

Life-sustaining treatment decisions

You can indicate in your Instructions if you do or do not want certain types of life-sustaining treatments utilized if you are in the above described conditions. Listed below are some common treatments for sustaining life to help you decide what is right for you.

Treatment	Benefits	Drawbacks	End-of-life decisions
1) Cardiopulmonary resuscitation (CPR)	<ul style="list-style-type: none"> • Involves several treatments used to restart the heart and to provide artificial respiration when breathing has stopped. • Most useful in the event of a potentially reversible heart or lung problem. 	<ul style="list-style-type: none"> • CPR can include electric shock to the chest and connecting the person to a machine called a ventilator by putting a tube down the windpipe. • CPR can be quite traumatic. If you do not respond to it quickly you could suffer irreversible brain damage or eventually die. 	<ul style="list-style-type: none"> • CPR was not designed to revive you if you have advanced cancer or are in shock due to a severe infection. • CPR should not be used to keep you alive for a few hours or days if you are hopelessly ill. It will only prolong your suffering.
2) Artificial ventilation	<ul style="list-style-type: none"> • A ventilator can take over your breathing and support your lungs until they recover enough to breathe again on their own. • A “trial period” on the respirator may be beneficial if you have a disease such as emphysema. Some people choose to live on a respirator for long periods of time. 	<ul style="list-style-type: none"> • The tube that is placed down your throat can cause some discomfort. If you are “intubated,” you cannot talk or eat orally. • You might become machine dependent if your lungs are unable to function again. 	<ul style="list-style-type: none"> • If you decide not to accept a respirator or do not wish to live out your life on a machine, you can be kept comfortable on medication and oxygen. • You may indicate to your doctors that if a “trial period” does not help, you do not want to continue on a respirator. Of course, you DO want to be kept very comfortable until you die.
3) Use of blood or blood products	<ul style="list-style-type: none"> • Blood products can improve symptoms associated with anemia such as shortness of breath, fatigue and chest pains. 	<ul style="list-style-type: none"> • Some infections such as HIV or hepatitis could be transmitted through blood products. • There can be spiritual issues or religious prohibition to sharing blood. • Blood products are expensive. • Repeated transfusions can cause liver disease. 	<ul style="list-style-type: none"> • Blood products are useful only for a matter of days. If the problem is long term the use of blood products will only prolong suffering. • Anemia that results from avoiding blood products does not cause pain or increase suffering.

Treatment	Benefits	Drawbacks	End-of-life decisions
<p>4) Dialysis</p>	<ul style="list-style-type: none"> • When your kidneys no longer work you can be attached to a machine to clean your blood of toxic substances that normally accumulate. • Some people choose to live for years with artificial dialysis treatments. 	<ul style="list-style-type: none"> • Dialysis can be physically draining. • Hemodialysis usually has to be done three times a week and takes three to four hours each time. 	<ul style="list-style-type: none"> • Dialysis for the hopelessly ill may only prolong the dying process. • Without dialysis, if you have kidney failure, you usually slip into a coma and die peacefully.
<p>5) Antibiotics</p>	<ul style="list-style-type: none"> • Antibiotics help the body fight infection. 	<ul style="list-style-type: none"> • Side effects can include diarrhea, rash and fungal infections. 	<ul style="list-style-type: none"> • At the end of life the body loses the ability to absorb nutrients and fight infections. Use of antibiotics will only prolong suffering.
<p>6) Surgery or invasive diagnostic tests</p>	<ul style="list-style-type: none"> • Diagnostic tests can provide more information for doctors to use in developing accurate treatment plans. 	<ul style="list-style-type: none"> • Pain and complications. • A diagnosis may not be associated with a treatment or cure. 	<ul style="list-style-type: none"> • Diagnosis may not be related to the patient's terminal condition and treatment would only prolong suffering.
<p>7) Feeding tube</p>	<ul style="list-style-type: none"> • If you are unable to eat, a feeding tube can be put into your stomach or small bowel to provide nutrition. • If you are ill but expected to recover, feeding tubes can be very helpful in providing nutrition needed for healing. 	<ul style="list-style-type: none"> • It is a common belief that hopelessly ill patients will “starve to death” unless placed on a feeding tube. In reality, you will not feel hungry or thirsty if you suffer from an advanced disease such as cancer, Parkinson’s or Alzheimer’s. • By providing your body with foods and liquids, feeding tubes may actually extend a painful life beyond what you would wish. Without liquids you will usually die in a few days. 	<ul style="list-style-type: none"> • Most people choose not to be kept alive by a feeding tube if their quality of life would be very poor, with no chance of improvement or recovery. • If you choose not to have a feeding tube or to use a feeding tube on a trial basis and your illness is hopeless, you can be kept very comfortable with medication.

Parts of this chart were adapted from Brandenburg M, Gifford: Developing a multidisciplinary brochure to teach patients and families about life-sustaining treatments, *Dimens of Crit Care Nurs* 16:328-332, 1997

My Choices Advance Directives

Advance directive for: _____

Address: _____

Date of birth: _____ Telephone: _____

This document has significant medical, legal and possible ethical implications and effects. Before you sign this document, you should become completely familiar with these implications and effects. The operation, effects and implications of this document may be discussed with a physician, lawyer and/or clergyman of your choice.

Please fill out SECTION I and/or SECTION II. SECTION III is required for this document to be valid.

SECTION I: Durable Power of Attorney for Health Care.

If you choose to leave this section blank, health professionals will attempt to contact your closest relatives if you should be unable to speak or make decisions for yourself. If your relatives are not reasonably available, a qualified substitute decision maker may be allowed to make decisions for you.

I do Do not want to designate another person as my healthcare agent to make medical treatment decisions for me if I should become incapacitated or unable to speak for myself.

The person I choose as my healthcare agent is:

Name: _____

Day phone: _____

Evening phone: _____

Street address: _____

City, State/Zip: _____

My second choice is:

Name: _____

Day phone: _____

Evening phone: _____

Street address: _____

City, State/Zip: _____

SECTION II: Instructions for Health Care (Living Will).

If you choose to leave this section blank, health professionals will attempt to contact your closest relatives if you should be unable to speak or make decisions for yourself. If your relatives are not reasonably available, a qualified substitute decision maker may be allowed to make decisions for you.

I, _____, ask that my family, my doctors and other healthcare providers, respect my choices as I have communicated them to my healthcare agent or as I have indicated below. **I understand that this document will be referred to only when I am unable to make decisions or speak for myself and when I have an incurable and irreversible condition that will result in death within a relatively short time, or if I become unconscious and to a reasonable degree of medical certainty, will not regain consciousness, or the risks and burdens of treatment would outweigh the expected benefits.**

END-OF-LIFE DECISIONS: I direct that my healthcare providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

(a) Choice Not to Prolong Life

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

(b) Choice to Prolong Life

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

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

- 1) I do Do not want cardiopulmonary resuscitation.
- 2) I do Do not want artificial ventilation.
- 3) I do Do not want blood or blood products.
- 4) I do Do not want dialysis.
- 5) I do Do not want antibiotics.
- 6) I do Do not want any form of surgery or invasive diagnostic tests.
- 7) I do Do not want a feeding tube.

See "Life-sustaining Treatment Decisions" on page 10 for more information.

I realize if I do not specifically indicate my preference regarding any forms of treatment listed, I may receive that form of treatment.

SECTION III: Signatures of Declarant and Witnesses.

I am thinking clearly, I agree with everything that is written in this document and I have made this document willingly. If any part of this form cannot be legally followed, I ask that all other parts be followed according to the laws of the state. I also revoke any previous healthcare directives I have made before.

My signature: _____ Date: _____

Print name: _____ Date: _____

If I cannot sign my name, I can ask someone to sign for me.

Signature of the person who I asked to sign this document for me.

_____ Date: _____

Print the name of the person who I asked to sign this document for me.

_____ Date: _____

Statement of Witnesses

I personally know the person who signed this document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

By signing as a witness I certify that I am:

- at least 18 years of age;
- not a healthcare agent appointed by the person signing this document;
- not related to the person signing this document;
- not directly financially responsible for that person's health care;
- not a healthcare provider directly serving the person at this time;
- not an employee of the healthcare provider directly serving the person at this time; and
- not aware that I am entitled to or have a claim against the person's estate.

Note: Two witnesses are required. A witness may be a WMC hospital volunteer but not an employee.

Witness 1 printed name

Witness 2 printed name

Witness 1 signature

Witness 2 signature

Date

Date

Optional Attachments: Initial if you have included any of these forms with this document.

____ What I want my healthcare agent to know

____ What I want my family to know

My Choices Attachment 1:

What I want my healthcare agent to know

Attachment 1: Advance Directive for _____ Dated _____

Initial statements you agree with.

I understand that my healthcare agent can make healthcare decisions for me. I want my agent to be able to do the following:

General Authority of the Healthcare Agent

- Make choices for me about my medical care or services, like tests, medicine or surgery. This care or service can 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 healthcare agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussion, according to my healthcare agent's understanding of my choices and values.
- Review and release my medical records and personal files as needed for my medical care.
- Move me to another state if needed.
- Determine which health professionals and organizations provide my medical treatment. My agent may arrange for admission to a hospital, hospice or nursing home for me. My agent can hire any kind of healthcare worker I may need to help me or to take care of me. My agent can also fire a healthcare worker if needed.

Specific Healthcare Decisions

Life-Sustaining Treatment

- If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends and environment, I want to stop or withhold all treatments that might be used to prolong my existence.

Treatments I would not want if I were to reach this point include:

- Tube feedings
- Artificial ventilation
- Cardiopulmonary resuscitation (CPR)
- Antibiotics
- Major surgery
- Blood or blood products

I would not choose to be kept alive with life-sustaining treatments if:

- I am likely to die in a short period of time and life support would only delay the moment of my death.
- I am in a coma and not expected to recover.
- I have permanent and severe brain damage and am not expected to recover.

Listed here are any other conditions under which I would not wish to be kept alive.

Pain and symptom control

If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable, even if it increases the risks of my dying sooner.

End-of-life care

If there is a opportunity to choose, I would prefer to receive my final care:

- at home,
- in a hospital,
- in an extended care facility, or
- in a hospice.

Organ donation

In the event of my death I wish my agent and caregivers to know:

- I wish to donate only the following organs or tissues if possible (name the specific organs or tissue)
- I wish to donate any organs or tissues if I am a candidate.
- I do not wish to donate any organs or tissues.

I also want my healthcare agent and caregivers to know the following:

My Choices Attachment 2:

What I want my family and loved ones to know

Attachment 1: Advance Directive for _____ Dated _____

Initial statements you agree with.

The people I consider to be my closest family members are:

This is how I want to be treated if I am near death and cannot speak for myself:

- I would like to have members of my church or synagogue notified that I am sick and ask them to pray for me.
- I would like to have a cool cloth put on my head if I have a fever.
- I would like to be kept clean, have warm baths as often as I can and clean linens at all times.
- I would like to have my hand held.
- I would like to have my favorite music played. *Suggestions:* _____
- I would like pictures of my loved ones near my bed.
- I would like to have my personal care such as shaving, nails, hair and teeth attended to as long as it does not cause me pain.
- I would like to have people with me.
- If I show signs of depression, nausea, shortness of breath or hallucinations, I want my caregivers to do what they can to help me.
- I would like people to pray for me.
- I would like to be cared for with kindness and cheerfulness.
- I would like my lips and mouth kept moist.

I want my family and loved ones:

- to know I love them.
- to remember me at my best.
- to forgive me if I hurt them.
- to have joyful memories of my life.
- to forgive each other and make peace.
- to know I forgive them for any hurt they may have caused me.

I want to be remembered in the following ways:

(complete other side)

I want my family to know that if there is an opportunity to choose, I would prefer to receive my final care:

- at home,
- in a hospital,
- in an extended care facility, or
- in a hospice.

I want my family to know the following about the donation of my organs or tissues:

- I wish to donate only the following organs or tissue if possible (name the specific organs or tissues), _____
- I wish to donate any organs or tissues if I am a candidate.
- I do not wish to donate any organs or tissues.

I also want my family to know:

If there is a memorial, I would like to include the following songs, messages, readings etc.
