FREQUENTLY ASKED QUESTIONS (FAQ) REGARDING ADVANCE DIRECTIVES

This FAQ was developed by The Patient Advisory Council of The Portland Clinic.

1. What does an Advance Directive do?

   - This form lets you choose a health care representative that can make health care decisions for you only if you cannot.
   - Your health care representative must agree to represent you and this person must sign the form.
   - The form lets you give directions to your representative for care if you cannot make health care decisions for yourself. For example:
     - If you are terminally ill
     - You are permanently unconscious.
     - You are in an advanced stage of progressive, fatal illness.

2. Who should complete an Advance Directive?

   - In Oregon, any one over the age of 18 may complete an Advance Directive.
   - It is especially important when you are ill and seeking medical care.

3. Where does the Advance Directive live in the medical record?

   - The Advance Directive is scanned in to your electronic medical record as document that is accessible to clinical staff.
   - There are certain fields in the electronic medical record that indicate to the doctor or staff when you have an Advance Directive on file, when you've been given an Advance Directive to complete and when it has been returned.

4. Should there be copies of the Advance Directive kept in other places?

   - Keep the originals in a safe but easily accessible place.
   - Give a copy to your doctor.
   - Give a copy to your health care agent and any alternate agents.
   - Keep a record of who has your advance directives.
   - Talk to family members and other important people in your life about your advance directives and your health care wishes.
   - Carry a wallet-sized card that indicates you have advance directives, identifies your health care agent, and states where a copy of your directives can be found. This is available at any Portland Clinic office.

5. How does communication take place regarding the Advance Directive when travelling?

   - You should keep a copy of your Advance Directive with you when travelling.

6. Who can access the Advance Directive?

   - Your Portland Clinic doctors and staff can access the scanned copy of your Advance Directive in your electronic health record.

7. How do I know when the Advance Directive is completed correctly?

   - Review your advance directives with your doctor and your health care agent to be sure you have filled out forms correctly

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8. How and when should I talk to my physician about Advance Directives?

- You can make an appointment to speak to your doctor regarding your Advance Directive at any time.
- You can submit a completed form to your doctor or a clinical staff member at any time.
- Make sure your doctor understands and supports your wishes.

9. Why should I have an Advance Directive?

- Advance directives are a way to protect your rights as a patient.
- It is your right to make decisions about your medical care, including the right to accept or to refuse medical or surgical treatment. If, however, through sickness or injury you become unable to make informed decisions about your medical care-including whether to accept or refuse treatment – an Advance Directive would help your healthcare providers and family to know your wishes.

10. How important is the Advance Directive?

- As a patient, you have the right to make your own informed decisions about medical care and to communicate these decisions to healthcare providers.
- An advance directive can express *both* what you want and don't want.

11. Is the Advance Directive a binding legal document?

- Yes, but meaningful discussion with your doctor and family is actually the most important step. The question of what is "legally effective" is misleading, because even a legally effective document does not automatically carry out your wishes.

12. Can the Advance Directive worksheet be simplified?

- No. The Advance Directive is a form that has been adopted under Oregon law.

13. What in-person patient resources are available to assist with the Advance Directive process?

- Your physician, nurse practitioner, or physician assistant can talk with you about advance directives and about your care options.

14. How is the fact that I have an Advance Directive communicated in the medical community? (i.e., between Primary Care Physician and Emergency Room).

- The Advance Directive will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.
- Oregon authorizes a special order, called a Physician Order for Life-Sustaining Treatment ("POLST"), that can be registered with the state to ensure that your out-of-hospital, end of life treatment preferences are honored. Moe information can be found at: http://www.or.polst.org/resources/

15. Is it possible to access my Advance Directive through MyChart?

- It is not possible to access your Advance Directive through MyChart currently, but The Portland Clinic hopes to have this capability in the future.

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About PART B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using PART B of this form. Your representative must accept on PART E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About PART C (Giving Health Care Instruction)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using PART C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE, and ADDRESS here:

_____
(Name)

_____
(Birthdate)

_____

_____
(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative.

My representative's address is _____

and telephone number is _____.

I appoint _____ as my alternate health care

representative. My alternate's address is _____

and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption, or that person was appointed before your admission into the health care facility.

PART B: APPOINTMENT OF HEALH CARE REPRESENTATIVE (CONTINUED)

1. Limits.

Special Conditions or Instructions: _____

_____

_____

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

_____

(Date)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____

(Signature of person making appointment)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in PART B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone that moment of my death:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____I want any other life support that may apply.
   _____I want life support only as my physician recommends.
   _____I want NO life support.

5. General Instruction.

   INITIAL IF THIS APPLIES:
   _____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. (Insert description of what you want done.)

_____

_____

_____

_____

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____I DO NOT have a health care power of attorney.

_____

(Date)

SIGN HERE TO GIVE INSTRUCTIONS

_____

(Signature)

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on the advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

_____

(Signature of Health Care Representative/Date)

_____

(Printed Name)

_____

(Signature of Alternate Health Care Representative/Date)

_____

(Printed Name)