

INFORMATION TO HELP YOU DIRECT YOUR CARE IF YOU BECOME INCAPACITATED

VIRGINIA MASON MEDICAL CENTER – Seattle WA

When you are critically ill or injured, you may lose the capacity to direct your care. Two legal documents in Washington State can help you outline your wishes for health care ahead of time: the “Directive to Physicians (Living Will)” and “Durable Power of Attorney for Health Care.”

Virginia Mason provides forms of these documents, which are described below. Please remember this information is not intended as legal advice. Any legal questions you may have should be directed to an attorney.

WHAT IS A DIRECTIVE TO PHYSICIANS (LIVING WILL)?

The Directive to Physicians is a document in which you specify the types of care you want when you are terminally ill and dying or when you are permanently unconscious. The advance directive may also be known as a health care directive or living will. It is intended to direct the actions of your family and physicians. The advance directive must be signed in the presence of two witnesses who are not related to you, are not potential heirs, are not your doctor or doctor’s employees, or employees of the health care facility in which you reside.

Although we have not provided a form for it, you may also make a mental health directive which specifies how treatment decisions should be made if you become unable to make sound choices due to mental illness.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A Durable Power of Attorney for Health Care is a legal document in which you name another person (called a health care agent) to make medical decisions for you if you lose the capacity to make informed health care decisions for yourself. You can include special instructions about treatment you do or do not want.

Who can you appoint as a health care agent? The person you appoint as your health care agent cannot be any of the following:

- Your physician
- An employee of your physician
- An administrator, owner, or employee of a health care facility in which you reside or receive care

The Durable Power of Attorney should be dated, signed and notarized. Note: the notary signature is not required in Washington State, but other states do require it, so notarizing is prudent in anticipation of relying on the form while traveling out of state.

Documents

Signed copies of the Directive to Physicians and the Durable Power of Attorney for Health Care should be retained as follows:

- copies should be given to your health care provider and be included in your official medical record
- copies should go to the person (and alternates) you have designated as your health care agent under the Durable Power of Attorney
- copies should go to your personal attorney, if any
- keep copies for yourself and give copies to someone you trust, for safekeeping

NAME

DOB



DIRECTIVE TO PHYSICIANS

Health Care Directive / Living Will

Directive made this _____ day of _____, 20 _____.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

- I If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand "terminal condition" means an incurable and irreversible condition caused by injury, disease or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards.
- II If I should be in a permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn. I understand that a "permanent unconscious condition" means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.
- III If I am diagnosed to be in a terminal or permanent unconscious condition, [Choose one]
I want _____ (initial) do not want _____ (initial)
artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.
- IV In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.
- V If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
- VI I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.
- VII I make the following additional directions regarding my care:

SIGNED: _____ DATE: _____

The declarer has been personally known to me and I believe him or her to be of sound mind. I am not related to the declarer by blood or marriage. In addition, I am not the attending physician, or an employee of the attending physician or health facility in which the declarer is a patient. I am not, at the time of the execution of this directive, a person who has a claim against any portion of the estate of the declarer upon the declarer's death pursuant to his/her will or applicable law.

WITNESS: _____ DATE: _____

WITNESS: _____ DATE: _____

NAME

DOB