

# DISTRICT OF COLUMBIA

## Advance Directive

### Planning for Important Healthcare Decisions

#### *Caring Connections*

1700 Diagonal Road, Suite 625, Alexandria, VA 22314

[www.caringinfo.org](http://www.caringinfo.org)

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

#### **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

**L**earn about options for end-of-life services and care

**I**mplement plans to ensure wishes are honored

**V**oice decisions to family, friends and health care providers

**E**ngage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit [www.nationalhospicefoundation.org/donate](http://www.nationalhospicefoundation.org/donate). Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #0544.

**Support for this program is provided by a grant from  
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## **Your Advance Care Planning Packet**

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## Using These Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive health care.
2. These materials include:
  - Instructions for preparing your advance directive.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 7 through 10, as they will give you specific information about the requirements in your state.
5. Refer to the Glossary of Terms About End-of-Life Decision-making if any of the terms are unclear, located in Appendix A.

### ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the list of state-specific contacts for Legal Assistance for Questions Pertaining to Health Care Advance Directives located in Appendix B.

## Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

### Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/) or by calling 1-866-627-7748.

### Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

### What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record.
- Conversations your doctor has about your care or treatment with nurses and others.
- Information about you in your health insurer's computer system.
- Billing information about you by your clinic / health care provider.
- Most other health information about you held by those who must follow this law.

## Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination.
- To pay doctors and hospitals for your health care and help run their businesses.
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object.
- To make sure doctors give good care and nursing homes are clean and safe.
- To protect the public's health, such as by reporting when the flu is in your area.
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes.
- Share private notes about your mental health counseling sessions.

## INTRODUCTION TO YOUR DISTRICT OF COLUMBIA ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **District of Columbia Power of Attorney for Health Care** lets you name someone to make decisions about your medical care — including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Before the Durable Power of Attorney for Health Care can go into effect, two physicians licensed to practice in the District of Columbia, including one psychiatrist, must certify in writing that you are mentally unable to make health care decisions.

2. The **District of Columbia Declaration** is the District of Columbia's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition and can no longer make your own medical decisions. The Declaration goes into effect if you have an incurable condition caused by injury, disease or illness, which would lead to your death with or without the use of life-sustaining medical care, and life-sustaining procedures would serve only to postpone your death. One other doctor must agree with your attending physician's opinion of your medical condition, and both must certify your diagnosis in writing.

Caring Connections recommends that you complete both of these documents to best ensure that you receive the medical care you want when you can no longer speak for yourself.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## COMPLETING YOUR DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

### **Whom should I appoint as my attorney-in-fact?**

"Attorney-in-fact" does not refer to a lawyer. Your attorney-in-fact is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your attorney-in-fact can be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An attorney-in-fact may also be called an "agent" or "proxy.") You cannot appoint your doctor or other health care provider as your attorney-in-fact.

You can appoint a second and third person as your alternate attorney(s)-in-fact. The alternate will step in if the first person you name as attorney-in-fact is unable, unwilling or unavailable to act for you.

### **How do I make my Power of Attorney for Health Care legal?**

The law requires that you sign your Power of Attorney for Health Care in the presence of two adult witnesses, who must also sign to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence, that you signed or acknowledged the Power of Attorney for Health Care in their presence and that they do not fall into any of the categories of people who cannot serve as witnesses.

These witnesses **cannot** be:

- You;
- the person you appointed as your attorney-in-fact;
- your health care provider; or
- an employee of your health care provider.

At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will, codicil or by operation of law.

*Note: You do not need to notarize your Durable Power of Attorney for Health Care.*

### **Should I add personal instructions to my Power of Attorney for Health Care?**

Caring Connections advises you not to add instructions to this document. One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical condition changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact's power to act in your best interest. Instead, we urge you to talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your District of Columbia Declaration (the living will).

## W COMPLETING YOUR DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

### **What if I change my mind?**

You may revoke your Durable Power of Attorney for Health Care by:

- notifying your attorney-in-fact orally or in writing,
- notifying your health care provider orally or in writing so that your revocation can be noted in your medical records and your attorney-in-fact can be contacted, or
- executing a new District of Columbia Durable Power of Attorney for Health Care.

*If you named your spouse as your attorney-in-fact and your marriage ends, your spouse's power to act on your behalf will automatically be revoked.*

## COMPLETING YOUR DISTRICT OF COLUMBIA DECLARATION

### How do I make my Declaration legal?

The law requires that you sign your District of Columbia Declaration, or direct another to sign it, in the presence of two adult witnesses, who must also sign the document to show that they are at least 18 years of age, that they believe you to be of sound mind, that they did not sign the document on your behalf, and that they do not fall into any of the categories of people who cannot serve as witnesses.

These witnesses **cannot**:

- be the person who signed the Declaration on your behalf and at your direction,
- be related to you by blood or marriage,
- stand to inherit from your estate upon your death,
- be directly financially responsible for your medical care,
- be your attending doctor or an employee of your attending doctor, or
- be an employee of a health care facility in which you are a patient.

If you are a patient in an intermediate care or skilled care facility, one of your witnesses must be a patient advocate or ombudsman.

*Note: You do not need to notarize your District of Columbia Declaration.*

It is your responsibility to provide notification to your attending doctor of the existence of the Declaration. When presented with the Declaration, your attending doctor shall make the Declaration or a copy of the Declaration a part of your medical records.

### Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions." For example, you may want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator, artificial feeding, or antibiotics." You may also want to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you have appointed an attorney-in-fact and you want to add personal instructions to your Declaration, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my Declaration are to be decided by my attorney-in-fact."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

## **COMPLETING YOUR DISTRICT OF COLUMBIA DECLARATION (CONTINUED)**

### **What if I change my mind?**

You may revoke your Declaration at any time or expressly direct someone to revoke your Declaration, regardless of your mental condition, by:

- obliterating, burning, tearing, or otherwise destroying or defacing the document, or directing another person to do so in your presence;
- executing, or directing another person to execute, a dated and signed written revocation which becomes effective when it is given to your doctor, who will then make it part of your medical record by noting the time, date, and place when he or she received the notification of the revocation;
- orally revoking your Declaration in the presence of a witness, 18 years or older, who must sign and date a written confirmation of your oral revocation. An oral revocation becomes effective once it is communicated to your doctor, who will then make it part of your medical record by noting the time, date, and place when he or she received the notification of the revocation.

**If you have questions about filling out your advance directive, please consult the list of state-based resources located in Appendix B.**

## AFTER YOU HAVE COMPLETED YOUR DOCUMENTS

Your District of Columbia Power of Attorney for Health Care and Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

1. Give photocopies of the signed originals to your attorney-in-fact and alternate attorney-in-fact, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
2. Be sure to talk to your attorney-in-fact and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
3. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
4. Remember, you can always revoke one or both of your District of Columbia documents.
5. Be aware that your District of Columbia documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-resuscitation orders for emergency medical services" or "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. **Caring Connections does not distribute these forms.**

These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. **Caring Connections does not distribute these forms.** We suggest you speak to your physician.

Caring Connections does not distribute these forms. We suggest you speak to your physician. If you would like more information about this topic contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

**DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE**  
**PAGE 1 OF 4**

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**INFORMATION ABOUT THIS DOCUMENT**

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

This document gives the person you name as your attorney in fact the power to make health-care decisions for you if you cannot make the decisions for yourself.

After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.

You have the right to take away the authority of your attorney-in-fact, unless you have been adjudicated incompetent, by notifying your attorney in fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney in fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.

If there is anything in this document that you do not understand, you should ask a social worker, lawyer or other person to explain it to you.

You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney in fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE ATTORNEY IN FACT

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DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE - PAGE 2 OF 4

DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

I, \_\_\_\_\_, of \_\_\_\_\_ (name)

\_\_\_\_\_, hereby appoint: \_\_\_\_\_ (home address)

\_\_\_\_\_, (name of attorney-in-fact)

\_\_\_\_\_, (home address)

\_\_\_\_\_, (work telephone number) \_\_\_\_\_ (home telephone number)

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person(s) to serve in the order listed below:

1. \_\_\_\_\_ (name of first alternate attorney in fact)

\_\_\_\_\_, (home address)

\_\_\_\_\_, (work telephone number) \_\_\_\_\_ (home telephone number)

2. \_\_\_\_\_

\_\_\_\_\_, (name of second alternate attorney in fact)

\_\_\_\_\_, (home address)

\_\_\_\_\_, (work telephone number) \_\_\_\_\_ (home telephone number)

**DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH  
CARE - PAGE 3 OF 4**

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With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

Statement of directives concerning life-prolonging care, treatment, services and procedures:

Special provisions and limitations:

By my signature I indicate that I understand the purpose and effect of this document.

I sign my name to this form on \_\_\_\_\_  
(date)

at: \_\_\_\_\_  
(address of location)

\_\_\_\_\_  
(signature)

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

ADD LIMITATIONS  
ON YOUR  
ATTORNEY IN  
FACT'S POWER  
(IF ANY)

PRINT THE DATE  
AND YOUR  
LOCATION AND  
SIGN THE  
DOCUMENT

YOUR WITNESSES  
MUST SIGN THE  
DOCUMENT ON  
THE NEXT PAGE

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**DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH  
CARE - PAGE 4 OF 4**

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WITNESSING  
PROCEDURE

WITNESSES MUST  
SIGN AND DATE  
THE DOCUMENT  
AND PRINT THEIR  
NAMES AND  
ADDRESSES

WITNESS #1

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal or an employee of the health-care provider of the principal.

First Witness' Signature: \_\_\_\_\_

Home Address: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

WITNESS #2

Second Witness' Signature: \_\_\_\_\_

Home Address: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE  
FOLLOWING DECLARATION.)

I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

ONE OF YOUR  
WITNESSES MUST  
ALSO AGREE WITH  
THIS STATEMENT  
AND SIGN BELOW

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*Courtesy of Caring Connections*  
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**DISTRICT OF COLUMBIA DECLARATION – PAGE 1 OF 2**

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INSTRUCTIONS

PRINT THE DATE

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_.  
(date) (month, year)

PRINT YOUR NAME

I, \_\_\_\_\_,  
(name)

being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

Other directions:

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**DISTRICT OF COLUMBIA DECLARATION - PAGE 2 OF 2**

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In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed \_\_\_\_\_

Address \_\_\_\_\_

SIGN THE DOCUMENT AND PRINT YOUR ADDRESS

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

WITNESSING PROCEDURE

WITNESSES MUST SIGN BELOW

WITNESS #1

Witness \_\_\_\_\_

WITNESS #2

Witness \_\_\_\_\_

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1700 Diagonal Road, Suite 625, Alexandria, VA 22314  
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## Appendix A

### Glossary of Terms About End-of-life Decision Making

***Advance directive*** - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

***Artificial nutrition and hydration*** – Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

***Assisted Suicide*** - Providing someone the means to commit suicide, such as a supply of drugs or a weapon, knowing the person will use these to end his or her life.

***Best Interest*** - In the context of refusal of medical treatment or end-of-life court opinions, a standard for making health care decisions based on what others believe to be "best" for a patient by weighing the benefits and the burdens of continuing, withholding or withdrawing treatment.

***Brain Death*** -The irreversible loss of all brain function. Most states legally define death to include brain death.

***Capacity*** - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

***Cardiopulmonary Resuscitation*** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

***Do-Not-Resuscitate (DNR) order*** - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

***Emergency Medical Services (EMS)***: A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

**Euthanasia** - The term traditionally has been used to refer to the hastening of a suffering person's death or "mercy killing". Voluntary active euthanasia involves an intervention requested by a competent individual that is administered to that person to cause death, for example, if a physician gives a lethal injection with the patient's full informed consent. Involuntary or non-voluntary active euthanasia involves a physician engaging in an act to end a patient's life without that patient's full informed consent. See also Physician-hastened Death (sometimes referred to as Physician-assisted Suicide).

**Guardian ad litem** - Someone appointed by the court to represent the interests of a minor or incompetent person in a legal proceeding.

**Healthcare Agent:** The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice care** - A program model for delivering palliative care to individuals who are in the final stages of terminal illness. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

**Incapacity** - A lack of physical or mental abilities that results in a person's inability to manage his or her own personal care, property or finances; a lack of ability to understand one's actions when making a will or other legal document.

**Incompetent** – Referring to a person who is not able to manage his/her affairs due to mental deficiency (lack of I.Q., deterioration, illness or psychosis) or sometimes physical disability. Being incompetent can be the basis for appointment of a guardian or conservator.

**Intubation**- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-Sustaining Treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

**Living Will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "health care declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.

**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, by controlling pain and symptoms, and by enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component. Palliative care is sometimes called "comfort care" or "hospice type care."

**Power of Attorney** – A legal document allowing one person to act in a legal matter on another's behalf pursuant to financial or real estate transactions.

**Respiratory Arrest:** The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

**Surrogate Decision-Making** - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

**Ventilator** – A Ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

**Withholding or withdrawing treatment** - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

## Appendix B

### Legal & End-of-Life Care Resources Pertaining to Health Care Advance Directives

#### LEGAL SERVICES

AARP has a lawyer referral listing on their website. These attorneys have been screened to meet AARP standards and have agreed to offer services to AARP members at reduced fee.

**NOTE:** AARP members receive a free initial consultation—up to 30 minutes—in person or by phone. If the consultation extends beyond 30 minutes, the attorney can charge for extra time, but only after a fee is agreed upon in advance. To receive a free consultation, you must be over the age of 50 and a full member of AARP.

Non members and members of AARP over the age of 50 can get legal information and advice on issues, including, but not limited to:

- Power of Attorney
- Living Wills and Trusts
- Employment
- Social security
- Medical and more
- Must be 50 and older and a member of AARP to receive a free 30 minute consultation, but you do not have to be a member to take advantage of their lawyer referrals
- Available to individuals of all income levels

**You can click on the following link for referrals:**

[http://www.aarp.org/families/legal\\_issues/find\\_lawyer/show\\_directory?directory=11360](http://www.aarp.org/families/legal_issues/find_lawyer/show_directory?directory=11360)

**OR**

**Visit their website for more information:**

[http://www.aarp.org/families/legal\\_issues/lrn/lrn\\_program\\_fees\\_and\\_benefits.html](http://www.aarp.org/families/legal_issues/lrn/lrn_program_fees_and_benefits.html)

**OR**

**Call toll free for a list of Lawyer Referrals: 1-888-687-2277**

#### END-OF-LIFE SERVICES

Individuals over the age of 18 can contact Self Help Offices (SHO) Legal Counsel for the Elderly to assist them with information and services available in their area.

SHO resources and services, include, but are not limited to:

- Food Stamps
- Housing
- Adult Day Care
- Legal Assistance
- Medicare and Medicaid
- Transportation and other services
- Must be 18 and older
- Free to individuals with low to moderate incomes

**Visit their website for more information about services:**

<http://dcoa.dc.gov/dcoa/cwp/view,a,3,q,598839.asp>

**OR**

**Call: 202-434-2094 or 202-895-9492, APPOINTMENT NEEDED**