Planning in Advance for Your Health Care

This booklet will help you to plan ahead. If you have any questions please call for assistance:

- **NWH Patient Relations Representative** 617-243-5052
- **NWH Pastoral Care: 617-243-6634**

We hope that you will choose Newton-Wellesley Hospital for all your health care needs. For more information about our programs and services or to locate a physician, call CareFinder at **(866) NWH-DOCS (694-3627)** or visit ***www.nwh.org***.

NEWTON-WELLESLEY HOSPITAL

2014 Washington Street
Newton, Massachusetts 02462

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617-243-6000

FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Personal Wishes Statement

This form is an expression of my wishes and is not legally binding.

I, ____, sign this form for the purpose of offering my Health Care Agent guidance so that he or she may make decisions based on an assessment of my personal wishes as well as medical information provided by my physicians. My Health Care Agent has authority to make such decisions in accordance with Massachusetts law.

If there is no reasonable expectation for my recovery and, in the opinion of my physician, I will die without life sustaining treatment that only prolongs the dying process, I ask that my Health Care Agent consider the following:
(Write your initials next to the lines that express your wishes.)

______ Treatment should be given to maintain my dignity, keep me comfortable and relieve pain.
______ If my heart stops, I do not want it to be restarted.
______ If I stop breathing, I do not want to have a breathing tube put into my throat and be hooked up to a breathing machine.
______ My physician may withdraw or withhold treatment that only serves to prolong the dying process. Treatment that may be withheld shall include, but not be limited to, the following:

______If I cannot drink, I do not want to receive fluids through a needle placed in my vein.
______If I cannot swallow, I do not want a tube inserted in my nose, mouth or surgically placed to give me food or fluids.
______If I have an infection, I do not want antibiotics administered to prolong my life, without hope of cure, unless necessary to keep me comfortable.

_____ If possible, I would like to die at home with hospice care or in a hospice residence.
______If I am in a nursing home I would like to die with hospice care.
______Unless necessary for my comfort, I would prefer NOT to be hospitalized.

______My faith tradition is ____
My spiritual contact person is ____
My faith community is ____
______I wish to have spiritual support.

______If possible, I wish to be an organ/tissue donor.

______Following is additional guidance for my Health Care Agent's consideration:
____
____
____
____

Signature: ____ Date: ____________

This Personal Wishes Statement was adapted from "My Choices: An Advance Directive for Health Care Choices," Missoula Demonstration Project, Missoula, Montana, and prepared by The Central Massachusetts Partnership to Improve Care at the End of Life. The Partnership grants permission to reproduce this document in its entirety, so long as the source, including this statement, is shown. 8/07

MASSACHUSETTS HEALTH CARE PROXY

Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The **Health Care Proxy** is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (known as the "Principal") can appoint any adult EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption. Whether or not you live in Massachusetts, you can use this form if you receive your health care in Massachusetts.

What can my Agent do?

Your Agent will make decisions about your health care *only* when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your doctor determines, in writing, that you lack the ability to make health care decisions. Your doctor will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

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Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1 At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (**Optional:** If you think your Agent might not be available at any future time, you may name a second person as an Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

2 Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank.

3 **BEFORE** you sign, be sure you have two adults present who will be witnesses and watch you sign the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

4 Have your witnesses fill in the date, sign their names and print their names and addresses.

5 **OPTIONAL:** On the back of the form are statements to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (*not* in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decisionmaking.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

AFTER FILLING IN THE FORM, REMOVE THIS INSTRUCTION PAGE. BE SURE TO TALK WITH YOUR AGENT.

YOUR BIRTH DATE (m/d/y) ____/____/____

MASSACHUSETTS HEALTH CARE PROXY

1 I, ______________________________ (Principal: PRINT your name), residing at

____
(Street) (City/town) (State)

appoint as my **Health Care Agent**: ______________________________ (Name of person you choose as Agent)

of ______________________________
(Street) (City/town) (State)

Agent's tel (h) ____________ (w) ____________ E-mail ____________

(**OPTIONAL**: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

____
(Name of person you choose as Agent)

of ______________________________
(Street) (City/town) (State) (Phone)

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed**: ______________________________

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

______________________________ (Name) ______________________________ (Street)

____
(City/town) (State)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.

In our presence, on this day ____/____/____ (mo / day / yr).

Witness #1 ______________________ (Signature) Witness #2 ______________________ (Signature)

Name (print) ______________________ Name (print) ______________________

Address ______________________ Address ______________________

5

Statements of Health Care Agent and Alternate Agent (OPTIONAL)

Health Care Agent: I have been named by the Principal as the Principal's **Health Care Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Health Care Agent**)______________________________

Alternate Agent: I have been named by the Principal as the Principal's **Alternate Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Alternate Agent**)______________________________

* * * * *

Health Care Proxy form developed by Massachusetts Health Decisions in association with the following member organizations of the Massachusetts Health Care Proxy Task Force:

Boston University Schools of Medicine and Public Health:
Law, Medicine, and Ethics Program
Deaconess ElderCare Program
Hospice Federation of Massachusetts
Massachusetts Bar Association
Massachusetts Department of Public Health
Massachusetts Executive Office of Elder Affairs
Massachusetts Federation of Nursing Homes
Massachusetts Health Decisions
Massachusetts Hospital Association
Massachusetts Medical Society
Massachusetts Nurses Association
Medical Center of Central Massachusetts
Suffolk University Law School:
Elder Law Clinic
University of Massachusetts at Boston:
The Gerontology Institute
Visiting Nurse Associations of Massachusetts

Providers: For prices and information on quantity orders, or for non-English language licensing, please contact
Massachusetts Health Decisions, PO Box 417, Sharon, MA 02067
Email: proxy@masshealthdecisions.org

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NWH Pastoral Care x6634
NWH Patient Relations Representative x5052

Advanced Directives: Summary

- **Advanced Directives** are healthcare choices that are specific, written and prepared in advance. They are intended to direct your medical care if you become unable to do so. There are many types of Advanced Directives.
- **The Healthcare Proxy** is the only legal form of Advanced Directive in Massachusetts.
- **The Healthcare Agent** is the person(s) specified in the Healthcare Proxy who will fulfill **your** healthcare choices for you, but **only** when you are unable to do so.

- **Regardless of your age, begin to think about these critical questions:**
  - What treatment limitations, if any, are important to me?
  - How do I want these limitations to be modified or supplemented at the end-of-life?
  - Who would I want to carry out my decisions, if I was unable to speak for myself?

- **Formalize your decisions.**
  - Appoint someone who would best represent your wishes to be your Healthcare Agent.
  - Discuss your decisions and wishes with your primary care doctor, family and friends.
  - Complete and sign a Massachusetts Health Care Proxy form.
  - Make copies of the form. Keep one at home and give copies to your doctor and family. If hospitalized, bring a copy with you.

- **Reassess your wishes.**
  - As your health may change, reconsider your wishes regularly.
  - Discuss any changes with your health care agent and make any necessary changes on the Healthcare Proxy form.

- **Become informed!**
  - Review some of the provided or online resources:
    - www.nationalhealthcaredecisionday.org/
    - www.nwh.org
      - Select “Community Health Resources”, then “Health Information” then “Massachusetts Health Care Proxy Form”.
  - Become familiar with key terms such as:
    - DNR (Do Not Resuscitate)
    - DNI (Do Not Intubate)
    - CMO (Comfort Measures Only)
    - Palliative Care
  - Be aware of some key therapies that may be offered at the end-of-life, such as a Feeding Tube, Mechanical Ventilation, Intensive Care and Hospice.
  - Ask your primary care doctor if you have any questions.

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