A Better Way of Dying: How to Make the Best Choices at the End of Life

by Jeanne Fitzpatrick, M.D. and Eileen M. Fitzpatrick, J.D. (2010)
http://www.amazon.com/dp/0143116754/ $11.75 (and others cheaper)
(this handout: http://dickatlee.com/issues/health/better_way_of_dying_review_ccc_form.pdf; 1.5MB)

Review From Publishers Weekly

Bringing together their respective expertise, sisters and debut authors Jean, an emergency room doctor, and Eileen, a practicing lawyer, explain the care pitfalls of death and dying that persist even for those who believe they're covered by a Living Will. Despite "clearly expressed wishes" to the contrary, many patients close to death are kept alive-using ventilators, antibiotics, intravenous feeding and other methods-by medical personnel ("most doctors still graduate... with basically no training in end-of-life situations"), family members unwilling to accept the inevitable, and nursing homes that benefit financially from keeping Medicaid recipients alive. To clear up ambiguities over end-of-life care, the authors advise putting together a one-page "***Contract for Compassionate Care***" that "gives you the option to choose a natural death" by delineating what care should be withheld [when what they call an "exit opportunity" presents itself] -- including hospitalization, antibiotics, usual medications, and hydration/nutrition. The authors outline a practical Compassion Protocol for creating the contract, which prioritizes communication with loved ones and health care professionals. The Fitzpatricks also provide detailed, authoritative and compassionate information on subjects most don't confront until it's too late, including hospice care ("an excellent source of... pain control, symptom management, and emotional and spiritual support"), nursing homes, and typical end-of-life scenarios (permanent unconsciousness, Alzheimer's dementia).

Biography

The authors are two sisters who were born and raised in Burlingame, California, a suburb thirteen miles south of San Francisco. Their formative years were very Ozzie and Harriet: backyard barbeques, shopping trips to the Emporium, sleepovers and girl scouts.
<snip additional interesting subsequent personal material>

Defying the social stereotypes of the times, both sisters ended up in challenging professions. Jeanne attended medical school at the University of Washington in Seattle, and has practiced emergency medicine in small rural hospitals in Washington, Alaska, Hawaii, New Mexico, and Oregon. Eileen received her J.D. from Harvard Law School. She left a corporate practice in Boston to pursue a writing career and currently lives in Southern California.

Beginning in the late-Nineties, the sisters found they shared an interest in the legal and medical issues surrounding death and dying. This was the point at which palliative care and the concept of "comfort care only" first began to surface at conferences and in the occasional academic article.

As a practical matter, they have each struggled with patients' and clients' shattered expectations as their end-of-life wishes collide with a medical system overwhelmingly geared to sustaining life at any cost. Together the sisters decided to write this book to present new options for choice and control at the end of life.

(see over for a scanned copy of the *Contract for Compassionate Care*)

DISCLOSURE PERMITTED TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

CONTRACT FOR COMPASSIONATE CARE

This is my doctor order sheet. It is based on my medical condition and wishes. It summarizes my treatment choices for end-of-life care and sets forth the timing options for when my treatment choices will go into effect. It also appoints my Health Care Decision Maker.

Last Name

First Name/Middle Initial

Date of Birth

I. RESUSCITATION ORDER: If I have no pulse and am not breathing (initial ONE):

_____ Resuscitate _____ Do NOT Resuscitate

II. MEDICAL INTERVENTION AND TIMING ORDER: I choose the following limitations to medical intervention at the end of my life (initial ALL that apply):

_____ **Comfort Care Only:** I choose to refuse medical intervention except as may be needed to provide comfort. Comfort measures are to be used where I live or reside. I am not to be sent to the hospital or emergency room again unless comfort measures fail.

_____ I do not want to receive antibiotics again.
_____ I do not want to continue my usual medications.
_____ I do not want food and water except as I choose it or request it. No intravenous fluids or feeding tubes.

I want the Orders chosen above to apply when: (initial ALL that apply):

_____ Immediately
_____ I am close to death
_____ I have an advanced progressive illness
_____ I am permanently unconscious
_____ I am experiencing extraordinary suffering
_____ I have dementia and have passed certain benchmarks known to my Health Care Decision Maker. Some of those benchmarks are:

_____
_____
_____

III. APPOINTMENT OF HEALTH CARE DECISION MAKER: I appoint

_____ as my Health Care Decision Maker. I appoint _____ as my alternate Decision Maker. I authorize my Health Care Decision Maker to direct my health care when I cannot do so. I authorize my Decision Maker to implement my options for withdrawal from medical intervention under circumstances known to him/her as best representing my own wishes.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

IV. SIGNATURE

I, _____, ask that my doctors, other health care providers, family, friends, and all others follow my wishes as communicated by my Health Care Decision Maker.

_____
Signature Date

_____
Address

WITNESS STATEMENT: I, the witness, declare that the person who signed this form is personally known to me, that he/she signed it in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

_____ _____
Signature of Witness #1 Date Signature of Witness #2 Date

_____ _____
Printed Name of Witness Printed Name of Witness

_____ _____
Address Address

PHYSICIAN SIGNATURE: I acknowledge that _____ has discussed this form with me and confirmed that it represents his/her wishes for health care at the end of life. I agree to comply with his/her wishes.

_____
Physician Signature Date

_____
Printed Name of Physician

_____
Address

V. REVIEW OF THIS CONTRACT

Review Date	Reviewer	Location of Review	Review Outcome	
			__ No Change __ Form Voided	__ New Form Completed
			__ No Change __ Form Voided	__ New Form Completed
			__ No Change __ Form Voided	__ New Form Completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED