What Matters Most?

Advance health care directive and values exploration workshop

Led by Redwing Keyssar, RN, BA
Director of Patient & Caregiver Education
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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:_____________
ADVANCE CARE PLANNING
Advance HealthCare Directive Fact Sheet for Consumers

What is an Advance HealthCare Directive (AHCD)?
An AHCD is a way to make your healthcare wishes known if you are unable to speak for yourself or prefer someone else to speak for you. An AHCD can serve one or both of these functions:

- Power of Attorney for Healthcare (to appoint an agent)
- Instructions for Healthcare (to indicate your wishes)

Is the AHCD different from a Durable Power of Attorney for Healthcare?
The AHCD was enacted by July 2000 legislation and replaced the DPAHC and the Natural Death Act Declaration. However, if you had already completed one of these forms that was valid before July 1, 2000, it is still valid now.

I’ve never completed an “Advance HealthCare Directive” before. Why should I?
Persons of all ages may unexpectedly be in a position where they cannot speak for themselves, such as an accident or severe illness. In these situations, having an “Advance HealthCare Directive” assures that your doctor knows your wishes about the kind of care you want and/or who the person is that you want to make decisions on your behalf.

Does this mean only one person can decide for me? What if I want others involved, too?
Often many family members are involved in decisionmaking. And most of the time, that works well. But occasionally, people will disagree about the best course of action, so it is usually best to name just one person as the agent (with a backup, if you want). And you can also indicate if there is someone who you do NOT want to make your decisions for you.

But I thought the doctors make all those life-and-death decisions anyway?
Actually, doctors tell you about your medical condition, the different treatment options that are available to you and what may happen with each type of treatment. Though doctors provide guidance, the decision to have a treatment, refuse a treatment or stop a treatment is yours.

What if something happens to me and no form has been completed?
If you are not able to speak for yourself, the doctor and healthcare team will turn to one or more family members or friends. The most appropriate decisionmaker is the one with a close, caring relationship with you, is aware of your values and beliefs and is willing and able to make the needed decisions.
My “values and beliefs?” But I haven’t talked with anyone about these!
That’s why it is a good idea to talk with family or close friends about the things that are important

to you regarding quality of life and how you would want to spend your last days and weeks.
Knowing the things that are most important to you will help your loved ones make the best
decisions possible on your behalf. If your agent doesn’t know your wishes, then he or she will
decide based on what is in your best interest.

What if I don’t want to appoint an agent? Or don’t have one to appoint?
You do not have to appoint an agent. You can still complete the Instructions for Healthcare and
this will provide your doctors with information to guide your care.

What kinds of things can I write in my Instructions for Healthcare?
You can, if you wish, write your preferences about accepting or refusing life-sustaining treatment

(like CPR, feeding tubes, breathing machines), receiving pain medication, making organ
donations, indicating your main doctor for providing your care, or other things that express your
wishes and values. If you have a chronic or serious illness, you also may want to talk with your
doctor, nurse practitioner or physician assistant about specific treatments that you could face and

ask him/her to help you document your decisions on a POLST form.

A POLST form – I’ve never heard of that!
POLST stands for Physician Orders for Life-Sustaining Treatment and was adopted in California in
2009. This is a voluntary form, which must be signed by you (or your decisionmaker) and your
physician, nurse practitioner or physician assistant, and indicates the types of life-sustaining
treatment you do or do not want if you become seriously ill. POLST asks for information about
your preferences for CPR, use of antibiotics, feeding tubes, etc. POLST doesn’t replace your
AHCD, but helps translate it into medical orders that must be followed in all healthcare settings
(home, nursing home, hospital).

If I appoint an agent, what can that person do?
Your agent will make all decisions for you, just like you would if you could. Your agent can
choose your doctor and where you will receive your care, speak with your healthcare team,
review your medical record and authorize its release, accept or refuse all medical treatments and
make arrangements for you when you die. You should instruct your decisionmaker on these
matters so he/she knows how to decide for you. The more you tell them the better they will be
able to make those decisions on your behalf.

When does my agent make decisions for me?
Usually the agent makes decisions only if you are unable to make them yourself – such as, if
you’ve lost the ability to understand things or communicate clearly. However, if you want, your
agent can speak on your behalf at any time, even when you are still capable of making your own decisions. You can also appoint a "temporary" agent— for example, if you suddenly become ill, you can tell your doctor if there is someone else you want to make decisions for you. This oral instruction is just as legal as a written one!

Are there other oral instructions that don't involve a written form?
Yes. You can make an individual healthcare instruction orally to any person at any time and it is considered valid. All healthcare providers must document your wishes in your medical record. But it is often easier to follow your instructions if they are written down.

Can I make up my own form or use one from another state?
Yes. That's why this law is so flexible. Any type of form is legal as long as it has at least 3 things: 1) your signature and date, 2) the signature of two qualified witnesses, and 3) if you reside in a skilled nursing facility, the signature of the patient advocate or ombudsman. These signatures, however, must include special wording.

Sounds difficult. Do I need an attorney to help with this?
No. Completing an Advance HealthCare Directive isn't difficult and an attorney is not necessary. But actually the most important part of this is talking to your loved ones. Without that conversation, the best form in the world may not be helpful!

OK, I'll talk to them! But what should I do with the form after I complete it?
Make copies for all those who are close to you. Take one to your doctor to discuss and ask that it be included in your medical record. Photocopied forms are just as valid as the original. And be sure to keep a copy for yourself in a visible, easy-to-find location – not locked up in a drawer.

What if I change my mind?
You can revoke your form (or your oral instructions) at any time. Also, it's a good idea to try and retrieve old forms and replace them with new ones.

Do doctors or hospitals require a patient to have an Advance HealthCare Directive form?
No, they cannot require you to complete one. But doctors and hospitals should have information available to you and your family about the form and your right to make healthcare decisions.

Resources
Check the Coalition for Compassionate Care of California website www.coalitionccc.org for updates on Advance HealthCare Directive materials and community education programs.
Advance HealthCare Directive Forms

- Download forms in English, Spanish and Chinese from the Coalition website at www.CoalitionCCC.org.
- Forms are often available at no charge from your local hospital – call the Social Services Department or Chaplain’s Department. Or ask your doctor.
- The California Medical Association has an Advance HealthCare Directive Kit available in English or Spanish for $5 that includes a form, wallet card and answers to commonly asked questions about advance directives. To order single copies, call 1-800-882-1262 or visit www.cmanet.org.
- Five Wishes is a user-friendly Advance Directive that addresses the medical, personal, emotional and spiritual wishes of seriously ill persons. To order single copies in English or Spanish at $5 each, send a check or money order to Aging With Dignity, PO Box 1661, Tallahassee, FL 32302-1661. A companion 30-minute video is available for $19.95. For more information call 1-888-5-WISHES.
- Caring Connections has state-specific forms that can be downloaded from its website at www.caringinfo.org.

Fact Sheets in Other Languages
Additional fact sheets in multiple languages are available on the Coalition website at www.coalitionccc.org/tools-resources/advance-care-planning-resources.

Booklets for Consumers

- **Finding Your Way: A Guide for End-of-Life Medical Decisions.** This 13-page, easy-to-read booklet helps those who are starting the advance care planning process or considering whether to initiate or withdraw life-sustaining treatment when the end of life is near. Also available in Spanish.
- **Mrs. Lee’s Story: Medical Decisions Near the End of Life.** This 16-page booklet written in Chinese and English relates the story of 91-year old Mrs. Ming Lee to introduce health issues that concern Chinese elders and their families. It includes basic information on Advance Care Planning and Advance Directives, pain management and hospice care.

These booklets are available to view online, or purchase through CCCC’s online store at www.CoalitionCCC.org.
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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
<table>
<thead>
<tr>
<th>To feel that my life is complete</th>
<th>To say goodbye to important people in my life</th>
<th>To remember personal accomplishments</th>
</tr>
</thead>
<tbody>
<tr>
<td>To take care of unfinished business with family and friends</td>
<td>To prevent arguments by making sure my family knows what I want</td>
<td>To have an advocate who knows my values and priorities</td>
</tr>
<tr>
<td>To be treated the way I want</td>
<td>To maintain my dignity</td>
<td>To keep my sense of humor</td>
</tr>
<tr>
<td>To have a doctor who knows me as a whole person</td>
<td>To have close friends near</td>
<td>Not dying alone</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>To have someone who will listen to me</td>
<td>To trust my doctor</td>
<td>To have a nurse I feel comfortable with</td>
</tr>
<tr>
<td>To be mentally aware</td>
<td>To have my funeral arrangements made</td>
<td>Not being a burden to my family</td>
</tr>
</tbody>
</table>
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
Durable Power of Attorney for Healthcare Decisions

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.

(Initial here)

OR

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

(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:

(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: __________________________________________

________________________________________
FIVE WISHES®

MY WISH FOR:

The Person I Want to Make Care Decisions for Me When I Can’t

The Kind of Medical Treatment I Want or Don’t Want

How Comfortable I Want to Be

How I Want People to Treat Me

What I Want My Loved Ones to Know

[Blank lines for personal information]

print your name

[Blank line for birthday]
Five Wishes

There are many things in life that are out of our hands. This Five Wishes booklet gives you a way to control something very important—how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed it is valid under the laws of most states.

What Is Five Wishes?
Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association’s Commission on Law and Aging, and the nation’s leading experts in end-of-life care. It’s also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won’t have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants through a Five Wishes living will. You can be there for them when they need you most. You will understand what they really want.

How Five Wishes Began
For 12 years, a man named Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC’s Today Show and in the pages of Time and Money magazines. Newspapers have called Five Wishes the first “living will with a heart.”
Who Should Use Five Wishes
Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. Over eight million Americans of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States
If you live in the District of Columbia or one of the 40 states listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state’s requirements under the law:

<table>
<thead>
<tr>
<th>Alaska</th>
<th>Idaho</th>
<th>Missouri</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Illinois</td>
<td>Montana</td>
<td>South Carolina</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Iowa</td>
<td>Nebraska</td>
<td>South Dakota</td>
</tr>
<tr>
<td>California</td>
<td>Louisiana</td>
<td>New Jersey</td>
<td>Tennessee</td>
</tr>
<tr>
<td>Colorado</td>
<td>Maine</td>
<td>New Mexico</td>
<td>Vermont</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Maryland</td>
<td>New York</td>
<td>Virginia</td>
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<tr>
<td>Delaware</td>
<td>Massachusetts</td>
<td>North Carolina</td>
<td>Washington</td>
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<td>Florida</td>
<td>Michigan</td>
<td>North Dakota</td>
<td>West Virginia</td>
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<tr>
<td>Georgia</td>
<td>Minnesota</td>
<td>Oklahoma</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Mississippi</td>
<td>Pennsylvania</td>
<td>Wyoming</td>
</tr>
</tbody>
</table>

If your state is not one of the 40 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state’s legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?
You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write “revoked” in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. AND
- Tell your Health Care Agent, family members, and doctor that you have filled out the new Five Wishes. Make sure they know about your new wishes.
The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- My attending or treating doctor finds I am no longer able to make health care choices, AND
- Another health care professional agrees that this is true.

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

<table>
<thead>
<tr>
<th>First Choice Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

<table>
<thead>
<tr>
<th>Second Choice Name</th>
<th>Third Choice Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
</tr>
<tr>
<td>City/State/Zip</td>
<td>City/State/Zip</td>
</tr>
</tbody>
</table>

Phone

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they are the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be at least 18 years or older (in Colorado, 21 years or older) and should not be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.
I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: (Please cross out anything you don't want your Agent to do that is listed below.)

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, 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.
- Interpret any instructions I have given in this form or given 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. My Health Care Agent can 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 Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. OR
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. OR
- Write the word “Revoked” in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.
I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- 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.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What “Life-Support Treatment” Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive.

If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a Do Not Resuscitate form or bracelet. Many states require a person to have a Do Not Resuscitate form filled out and signed by a doctor. This form lets ambulance personnel know that you don’t want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a Do Not Resuscitate form filled out.
Here is the kind of medical treatment that I want or don’t want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

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 (Choose one of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

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 I have brain damage, and life-support treatment would only delay the moment of my death (Choose one of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose one of the following):

- I want to have life-support treatment.
- I do not want life-support treatment. If it has been started, I want it stopped.
- I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write “end-stage condition.” That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)
The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 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 also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

**WISH 3**

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don’t agree with.)

- 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 I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I wish to have my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

**WISH 4**

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don’t agree with.)

- 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 my hand held and to be talked to when possible, even if I don’t seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.
WISH 5
My Wish For What I Want My Loved Ones To Know.
(Please cross out anything that you don't agree with.)

- 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 in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- 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 time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location__________________________.
- The following person knows my funeral wishes: ____________________________.

If anyone asks how I want to be remembered, please say the following about me:

__________________________________________________________________________
__________________________________________________________________________

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. Please attach a separate sheet of paper if you need more space.)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, ____________________________, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature: ____________________________________________

Address: __________________________________________________

Phone: __________________________ Date: ______________________

Witness Statement - (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter “person”) is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person’s health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person’s health care provider,
- Financially responsible for the person’s health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state’s rules, please follow the above.)

Signature of Witness #1

__________________________________________________________

Printed Name of Witness

______________________________

Address

______________________________

Phone

Signature of Witness #2

__________________________________________________________

Printed Name of Witness

______________________________

Address

______________________________

Phone

Notarization - Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF ____________________________    COUNTY OF ____________________________

On this ______ day of ____________________, 20____, the said ____________________________________________, and ____________________________________________, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: ____________________________

Notary Public
What To Do After You Complete Five Wishes

• Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.

• Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.

• Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.

• Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.

• Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.

• If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.

• I have given the following people copies of my completed Five Wishes:

Residents of WISCONSIN must attach the WISCONSIN notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, NEW YORK, NORTH DAKOTA, SOUTH CAROLINA, and VERMONT Must Follow Special Witnessing Rules.
If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

Name
Address
City/State/Zip
Phone

My primary care physician is:

Name
Address
City/State/Zip
Phone

My document is located at:

Cut Out Card, Fold and Laminate for Safekeeping
Here's What People Are Saying About Five Wishes:

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

Cheryl K.
Longwood, Florida

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

Susan W.
Flagstaff, Arizona

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

Diana W.
Hanover, Illinois

To Order:

Call 1-888-5-WISHES to purchase more copies of Five Wishes, the Five Wishes Video, or Next Steps guides. Ask about the "Family Package" that includes 10 Five Wishes, 2 Next Steps guides and 1 video at a savings of more than 50%. For more information visit Aging with Dignity's web site, or call for details.

1-888-5-WISHES (1-888-594-7437)

Aging with Dignity

P.O. Box 1661
Tallahassee, Florida 32302-1661
www.agingwithdignity.org
1-888-594-7437
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

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)

A  CARDIOPULMONARY RESUSCITATION (CPR):  If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B  MEDICAL INTERVENTIONS:  If person has pulse and/or is breathing.

☐ Comfort Measures Only  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. Transfer to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions  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.
☐ Transfer to hospital only if comfort needs cannot be met in current location.

☐ Full Treatment  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. Transfer to hospital if indicated. Includes intensive care.

Additional Orders:__________________________________________________________

C  ARTIFICIALLY ADMINISTERED NUTRITION:  Offer food by mouth if feasible and desired.

☐ No artificial means of nutrition, including feeding tubes. Additional Orders: _________________________

☐ Trial period of artificial nutrition, including feeding tubes. _________________________________

☐ Long-term artificial nutrition, including feeding tubes. _______________________________________

D  INFORMATION AND SIGNATURES:

Discussion with:
☐ Patient (Patient Has Capacity)  ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ________ available and reviewed → Health Care Agent if named in Advance Directive:

Name: __________________________________________ Phone: __________________________

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the person’s medical condition and preferences.

Print Physician Name: ________________________  Physician Phone Number: ______________________

Physician Signature: (required)  Physician License Number: ______________________

Date:

Signature of Patient or Legally Recognized Decisionmaker
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.

Print Name: _______________________ Relationship: (write self if patient)

Signature: (required)  Date:

Address: _______________________ Daytime Phone Number: ______________________

Evening Phone Number: ______________________

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

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

Patient Information

Name (last, first, middle): Date of Birth: Gender: M F

Health Care Provider Assisting with Form Preparation

Name: Title: Phone Number:

Additional Contact

Name: Relationship to Patient: Phone Number:

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.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
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 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.

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!

FAITH FITZGERALD, MD
Sacramento, California

THE EDITORS

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THE EDITORS

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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.
Personal Simple California Advance Health Care Directive

Sample

PLEASE SEE ADDENDUM FOR DETAILS

MY DESIGNATED AGENTS:
The persons listed here will make my medical decisions ONLY if I cannot make my own:

1.
2.
3.

My Agents have the authority to discuss my situation with the medical team and potentially change some previous decisions if my doctors believe it is in my best interest and the hospital Palliative Care team has been consulted. (SEE addendum)

However, they must adhere to my requests regarding:

- NO CPR
- NO INTUBATION
- NO DIALYSIS

  o SEE Addendum for all other decisions

Let it be known that I consider my life worth living ONLY IF:

- I am cognitively intact
- I am able to recognize and communicate with friends and family
- I am able to take care of myself physically
- I am free from severe pain
- I can live without artificial “life support”—ventilator, IV drips, dialysis, artificial nutrition or hydration, other than for a very short time—no more than 2 weeks

IF I am dying, it is important for me to be at “home” if possible, or else in a residential Hospice facility.

SPIRITUALITY is of prime importance to me, especially at the end of my life. See Addendum for details of the environment I wish to have around me.

My doctors/healthcare providers should know that I believe that the SPIRIT has guided my Life and will guide my dying process. My Agents understand what this means to me

IF I am so sick that my death is imminent I DO NOT WANT LIFE SUPPORT TREATMENTS OF ANY KIND AND I WANT THE FOCUS ON BEING KEPT COMFORTABLE, WITH _________
WHATEVER MEDICATIONS ARE NECESSARY. I PREFER TO A.N.D. (ALLOW NATURAL DEATH) RATHER THAN DNR (DO NOT RESUSCITATE)

AFTER DEATH:

1. **My agents will be responsible for after death ceremony** of washing my body and attending to me after death. If I am at home, the mortuary should only be contacted after any ceremony is completed and they should be directed NOT to cover my head until they have taken me out of my home.

2. **My agents have the authority to have my body cremated**. It depends where I am living at the time of death as to the exact location of the mortuary. My agents know how I wish to have my cremains disposed.
   1. I do not want to donate any organs
   2. I do not want an autopsy

It is my wish that a memorial be held after my death, at a time when it is convenient for people to attend. I hope that friends, family and colleagues will gather to celebrate our Love for each other and the gratitude I have for the gift of an amazing Life.
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.
**Note:** "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: 
My 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 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.

### 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
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.

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.

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.
Who is eligible for medical aid in dying?

To be eligible for medical aid in dying under California’s law, an individual must be:

> An adult
> Terminally ill
> Given a prognosis of six months or less to live
> Mentally capable of making their own healthcare decisions

An individual must also be:

> A resident of California
> Acting voluntarily
> Making an informed decision which includes being given information about all other end-of-life options
> Informed that s/he may choose to obtain the aid-in-dying drug, but not take it
> Capable of self-administering and ingesting the aid-in-dying drug

Two California physicians must agree that you are eligible to use the California End of Life Option Act. One physician prescribes the medication, and the other physician gives a consulting opinion. If either physician is unable to determine your mental capacity in making the request, a mental health professional (psychiatrist or psychologist) must evaluate you and ensure that you are capable of making your own healthcare decisions.

In addition to the requirements listed above, steps must be followed in order for a person to qualify for a prescription for aid-in-dying medication. Please see Compassion & Choices’ California End of Life Option Act - Information for State Residents.

Is the practice of medical aid in dying trusted?

Yes. Medical aid in dying is a safe and trusted medical practice because the eligibility requirements ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the choice of a peaceful death are able to request and obtain aid-in-dying medication. In California, the law specifically states that no person can qualify for aid-in-dying medication based solely on their disability or age.

In the more than 30 combined years of medical aid in dying in authorized states, there has not been a single instance of documented abuse. In Oregon, end-of-life care has improved overall since the law’s implementation, in large part due to the dialogue the Death With Dignity Act encourages between people and their doctors. Hospice referrals are up, as is the use of palliative care. Oregon now has the lowest rates of in-hospital deaths and the highest rates of at-home deaths in the nation, and violent suicide among hospice patients has virtually disappeared. Almost two decades of rigorously
observed and documented experience in Oregon shows us the law has worked as intended, with none of the problems opponents had predicted.

**How does the public feel about medical aid in dying?**

The American public consistently supports medical aid in dying by large majorities in independent national and state surveys. Polling outlets such as Gallup (68% support in May 2015) and Harris (74% support in November 2014) both report strong support for medical aid in dying.

**How does the medical profession feel about medical aid in dying?**

A 2014 Medscape survey of 17,000 doctors representing 28 medical specialties demonstrated that a majority of physicians (54% vs. 31%) support a terminally ill patient’s decision to end their life. In California, the End of Life Option Act was endorsed by more than 75 organizations including the American Nurses Association/California, California Psychological Association and California Primary Care Association. A growing number of national organizations representing healthcare professionals have accepted medical aid in dying as an end-of-life option for mentally capable, terminally ill adults including the California Medical Association, the American Public Health Association and the American Association of Hospice & Palliative Medicine.

**What can I do to make sure my doctor will support me if I ever want to access medical aid in dying?**

Ask your doctor and medical providers now whether they will support your end-of-life choices, including medical aid in dying. This will encourage your medical providers to listen to your priorities and become prepared to provide you with the treatment you may want in the future. If your medical providers are unable or unwilling to support your end-of-life choices, you have the option to change your care to a healthcare team that puts your wishes first.

**My doctors want to better understand medical aid in dying; where can they learn more?**

Doctors can call Compassion & Choices’ Doc2Doc consultation line at 800-247-7421 for a free, confidential consultation and information on end-of-life care with our medical directors who have extensive medical aid-in-dying experience.

**How long does the process take to request and obtain the aid-in-dying medication?**

The process to request and obtain aid-in-dying medication can be a lengthy one (and may not be successful) if you do not have a supportive healthcare team. The average length of time is between 15 days to three months and requires at least two doctor visits. Therefore, it is very important for individuals who may want to access the law to talk to their doctors early.

**Where can I find the necessary forms?**

The State Department of Health will be uploading information and forms to its website before the law becomes effective on June 9, 2016.

**Are there other resources available to learn more about medical aid in dying?**

You can call our California Information Hotline at 1-800-893-4548 or visit [http://www.EndOfLifeOption.org](http://www.EndOfLifeOption.org) for more information and resources.
Do all doctors have to participate in medical aid in dying?

No. Doctors and medical providers are not required to participate, so it is important to ask your healthcare team whether they will support your end-of-life choices. And some healthcare systems may actually prohibit their employees from participating in medical aid in dying – however, no healthcare system can prohibit their employees from providing information about medical aid in dying to patients or referring patients to supportive healthcare systems.

What cause of death is listed on the death certificates of individuals who have accessed medical aid in dying?

The underlying illness should be listed as the cause of death. The law specifies that a death resulting from self-administering aid-in-dying medication is not suicide.

Does accessing medical aid in dying affect a person’s will or insurance?

Accessing medical aid in dying does not adversely affect a person’s will or insurance. The law specifically mandates that wills, insurance, contracts and annuities are not affected if a qualified individual shortens their dying process by ingesting aid-in-dying medication.

Resources

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

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
11. When Breath Becomes Air, Paul Kalanithi, MD; 2016, Random House
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)
24. The Dying Time; Practical Wisdom for the Dying and Their Caregivers, by Joan Furman and David McNabb, Bell Tower, 1997
RESOURCES AND WEBSITES

UCSF MERI Center - Advance Care Planning & Advance Directive 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
San Jose Office, Headquarters
2290 North First Street, Suite 101
San Jose, CA 95131
Phone: 408.372.9900
Website: https://www.alz.org/

American Cancer Society
San Francisco County Unit
601 Montgomery St., Ste. 650
San Francisco, CA 94111
Phone: 415-394-7100
Fax: 415-495-1877
Website: www.cancer.org

American Heart Association
San Francisco Division
120 Montgomery St., Ste. 1650
San Francisco, CA 94104
Phone: 415-433-2273
Fax: 415-228-8402
Website: www.americanheart.org

California Coalition for Compassionate Care
Phone: 916-552-7678
Fax: 916-552-7585
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

California Medical Association
Phone: 415-541-0900
Website: 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
Advance Directive forms for all states can be downloaded from website.

Family Caregiver Alliance
Phone: 415-434-3388
Toll-free: 800-445-8106
Fax: 415-434-3508
Website: www.caregiver.org
E-mail: info@caregiver.org

Go Wish Cards
Website: http://www.gowish.org/index.php
Body Donation

CALIFORNIA

University of California, San Francisco
Willed Body Program
Department of Anatomy, AC-14
San Francisco, CA 94143-0902
Phone: 415-476-1981
Fax: 415-502-1460

Loma Linda University
Bodies for Science Program
Telephone: 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

University of California, Davis
UC Davis, Body Donation Program
Phone: 916-734-9560
Fax: 916-734-9563
Email: dbpinfo@ucdavis.edu

University of California, San Diego
Body Donation Program
Phone: 858-534-4536
Website: http://bodydonation.ucsd.edu

University of California, 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
University of Southern California
USC Willed Body Program
Program Manager: Darby Brakke
Phone: 323-442-1229
Fax: 323-442-3145
Email: brakke@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 Director: Nina McCoy
Phone: 909-469-5431
Email: nmccoy@westernu.edu
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.