)

(*work phone*)

(*cell/pager*)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as first alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

(*home phone*)

(*work phone*)

(*cell/pager*)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

(*home phone*)

(*work phone*)

(*cell/pager*)

**AGENT'S AUTHORITY:**

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*(Add additional sheets if needed.)*

**WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:**

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

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*(Initial here)*

**OR**

My agent's authority to make health care decisions for me takes effect immediately.

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*(Initial here)*

**AGENT'S OBLIGATION:**

My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**AGENT'S POSTDEATH AUTHORITY:**

My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

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*(Add additional sheets if needed.)*

**NOMINATION OF CONSERVATOR:**

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## **PART 2 INSTRUCTIONS FOR HEALTH CARE**

If you fill out this part of the form, you may strike any wording you do not want.

### **END OF LIFE DECISIONS:**

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

#### **Choice Not To Prolong Life:**

*(Initial here)*

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

**OR**

#### **Choice To Prolong Life:**

*(Initial here)*

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

### **RELIEF FROM PAIN:**

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

*(Add additional sheets if needed.)*

### **OTHER WISHES:**

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

*(Add additional sheets if needed.)*

**PART 3 DONATION OF ORGANS AT DEATH (OPTIONAL)**

I. Upon my death:

I give any needed organs, tissues, or parts \_\_\_\_\_  
(Initial here)

**OR**

I give the following organs, tissues, or parts only: \_\_\_\_\_  
\_\_\_\_\_  
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II. and III.

My gift is for the following purposes:

Transplant \_\_\_\_\_ Research \_\_\_\_\_  
(Initial here) (Initial here)

Therapy \_\_\_\_\_ Education \_\_\_\_\_  
(Initial here) (Initial here)

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors.

It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

2. My donated tissue may be used for applications outside of the United States.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

3. My donated tissue may be used by for-profit tissue processors and distributors.

Yes \_\_\_\_\_ No \_\_\_\_\_  
(Initial here) (Initial here)

(Health and Safety Code Section 7158.3)

#### **PART 4 PRIMARY PHYSICIAN (OPTIONAL)**

I designate the following physician as my primary physician:

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name of Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

#### **PART 5 SIGNATURE**

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

##### ***SIGNATURE:***

Sign and date the form here

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(*patient*)

Print name: \_\_\_\_\_  
(*patient*)

Address: \_\_\_\_\_

##### ***STATEMENT OF WITNESSES:***

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

**FIRST WITNESS**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**SECOND WITNESS**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**ADDITIONAL STATEMENT OF WITNESSES:**

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
(witness)

Print name: \_\_\_\_\_  
(witness)

**YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.**

State of California )

County of \_\_\_\_\_ )

)

On (date) \_\_\_\_\_ before me, (name and title of the officer) \_\_\_\_\_

personally appeared (name(s) of signer(s)) \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature: \_\_\_\_\_ [Seal]  
 (notary)

#### **PART 6 SPECIAL WITNESS REQUIREMENT**

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

#### **STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM

Signature: \_\_\_\_\_  
 (patient advocate or ombudsman)

Print name: \_\_\_\_\_  
 (patient advocate or ombudsman)

Address: \_\_\_\_\_  
 \_\_\_\_\_

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY



EMSA #111 B  
(Effective 4/1/2011)

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

**First follow these orders, then contact physician.**  
This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

<b>A</b> Check One	<b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <i>If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>													
	<input type="checkbox"/> <b>Attempt Resuscitation/CPR</b> (Selecting CPR in Section A <b>requires</b> selecting Full Treatment in Section B) <input type="checkbox"/> <b>Do Not Attempt Resuscitation/DNR</b> (Allow Natural Death)													
<b>B</b> Check One	<b>MEDICAL INTERVENTIONS:</b> <i>If person has pulse and/or is breathing.</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Comfort Measures Only</b> Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <b>Transfer to hospital only</b> if comfort needs cannot be met in current location.</li> <li><input type="checkbox"/> <b>Limited Additional Interventions</b> In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.  <input type="checkbox"/> <b>Transfer to hospital only</b> if comfort needs cannot be met in current location.</li> <li><input type="checkbox"/> <b>Full Treatment</b> In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. <b>Transfer to hospital if indicated. Includes intensive care.</b></li> </ul> <b>Additional Orders:</b> _____													
<b>C</b> Check One	<b>ARTIFICIALLY ADMINISTERED NUTRITION:</b> <i>Offer food by mouth if feasible and desired.</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> No artificial means of nutrition, including feeding tubes. Additional Orders: _____</li> <li><input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____</li> <li><input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. _____</li> </ul>													
<b>D</b>	<b>INFORMATION AND SIGNATURES:</b> <p>Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker</p> <p><input type="checkbox"/> Advance Directive dated _____ available and reviewed → Health Care Agent if named in Advance Directive:  <input type="checkbox"/> Advance Directive not available  <input type="checkbox"/> No Advance Directive            Name: _____            Phone: _____</p> <p><b>Signature of Physician</b>            My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.</p> <table border="1"> <tr> <td>Print Physician Name:</td> <td>Physician Phone Number:</td> <td>Physician License Number:</td> </tr> <tr> <td colspan="2">Physician Signature: (required)</td> <td>Date:</td> </tr> </table> <p><b>Signature of Patient or Legally Recognized Decisionmaker</b>            By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.</p> <table border="1"> <tr> <td>Print Name:</td> <td>Relationship: (write self if patient)</td> </tr> <tr> <td colspan="2">Signature: (required)</td> </tr> <tr> <td colspan="2">Address: Daytime Phone Number: Evening Phone Number:</td> </tr> </table>		Print Physician Name:	Physician Phone Number:	Physician License Number:	Physician Signature: (required)		Date:	Print Name:	Relationship: (write self if patient)	Signature: (required)		Address: Daytime Phone Number: Evening Phone Number:	
Print Physician Name:	Physician Phone Number:	Physician License Number:												
Physician Signature: (required)		Date:												
Print Name:	Relationship: (write self if patient)													
Signature: (required)														
Address: Daytime Phone Number: Evening Phone Number:														

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY****Patient Information**

Name (last, first, middle):	Date of Birth:	Gender: <input checked="" type="checkbox"/> M <input type="checkbox"/> F
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**Health Care Provider Assisting with Form Preparation**

Name:	Title:	Phone Number:
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**Additional Contact**

Name:	Relationship to Patient:	Phone Number:
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**Directions for Health Care Provider****Completing POLST**

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

**Using POLST**

- Any incomplete section of POLST implies full treatment for that section.

**Section A:**

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

**Section B:**

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

**Reviewing POLST**

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

**Modifying and Voiding POLST**

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

## Letter to My Future Doctor

FAITH FITZGERALO, MD, Sacramento, California

*Everyone is talking. Physicians, politicians, newspaper columnists, patients, families, authors, talk show hosts, all are debating our right to decide how and when we will die. It is necessary and wise to obtain a medical directive. One question we must ask ourselves as physicians is, Can we do what we ask our patients to do? Here is one physician's medical directive.*

, We are in an era of ethical conundrums, especially in the distinction between what we *can* do and **if** what we *ought* to do regarding the continuation of life. I admit that, knowing as much as I do, I fear your enthusiasms and your doubts. Because I do not know you yet, I want to take this chance to make myself clear to you.

I believe that my body is a vehicle for my brain, no more than a machine that allows my mind to function. So long as my brain works, that is, receives and sends coherent messages, I would wish to live.

If my brain fails-by trauma, a residual of metabolic disarray, degenerative process, tumor, ischemia, infection, or other chronic or acute event-let me die.

If I am in a chronic vegetative state, irreversible coma, or dementia to the point where I require help in basic functions-let me die.

It can be argued that you won't be sure of the permanence of such a state of cerebral dysfunction, but I don't require absolutes.

If in your best opinion the strong likelihood is for continued brain dysfunction-let me die.

I cannot make decisions now about dismemberment, physical limitations, chronic pain, ..terminal" disease, and the like, since the circumstances of these may vary greatly. I would want to make a decision at the time, after talking with you.

If I am incapable and unlikely, because of the nature of my illness, ever to be capable of making such a decision, I will be by definition in the category of projected cerebral dysfunction already discussed-let me die.

What do I mean by "Let me die"? I mean let me die without vacillation: no antibiotics, fluids, enteral or parenteral sustenance, electrolyte manipulations, supportive machinery, or emergency interventions other than are necessary to relieve pain. Don't let your fear of the law, or the strident desires of others, override your common sense. Should someone accuse you of "playing God," tell them that I said that death is a natural end; it is the futile prolongation of severely damaged life that is "playing God." Moreover, I now also give you permission to take organs from me that might benefit others-eyes, kidneys, heart, skin, liver ... whatever.

I was not for millions of years, the time before my birth; I will not be for all of subsequent time beyond my death; the one is no different to me from the other. Neither terrifies. I will die. Let it be when the mind I have defined as myself has ceased to allow-me to function as a sentient being, interacting with others in a creative and independent way.

I'll make a bargain with you: I will, by this declaration, release you from your doubts about what to do, and you, in turn, will allow me to escape from a future threatened by senseless animation. Let this be our final act as:colleagues.

FAITH FITZGERALD, MD  
Sacramento, California

*Have you written your own declarations of intent and have you notified your own physician or family about them? We challenge you, the readers of THE WESTERN JOURNAL OF MEDICINE, to send us your comments. A public declaration will reveal varieties of opinion. It will put in writing your easy-to-say claims; it will give you an idea of the challenges involved in constructing these directives. This should be interesting!*

THE EDITORS

(Fitzgerald F: Letter to my future doctor. West J Med 1992 Mar; 156:313)

From the Department of Internal Medicine, Housestaff Affairs, University of California, Davis, School of Medicine, Sacramento.

Reprint requests to Faith Fitzgerald, MD, Department of Internal Medicine, Housestaff Affairs, University of California, Davis, Medical Center, 2315 Stockton Blvd, Rm 6305, Sacramento, CA 95817.

# SAMPLE

## 'Five Wishes' 10/16/2014 rev.10/25/2016

I choose as my Health Care \_\_\_\_\_

I understand that my Health Care Agent can make health care decisions for me, if and when I am unable to. I want my Agent to be able to do following: Make choices about medical care, services, tests, drugs, surgery. This care or service could be to find out what my health problem is (but only if such information could be actionable) or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.

### My Health Care Agent may do the following

Interpret any instructions I have given in this document or in other discussions, according to my Health Care Agent's understanding of my wishes and values.

Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me, if such becomes advisable.

Hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.

Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.

See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my HCA can sign it for me.

Authorize any medication or procedure needed to help with pain, not authorize routine procedures such as X-Rays, that do not yield information needed for my care.

Take any legal action needed to carry out my wishes.

### Medical Care

I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise, and even if, when there is no prospect of any degree of recovery that would enable me to resume being my own decision maker, the medicine risks ending my life.

I want to be offered food and fluids by mouth and kept clean and warm.

The kind of medical treatment that I want or don't want, in the four situations below:

I want my Health Care Agent, my family, my doctors and other health care providers to know these directions.

**Nate:** "life-support"refers to any medical procedure, device or medication to keep me alive, including but not limited to tube feeding, CPR, major surgery, dialysis, antibiotics

Situation: Close to death

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death, I do not want life-support treatment. If it has been started, I want it stopped.

Situation: In a coma and not expected to wake up or recover

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and life-support treatment would only delay the moment of my death, I do not want life-support treatment. If it has been started, I want it stopped.

Situation: Permanent and severe brain damage and not expected to recover

e.g., I can open my eyes, but I cannot speak or show any evidence of understanding and I am not expected to get better.

I want to have life-support treatment if my doctor believes it could help.

I want to be confident that even if I cannot speak or write, my communication will be paid attention to. The means of communication could be as simple as having someone recite the alphabet and writing down the letters at which I blink or give whatever signal I am capable of.

I want my Health Care Agent or someone she designates to establish whether I can communicate despite inability to speak, write, or move a limb.

If it is established that I am unable to communicate by any means, and if the problem is not reversible, I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

The following deal with my personal, spiritual and emotional wishes.

I want to be treated with dignity near the end of my life, so I would like people to do the things written below when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers.

I wish for my family to know about options for hospice care to provide emotional support for them and guidance in how to talk to my grandsons and how to deal with my disabled son.

In regard to how I want people to treat me

I wish to be cared for with kindness and cheerfulness, and not sadness.

I wish my daughter (and of course my grandsons) not to be exposed to sights or situations which could be disturbing to them. This may require asking them to wait outside the room during personal hygiene care. It might require asking them to wait outside the room until any severe behavioral difficulties are resolved (agitation, hallucinations, anxiety).

If I show signs of depression, anxiety, nausea, shortness of breath, agitation or hallucinations, I want my caregivers to do whatever they can to help me.

I want my lips and mouth kept moist to stop dryness.

I do not wish to be touched other than in the course of medical care, personal hygiene care, or any care deemed necessary by my doctors and health care providers, with the exception of the following people:

my daughter, my grandsons and the following friends, should any of them be present:  
xxxxxxxxxxMy Health Care Agent can use her judgment to add someone to the list above if she deems it appropriate.

I do not wish to have anyone else use touch to comfort me. This includes hold my hand, smooth my hair, put their hand on my shoulder, offer kisses, fix my blankets or perform any related activities.

I specifically do not wish to have "healing touch" or stroking or related practices, nor Reiki or related practices used on me. I do not wish to have informal or formal practices involving transmission or summoning of "energy". I do not wish to have objects considered to have magical powers placed in my presence.

I wish there to be no praying, no reference to gods, nor any chanting or singing in my presence or hearing. Exception: a Sh'ma, if someone comes by who can recite those few words.

I want to hear the human voices of the people present in the room, and music only when there is no one to talk to me. I wish to be talked to when possible, even if I don't appear to respond to others' voices.

In the event music is played, I would prefer Mozart, or Bach, played quietly. I do not wish to hear any music that is interrupted by ads for products or donor organizations. I don't want to hear a television set.

I wish to have large pictures of my daughter and grandsons placed where they are visible to me despite my positioning and any limitations of movement I may have.

I wish to be in a room with a window that can be opened, and that the window be kept open as possible

I wish to be placed so that I can look out the window, despite my positioning and any limitations of movement I may have, and be able to see a tree, or trees in the distance or some other aspect of nature.

I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.

I wish to have the following personal care procedures as long as they do not cause me pain or discomfort: nail clipping, teeth brushing, slight, natural-looking enhancement of my eyebrows. I wish to be kept fresh and clean at all times.

### **My wishes for what I want my loved ones to know**

I wish to have my family and friends know that I love them.

I wish to be forgiven for the times I have hurt my family, friends and others.

I wish to have my family, friends and others know that I forgive them for when they may have hurt me. "Family, friends (and others)" does not include my third husband.

I wish my family to commit to loving and supporting each other, especially my disabled son, Benjamin.

I wish for my family to remember what I was like when I was not ill.

I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.

I wish for my family and friends to look at my dying as a valid part of my life and of theirs. This will help me live a meaningful life in my final days.

I wish for my family to seek counseling if they experience emotional distress. I wish for them to know that hospice is a good source of counseling, and also of guidance for how to talk about my death with my grandsons.

I wish to donate my remains to UCSF for medical teaching and research.

I can accept the reality of my death. My death is not the end of the world. The accelerating destruction of a liveable habitat, however does risk ending a world in which human beings can live.

If anyone wishes to honor my memory, I ask them to do all they can to bring Climate Change into the minds and conversations of the people they connect with, so that it becomes socially acceptable to talk and think about it; and to make personal choices and political choices that are in the interests of our children and grandchildren, with the goal that they will enjoy nature as we have enjoyed it, will breathe fresh air, will have an adequate water supply, and will be nurtured by delicious produce.

If anyone wishes to make a charitable donation in my memory I welcome them to donate to the charity of their choice.

I do not wish to have a funeral.

If my daughter or if a friend wishes to hold a gathering to remember me, I would like it to be done with a minimum of fuss. I do not want anyone to fly, or to drive a major distance, to attend. My wish is that this gathering be of comfort to those of my family who are capable of receiving comfort from it, and to my friends. It can take place anytime, within a year of my death. I specifically do not want it to be a "celebration of life". I want people to share whatever memories and emotions they experience.

I wish there to be food and drink available at or after this gathering, expenses to come from my estate. I would like it to include plain cake (sponge cake if obtainable) and red wine. I would prefer nothing more elaborate.

If it does not take place at my daughter's home, I would like it to take place at a space at the Jewish Home on Silver Avenue, San Francisco. This should not be interpreted as a request for prayers or references to religion. Fee or donation expenses should also come from my estate.

It may be that the university holds periodic memorials for people whose bodies have been donated. They would presumably inform you.

I wish for death notices to be published in the primary newspapers of-----

Metta is a Pali word that means loving kindness. This is a meditation of compassion for caregivers.

### **Metta for Caregivers**

(from Joan Halifax, *Being with Dying* teachers' manual)

The emphasis in these practices is on balance—the balance between opening one's heart endlessly, and accepting the limits of what one can do. The balance between compassion and equanimity. Compassion is the trembling or the quivering of the heart in response to suffering. Equanimity is a spacious stillness that can accept things as they are. The balance of compassion and equanimity allow us to care, and yet not get overwhelmed and unable to cope because of that caring.

The phrases we use reflect this balance. Choose some phrases that are personally meaningful to you. You can alter them in any way, or use one that you have created out of your unique personal significance.

To begin the practice, take as comfortable a position as possible, sitting or lying down. Take a few deep soft breaths to let your body settle. Bring your attention to your breath, and begin to silently say your chosen phrases in rhythm with the breath...you can also experiment with just having your attention settle in the phrases, without using the anchor of the breath. Feel the meaning of what you are saying, yet without trying to force anything...let the practice carry you along.

*May I offer my care and presence unconditionally, knowing it may be met by gratitude, indifference, anger or anguish.*

*May I find the inner resources to truly be able to give*

*May I offer love, knowing I cannot control the course of life, suffering or death*

*May I remain in peace, and let go of expectations*

*I care about your pain, yet cannot control it*

*I wish you happiness and peace, but I cannot make your choices for you*

*May this experience be a heavenly messenger for me, helping me open to the true nature of life*

*May I see my limits compassionately, just as I view the suffering of others*

*May I, and all beings, live and die in ease*



# CPR/DNR

Being asked to make a decision about cardiopulmonary resuscitation (CPR) can be complicated. Few of us have ever seen CPR performed. Our understanding of CPR may come from what we see on TV ...where it looks easy and seems to be very successful without any complications. Unfortunately, these TV images of CPR are not completely accurate.

This brochure provides answers to some common questions about what CPR involves and what else is important to think about when making a decision about CPR.

COALITION for COMPASSIONATE CARE of CALIFORNIA

## WHAT DOES CPR LOOK LIKE?

CPR is a longer process than most people realize. It is an attempt to re-start the heart when the heart has stopped beating. The person is placed on a hard board or on the ground and the center of the chest is pushed in about 2 inches (to provide 100 to 125 pounds of pressure). These chest compressions must be done 100 times each minute. Artificial respiration using a special mask and bag over the person's mouth to pump air into the lungs may be started. When the emergency team arrives, a breathing tube may be inserted into the windpipe to provide oxygen, and a number of electrical shocks may be given with paddles that are placed on the chest. An intravenous line (IV) will be placed in a vein and medications will be given through the IV line.

If the heart continues to respond to these treatments, the person is taken to the emergency department. Those who survive will then be transferred to the intensive care unit at the hospital and attached to a ventilator (breathing machine) and a heart monitor. At this stage, most persons are still unconscious.

## WHO IS LEAST LIKELY TO BENEFIT FROM CPR?

Risk factors that are more frequent among older persons may contribute to lower chances of CPR survival as age increases. Most older adults do not have the type of heart rhythm that responds to CPR. Having any chronic disease that affects the heart, lungs, brain and kidneys can lower chances for survival after cardiac arrest. If a person has multiple advanced chronic illnesses, CPR survival will be even lower.

Individuals in advanced stages of dementia have CPR survival rates three times lower than those without dementia. Several studies that looked at survival of frail nursing home residents in advanced stages of illness who were dependent on others for all of their care showed CPR survival rates of 0 – 5% even if they were transferred from the nursing home to the hospital before the cardiac arrest.

continued on next page

# A GUIDE FOR DECISION MAKING

Older adults in terminal stages of cancer had CPR survival rates 0 – 1%. Unlike younger persons whose healthy bodies may be able to withstand the shock of a cardiac arrest and respond to treatment, those at an advanced age with serious underlying health problems may be dying from progressive organ failure. Their bodies do not have enough reserve to tolerate the lack of oxygen that occurs with cardiac arrest, their hearts may not be able to pump effectively enough to respond to CPR attempts. Those with liver or kidney failure may not be able to use the emergency drugs that are given.

## WHO IS MOST LIKELY TO BENEFIT FROM CPR?

The success of CPR depends on the reason the heart stopped, how healthy the person was before the heart stopped, and how long the heart has been stopped before CPR is started. It is hard to know in advance how effective CPR will be for a specific person, but many studies have shown who is most likely to benefit from CPR and who is not. In general, about 15% of all those who have CPR will survive. This number may increase for those who have no major health problems, have a sudden, unexpected collapse, have CPR started within a few minutes of when the heart stops, and have the type of heart rhythm that responds to electrical shocks.

## ARE THERE ANY COMPLICATIONS FROM CPR?

On TV CPR looks fast and uncomplicated. It is different in real life situations. Serious complications are likely. The most common complications are rib fractures that have been documented in up to 97% of CPR attempts, and breastbone fractures documented in up to 43% of cases. The risk of these fractures increases with age as does the chance for multiple fractures. This may be due to a decrease in muscle mass and an increased rate of osteoporosis with age. Approximately 59% of those who have CPR will have bruising of the chest, and about 30% may have burns from the defibrillator.

Permanent brain damage may occur from lack of oxygen in up to 50% of those who have CPR attempted.

Other less frequent complications of CPR that have been identified include bleeding in the chest (0-18%), damage to the trachea or esophagus (0-20%), damage to abdominal organs (0-31%), lung damage (0-13%), and damage to lips and teeth (0-8%).

## WHAT HAPPENS IF I DECIDE NOT TO HAVE CPR?

After careful consideration of all possible benefits and risks, many individuals decide that they do not want CPR attempted. However, some people are afraid that if they say they don't want CPR they won't get the kind of care they should. A decision not to have CPR applies only to the CPR process. Overall care and treatment will not be affected by choosing not to have CPR. If you do not want CPR done, an order will be written in the medical record so that CPR will not be attempted if the heart stops beating and breathing stops. The order is called a DNR (Do NOT Resuscitate) order and is used to protect a person from unnecessary attempts at CPR.



COALITION FOR  
COMPASSIONATE CARE  
OF CALIFORNIA

Phone: 916-489-2222 • [www.CoalitionCCC.org](http://www.CoalitionCCC.org)

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Development of this brochure was made possible  
through a grant from the California HealthCare  
Foundation, based in Oakland, California

**Suggested Reading List for books on Palliative and End of Life Care**

1. **Last Acts of Kindness: Lessons for the Living from the Bedside of the Dying**, by Judith Redwing Keyssar RN, Createspace 2010.
2. **A Beginner's Guide to the End: How to Live Life to the Full and Die a Good Death** ;BJ Miller, MD and Shoshana Berger; 2019, Simon and Shuster
3. **Life After the Diagnosis**; Steven Pantilat, MD, 2017, Da Capo Press
4. **Dying Well**, by Ira Byock, MD, Riverhead Trade, 1998
5. **The Four Things that Matter Most (2004) and The Best Care Possible (2012)** by Ira Byock
6. **The Wild Edge of Sorrow; Rituals of Renewal and the Sacred Work of Grief**; Francis Weller; 2015,Random House
7. **Elderhood: Redefining Aging, Transforming Medicine, Reimagining Life**; Louise Aronson, MD; 2019; Bloomsbury Pub
8. **Extreme Measures**, Jessica Zitter, MD, 2017, Avery Press
9. **Being with Dying: Cultivating Compassion and Fearlessness in the Presence of Death**; Joan Halifax, 2009;
10. **The Four-fold Way: Walking the Paths of the Warrior, Teacher, Healer and Visionary**, by Angeles Arrien, HarperOne 1993
11. **When Breath Becomes Air**, Paul Kalanithi, MD; 2016, Random House
12. **Being Mortal**, by Atul Gawande, Henry Holt and Company, 2014.
13. **The Grace in Dying**, by Kathleen Dowling Singh, HarperOne, 1998.
14. **Who Dies**, by Stephen Levine, Anchor Books, 1982.
15. **A Year to Live: How to Live This Year as If It Were Your Last**, Three Rivers Press, 1998 (any of Stephen Levine's books)
16. **The Way of Council** by Jack Zimmerman and Virginia Coyle, Bramble Books, 1996.
17. **Mortally Wounded**, by Michael Kearney, MD, Scribner, 1996.
18. **Rituals of Healing, Using Imagery for Health and Wellness**, by Jeanne Achterberg, Barbara Dossey, Leslie Kolkmeier, Bantam New Age Books, 1994.
19. **How We Die, Reflections on Life's Final Chapter**, by Sherwin B. Nuland, MD, Alfred A. Knopf, 1994.
20. **Caring for the Dying**, The Doula Approach to a Meaningful Death, Henry Fersko-Weiss, Conari Press, 2019
21. **Tuesdays with Morrie**, by Mitch Albom, Doubleday, 1997.
22. **Kitchen Table Wisdom and My Grandfather's Blessings**, by Rachel Naomi Remen, MD; Riverhead Books, 1997/2000.
23. **The Tibetan Book of Living and Dying**, by Sogyal Rinpoche; Harper, 1993.
24. **The Dying Time; Practical Wisdom for the Dying and Their Caregivers**, by Joan Furman and David McNabb, Bell Tower, 1997
25. **The Good Death**, by Marilyn Webb, Bantam, 1997.
26. **Caring for Your Dead**, by Lisa Carlson, Upper Access, 1998.
27. **How Then, Shall We Live?: Four Simple Questions that Reveal the Beauty and Meaning of Our Lives**, by Wayne Mueller, Bantam, 1997.
28. **Start Where You Are: A Guide to Compassionate Living and When Things Fall Apart**, by Pema Chodron, Shambhala, 2004/2001

## RESOURCES AND WEBSITES

### **UCSF MERI Center - Advance Care Planning Resource Page**

**Website:** <https://meri.ucsf.edu/advance-care-planning>

### **Prepare for Your Care**

**Website:**

<https://prepareforyourcare.org/welcome>

### **Advanced Directive for Dementia**

**Website:** <https://dementia-directive.org/>

### **Alzheimer's Association**

Northern California & Nevada

**Phone:** 408.372.9900

**Website:** <https://www.alz.org/>

### **American Cancer Society**

**Phone:** 415-394-7100

**Website:** [www.cancer.org](http://www.cancer.org)

### **American Clinicians Academy on Medical**

### **Aid in Dying Website:**

<https://www.acamaid.org/patient-information/>

### **American Heart Association**

San Francisco Division

**Phone:** 415-433-2273

**Website:** [www.americanheart.org](http://www.americanheart.org)

### **California Coalition for Compassionate Care**

**Phone:** 916-552-7678

**Website:** <https://coalitionccc.org/>

Spanish and Chinese AHCD fact sheets are available.

### **California Department of Aging**

**Phone:** 800-510-2020

The California Department of Aging has a toll-free number to help seniors and functionally impaired adults locate legal services in their community.

**Phone:** 415-541-0900

**Website:** [www.cmanet.org](http://www.cmanet.org)

### **California Medical Association**

**Phone:** 415-541-0900

**Website:** [www.cmanet.org](http://www.cmanet.org)

CMA's Advance Health Care Directive Kit can be ordered for \$5.00 by phone at 415-882-3388. Both English and Spanish kits are available.

### **California Organ Donation/Donate Life via DMV**

**Website:**

<https://www.dmv.ca.gov/portal/dmv/detail/about/donatelife/donatelife>

### **Compassion & Choices**

**Phone:** 800-247-7421

**Website:** [www.compassionindying.org](http://www.compassionindying.org)

Advance Directive forms for all states can be downloaded from website.

### **Family Caregiver Alliance**

**Phone:** 415-434-3388

**Toll-free:** 800-445-8106

**Website:** [www.caregiver.org](http://www.caregiver.org)

**E-mail:** [info@caregiver.org](mailto:info@caregiver.org)

### **Go Wish Cards**

**Website:** [www.codaalliance.org](http://www.codaalliance.org)

**To Purchase decks:**

<https://codaalliance.org/go-wish/>

**To play online:**

<http://www.gowish.org/gowish/gowish.html>

## Body Donation Resources

### **University of California, San Francisco Willed Body Program**

**Phone:** 415-476-1981

**Fax:** 415-502-1460

**Website:** <https://meded.ucsf.edu/willed-body-program>

### **Loma Linda University Bodies for Science Program**

**Phone:** 909-558-4301

**Website:** <http://www.llu.edu/medicine/anatomy/willed.page>

### **UCLA Donated Body Program David Geffen School of Medicine**

**Phone:** 310-794-0372

**Fax:** 310-794-0334

**Website:** <http://www.donatedbodyprogram.ucla.edu>

### **UC Davis, Body Donation Program**

**Phone:** 916-734-9560

**Fax:** 916-734-9563

**Website:** <https://health.ucdavis.edu/bodydonation/>

### **UC San Diego Body Donation Program**

**Phone:** 858-534-4536

**Website:** <http://bodydonation.ucsd.edu>

### **UC Irvine Willed Body Program**

**Phone:** 949-824-6061

**Website:** <http://www.som.uci.edu/willedbody/index.asp>

### **Los Angeles College of Chiropractic Medicine**

Phone: 231-947-8755 x252

### **USC Anatomical Gift Program**

**Phone:** 323-442-1229

**Fax:** 323-442-3145

**Website:** <https://agp.usc.edu/>

### Stanford University School of Medicine

**Phone:** 650-723-2404

**Website:** <http://med.stanford.edu/anatomy/donate/>

### **Western University of Health Sciences College of Osteopathic Medicine of the Pacific**

#### **Body Donation Program**

**Phone:** 909-469-5431

**Website:** <https://www.westernu.edu/osteopathic/body-donation-program/>

## Go Wish Cards

Go Wish gives you an easy, even entertaining way to talk about what is most important to you. The cards help you find words to talk about what is important if you were to be living a life that may be shortened by serious illness. Playing the game with your relatives or best friends can help you learn how you can best comfort your loved ones when they need you most. Go Wish can be played by one, two or more people.

Each deck has 36 cards. Thirty-five of the cards describe things that people often say are important when they are very sick or dying. The cards describe how people want to be treated, who they want near them, and what matters to them. One card is a "wild card." You can use this card to stand for something you want that isn't on any of the other cards.

### Ways to Play:

#### Go Wish Solitaire

This is a good way to figure out what is important to you and why.

1. Read through all 36 cards. Sort them into three piles:

- Very important to me
- Somewhat important to me
- Not important to me

**NOTE:** Putting a card in the "Not important to me" pile does not necessarily mean that you don't care about what is written on the card. It could simply mean that this is something that you have already taken care of. For example, if all of your financial affairs are competely in order, taking care of your financial affairs is no longer one of your top ten concerns.

2. You can use the wild card to stand for something you want that is not on any of the other cards. For example: "To live in my own home." or "To be able to recognize my family and friends." That card can go into any of the three piles.

3. When you have three piles, sort through your "very important" pile. Choose the 10 wishes that mean the most to you. If you don't have 10 cards in your "very important" pile, choose some from your "somewhat important" pile. If you have more than 10 in your "very important" pile, sort through them and put some of the cards into the "somewhat important" or "not important" piles until you only have 10 cards in your "very important" pile.

4. Rank your 10 "very important" cards, putting the most important ones at the top of the pile. This is your Top 10.

**5. Think about how you would explain to your family or friends why those things are your Top 10 wishes. Think about your "not important" pile and how you would explain to your family or friends why those things are not important to you. Then make time to talk to them about your choices.**

**Make time to talk to your loved ones about your choices.**

#### Playing Solitaire On-Line

Playing the solitaire version on-line is exactly like playing with the actual cards. We've added sound so that you can hear the contents of each card. By default the sound is turned on. If you'd like to turn the sound off, mute (turn off) your speakers. As you view (and hear) each card from the main pile, you can click to put each card in the "Very Important," "Somewhat Important," or "Not Important" stacks below. Move your mouse over any card in any stack and you can view it again and move it to another stack or back to the main pile.

When you have completed your sorting, you can save your stacks by clicking "save." You'll be asked to pick a file name for your stack (no spaces allowed). Pick something you'll remember! Plus, you'll be able to email the name of your sorted stacks to yourself or others.

**Think about how you would explain to your family or friends why those things are your Top 10 wishes. Think about your "not important" pile and how you would explain to your family or friends why those things are not important to you. Then make time to talk to them about your choices.**

Your stacks will remain here at Go Wish for years to come so that you can revisit them to remind yourself of your saved wishes. Plus, you can resort them and save them as a different name as time moves on and your desires change. There is NO personal information stored with these stacks so your privacy remains intact! Share your file name only with those you wish to know about your wishes.

## Go Wish Pairs

This can be a good game to play with someone who might become your health care agent. It is especially important for that person to understand your wishes. It is best to play with two decks of cards.

If you are playing with the actual printed cards, you will need two decks. If you are playing on-line, each of you should play on your own computer connected to the Internet. You don't have to be in the same room or even the same time-zone to play on-line!

Each play reads through all 36 cards. Each play divides them into three piles.

Player A sorts the cards into three piles:

- Very important to me
- Somewhat important to me
- Not important to me

Player B sorts the cards into three piles:

- Very important to Player A
- Somewhat important to Player A
- Not important to Player A

Go Wish was developed by **Coda Alliance**, made possible in part by a grant from the **Archstone Foundation**. For more information about Coda Alliance, a community-based, not-for-profit organization helping individuals and their families plan and prepare for end-of-life issues, go to <http://www.codaalliance.org>

**To be  
free from  
pain**

**To be  
free from  
anxiety**

**Not being  
short of  
breath**

**To be  
kept clean**

**To have  
human touch**

**To have  
my financial  
affairs  
in order**

**To have  
my family  
prepared  
for my death**

**To die  
at home**

**To know  
how my  
body will  
change**

**To feel  
that my  
life is  
complete**

**To say  
goodbye to  
important  
people in  
my life**

**To remember  
personal  
accomplish-  
ments**

**To take care  
of unfinished  
business  
with family  
and friends**

**To prevent  
arguments  
by making  
sure my family  
knows what  
I want**

**To have  
an advocate  
who knows  
my values  
and priorities**

**To be  
treated the  
way I want**

**To maintain  
my dignity**

**To keep  
my sense  
of humor**

**To have  
a doctor  
who knows  
me as a  
whole person**

**To have  
close friends  
near**

**Not  
dying  
alone**

**To have  
someone  
who will  
listen to me**

**To trust  
my doctor**

**To have  
a nurse  
I feel  
comfortable  
with**

**To be  
mentally  
aware**

**To have  
my funeral  
arrangements  
made**

**Not being  
a burden to  
my family**

To be  
able to help  
others

To be  
at peace  
with God

To pray

To be  
able to talk  
about what  
scares me

Not being  
connected  
to machines

To meet  
with clergy  
or a chaplain

To be  
able to talk  
about what  
death means

To have  
my family  
with me

WILD  
CARD

## I Will Not Die an Unlived Life

by *Dawna Markova*

I will not die an unlived life  
I will not live in fear  
of falling or catching fire.  
I choose to inhabit my days,  
to allow my living to open me,  
to make me less afraid,  
more accessible,  
to loosen my heart  
until it becomes a wing,  
a torch, a promise.  
I choose to risk my significance;  
to live so that which came to me as seed  
goes to the next as blossom  
and that which came to me as blossom,  
goes on as fruit.