Four Women Health Services
Policies and Procedures

Title: **Advanced Directives and Living Will**

Purpose: **To establish Four Women's policy on honoring Advanced Directives for patients seeking elective abortions**

Policy:

1. Four Women recognizes the patient's right to have Advanced Directives according to the Federal and State of Massachusetts laws and statutes. Massachusetts does not recognize living wills, but they do recognize Health Care Proxies.

2. Four Women also recognizes that the purpose of being an ambulatory surgery is to provide elective surgical procedures to ASA Class I, II and stable III patients. Therefore, the Medical Director and Governing Body have elected not to recognize and/or provide patient care during the patient's admission to the Four Women in accordance with the patient's advanced directives.

3. Patients and/or significant others will be provided information regarding the Four Women policy on Advanced Directives and Health Care Proxy prior to the date of surgery. If it is not possible to provide the information prior to entering the clinic, the patient will be given the policy prior to initiating the check-in process.

Procedure:

1. Patients will be asked at the time of the Pre Op Telephone Call if they received the Advanced Directives and if they have any questions and it will be documented on the intake.

2. Patients will be asked on admission if they have Advanced Directives in place and the answer will be documented on the medical record. In addition, patients will be asked if they received the Advanced Directives policy and procedure prior to admission and if they have any questions.

3. If the patient does not have Advanced Directives, the patient will be offered limited information regarding Advanced Directives and how they can obtain additional information. Legal opinions will not be provided or offered by personnel and/or medical staff.

4. If the patient has a copy of the document (Advanced Directive), a copy will be made and placed within the medical record in the event the patient is transferred to a tertiary care facility. In addition, documentation will be made in a prominent place of the clinical record whether or not the individual has executed an Advanced Directive.

   The patient will be requested to sign a Release of Understanding (Advanced Directives) if the patient and/or the patient's authorized representative elects to continue with the surgery. The executed Release of Understanding will be filed within the medical record.

5. If a patient refuses to sign the Release of Understanding, the Anesthesia provider and/or the Surgeon will be notified and he/she will discuss with the patient the impact of the center's

policy of not recognizing the documents while admitted as a patient at Four Women.

6. Post the patient/anesthesia provider/surgeon discussion, the patient will be required to sign a Release of Understanding (Advanced Directives) if the patient and/or the patient's authorized representative elects to continue with the surgery. The executed Release of Understanding will be filed within the medical record.

7. If the patient elects not to continue with the procedure, a notation will be made on the medical record as to why the procedure was cancelled.

8. In the event that the procedure is continued and the patient would require transfer to a tertiary care facility, a copy of the Advanced Directives will be made and accompany the patient.

Reference: CMS Conditions of Coverage effective May 2009

_____ _____

Medical Director Date

Four Women Health Services

PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVE OR MEDICAL POWERS OF ATTORNEY

All Patients have the right to participate in their own health care decisions and to make advance directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the Patient's expressed wishes when the Patient is unable to make decisions or unable to communicate decisions. Four Women respects and upholds those rights.

However, unlike in an acute care hospital setting, Four Women does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to these questions. Have you executed an advance health care directive, a living will, a power of attorney that authorizes someone to make health care decisions for you?

- □ Yes, I have an advance directive, living will or health care power of attorney
- □ No, I do not have an advance directive, living will or health care power of attorney
- □ I would like to have information on advance directives

If you checked the first box "yes" to the question above, please provide us a copy of that document so that it may be made a part of your medical record.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED. IF I HAVE INDICATED I WOULD LIKE ADDITIONAL INFORMATION, I ACKNOWLEDGE RECEIPT OF THAT INFORMATION.

BY: _____
(PATIENT'S SIGNATURE)

If consent to the procedure is provided by anyone other than the Patient, this form must be signed by the person providing the consent or authorization.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS AND AGREE TO THE POLICY AS DESCRIBED..

BY: _____
(SIGNATURE)

_____
(PRINT NAME)

RELATIONSHIP TO PATIENT:

- □ COURT APPOINTED GUARDIAN
- □ ATTORNEY IN FACT
- □ HEALTH CARE SURROGATE
- □ OTHER _____