ADVANCE HEALTHCARE DIRECTIVE

Introductory Notes:

An **Advance Healthcare Directive** is a statement made by a competent adult relating to the type and extent of medical treatments and care he or she would or would not want to receive in the future should he or she be unable to express their wishes at that time. The commonly used term "Living Will" refers specifically to a written advance healthcare directive.

It must be stressed that an Advance Healthcare Directive is not asking doctors or nurses to do anything illegal - it is NOT a request for euthanasia. It is everyone's right to accept or refuse medical treatment. And, if death results from the withholding or withdrawing of life-sustaining treatment, it must not be considered as a suicide.

While these directives are not yet legally-binding documents in Ireland, as they are the honest and intelligent expressions of someone's wishes, it is hoped that they will be of considerable benefit to the families, friends and medical advisers of those who complete them. By talking about these issues ahead of time, family disagreements will hopefully be minimized, and the burden of responsibility will be taken away from the relatives of those who have lost their mental capacity to make decisions about their personal medical treatment and care.

TO MY FAMILY, MY DOCTOR AND ALL OTHER PERSONS CONCERNED

this Advance Healthcare Directive is made by me

(*full name in capitals*) ____

of (*full address*) ____

____

at a time when I am of sound mind and not suffering from any mental or physical condition which impairs my capacity to make the healthcare decisions described in this document.

If the time comes when I lack the capacity to give directions for my medical care, this document should be considered as my advance directive on how I wish to be treated based upon my own values, wishes and beliefs.

I wish it to be understood that I fear degeneration, prolonged dependence and an inability to communicate far more than I fear death itself. I ask my doctors and nurses to bear this statement in mind when considering what my intentions would be in any uncertain situation (*please delete, and initial, this paragraph if you do not agree with it*).

Additional personal identification:

Date of Birth:

Either PPS Number (in the Republic of Ireland):
Or NHS Number (in Northern Ireland):

COPIES of this Advance Healthcare Directive have been given to the following (eg: your GP, Health Care Proxy, Spouse, Best Friend, Solicitor):

Name:__________________________Address:____
Telephone:_______________

Name:__________________________Address:____
Telephone:_______________

Name:__________________________Address:____
Telephone:_______________

GENERAL MEDICAL TREATMENT

*(Two specific medical circumstances are set out at right, **A and B**. For each one, choose either statement (1) or (2) if it clearly expresses your wish as to the medical treatment you would like for that circumstance. If neither (1) or (2) clearly expresses your wish, then leave both boxes blank)*

(Treat each situation separately. You do not have to make the same choice for each condition)

A

Imminently life-threatening physical illness from which there is little or no prospect of recovery

I (*name*)

____

declare that my medical treatment wishes are as follows:

If I suffer from physical injury or illness which, in the opinion of at least two doctors (one a consultant) not involved in my care, is imminently life threatening and from which there is very little or no likelihood of recovery:

Please initial the appropriate box

(1) I wish to be kept alive for as long as possible and request and consent to all appropriate medical treatment

[ ]

OR

(2) I refuse medical treatment aimed at prolonging or artificially sustaining my life. I consent only to palliative care where the aim is to keep me comfortable and, so far as possible, free from pain. I refuse all other medical treatment.

[ ]

(*Examples of an imminently life-threatening condition are the last stages of cancer, motor neurone disease, or an extensive stroke. Please note this list is not exhaustive and is for illustrative purposes only*)

B

Very serious mental impairment with no prospect of recovery together with a physical need for life-sustaining treatment

I (*name*)

____

declare that my medical treatment wishes are as follows:
If my mental impairment is so severe that I do not understand what is happening to me, and in the opinion of at least two doctors (one a consultant) not involved in my care, there is very little or no likelihood of significant improvement, and my physical condition is such that medical treatment is required to keep me alive:

Please initial the appropriate box

(1) I wish to be kept alive for as long as possible and request and consent to all appropriate medical treatment

[ ]

OR

(2) I refuse medical treatment aimed at prolonging or artificially sustaining my life. I consent only to palliative care where the aim is to keep me comfortable and, so far as possible, free from pain. I refuse all other medical treatment.

[ ]

(*Examples of a very serious mental impairment are advanced Alzheimer's disease, very severe disease or damage of the nervous system, and persistent vegetative state (exceeding six months)
Please note this list is not exhaustive and is for illustrative purposes only*)

SPECIFIC CHOICES REGARDING TREATMENT

(*Depending on what you have decided in the previous section, it is now very important to be specific about refusing or accepting the following forms of treatment which may be required when you are unable to communicate with your doctor(s) and there is also very little likelihood of your recovery - you must initial the appropriate box*)

I [ ] do OR I [ ] do NOT want cardio-pulmonary resuscitation (CPR)

I [ ] do OR I [ ] do NOT want artificial ventilation

I [ ] do OR I [ ] do NOT want artificial feeding (by tube, intravenous or subcutaneous) other than for basic hydration

I [ ] do OR I [ ] do NOT want antibiotics

I [ ] do OR I [ ] do NOT want blood or blood products

I [ ] do OR I [ ] do NOT want kidney dialysis

I [ ] do OR I [ ] do NOT want any form of surgery or invasive diagnostic tests

I [ ] do OR I [ ] do NOT want any new treatment (except for analgesics or sedatives) without specific discussion with my Health Care Proxy (who I have named in the next section)

I [ ] want to be given all necessary palliative care to control pain, respiratory distress and other severe symptoms, which might arise, even if this might shorten my life.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that particular treatment.
Also, I understand that, while a refusal of treatment should be respected (although this may shorten my life), a request for a specific treatment may be rejected by a doctor if it is against that doctor's clinical judgement.

Furthermore, nothing should be done to keep me artificially alive: if such means are taken in an emergency, and my existence depends on them alone, they should be discontinued as quickly as possible (*please delete, and initial, this statement if you do not agree with it*)

If any doctor treating me will not agree with my wishes, I ask that my care be transferred to another doctor, or healthcare provider, who will respect them. This transfer should be done as quickly as possible and with the utmost respect to all concerned.

If I am PREGNANT, I wish to receive all the medical care necessary to ensure the safe delivery of my child. Once this has happened, all my wishes, as stated elsewhere in this directive, should be reinstated.

(If you want to complete the following section, on this page, please consult your GP or consultant before doing so)

I HAVE BEEN DIAGNOSED AS HAVING____

I have the following wishes regarding specific investigations and treatment associated with this diagnosis (*such requests may be rejected by a doctor if these are against that doctor's clinical judgement*):

(*If the circumstances you wish to describe require more space, add another page, and sign and date that page*)

HEALTH CARE PROXY

(This person can be any adult who you know very well)

(In addition, someone can be nominated in an Enduring Power of Attorney to make decisions about your care: this is an optional choice, and should be discussed with your solicitor)

I have asked ___________________________

to take part in discussions about my medical care on my behalf if I am unable to make my wishes known for myself. I have discussed my views about my future medical treatment with him/her and given him/her a copy of this document. I want everyone who is caring for me to respect the views expressed by my Health Care Proxy on my behalf: he/she will do their best to explain my wishes and expectations if these are unclear in this document.

I (*insert full name of Health Care Proxy*)

____

of (*insert full address*)

____

____

____

agree to be Health Care Proxy of

____

Signature of Health Care Proxy

____

Date of signature ____________________

Daytime telephone number_____________

Evening telephone number _____________

Mobile telephone number ______________

GP DETAILS

(It is recommended that your GP completes this section, but it is not essential)

My General Practitioner is

____

GP's Address

____

____

____

GP's declaration

I have discussed the matters contained in this Advance Healthcare Directive with

____

I am satisfied that he/she has the capacity to make the decisions contained in this document and I am satisfied that he/she understands the consequences of those decisions.

GP's signature

____

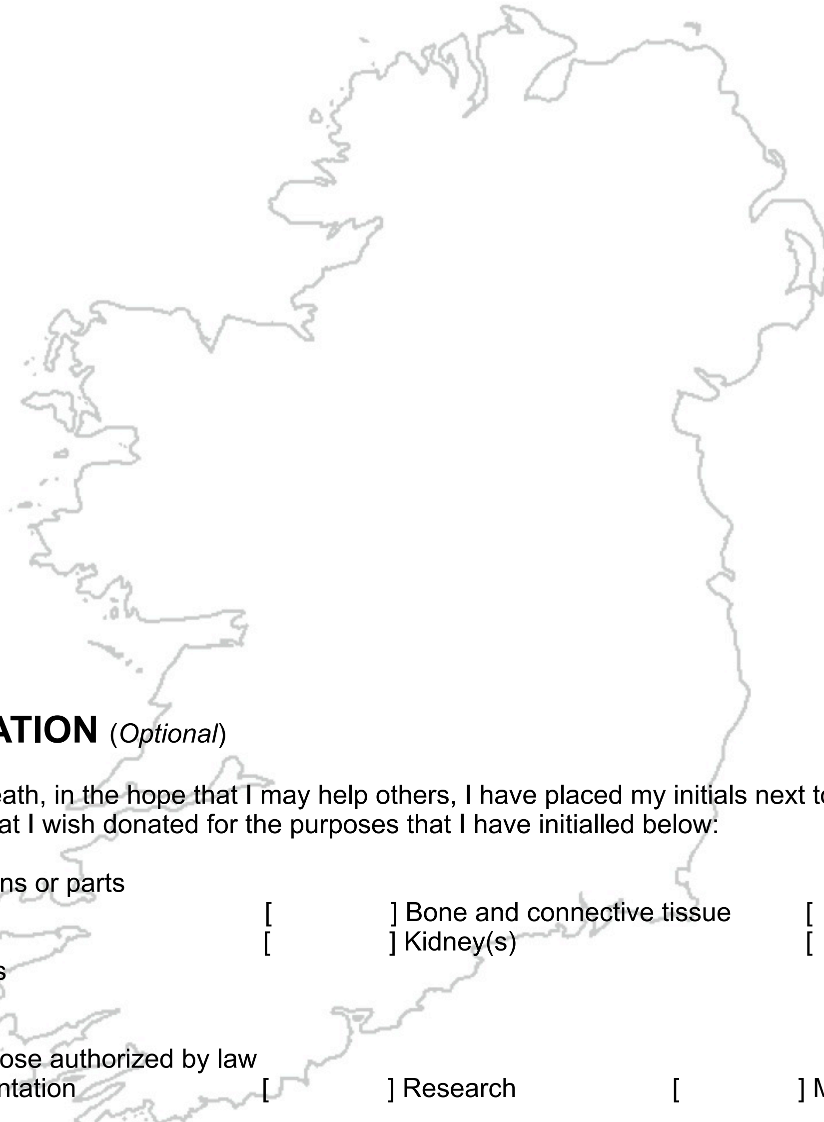
Date of signature ____________________

GENERAL COMMENTS

I express my heartfelt thanks to everyone who faithfully follows my requests.

It is my wish that no legal action is taken against anyone because they have acted in good faith in accordance with what I have requested in this Advance Healthcare Directive.

(*In the following space, you can write whatever you think is relevant to the directives you have requested in this document. For example, how do your personal beliefs affect how you want to be treated; if it is practical, would you prefer to die at home; are there any requests you want to make about your funeral? And, of course, if you need more space, add another page, sign and date it*)



ORGAN DONATION (*Optional*)

In the event of my death, in the hope that I may help others, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes that I have initialled below:

[ ] Any organs or parts
[ ] Eyes [ ] Bone and connective tissue [ ] Liver
[ ] Heart [ ] Kidney(s) [ ] Lung(s)
[ ] Pancreas

For the purposes of:
[ ] Any purpose authorized by law
[ ] Transplantation [ ] Research [ ] Medical education

____________________________________ ____________________________________

(*Your signature, and date*) (*Signature of your next-of-kin, and date*)

SIGNATURES

(*This Advance Healthcare Directive should be witnessed by two adults, neither of whom can be a relative or anyone who stands to gain from your death. They should watch you sign and then add their own signatures - in doing so, they are also indicating that, in their view, you have signed this document freely, under no constraint or undue influence*)

Your Signature:____ Date:_________________________

Witness one:__________________________________ (*Name in capitals*)____________________________

Address:____

Witness two:__________________________________ (*Name in capitals*)____________________________

Address:____

REVIEW DATES

This Advance Healthcare Directive was reviewed and confirmed by me as not requiring any change on the following dates (*ideally, it should be reviewed every two years*):

(*Your signature*)	(*Date*)

(*You have the right to change or cancel this Advance Healthcare Directive at any time. If you do, you must advise everyone, who has a copy, that you have done so. If you make any major changes, it is naturally advisable to write a new Advance Healthcare Directive. Otherwise, all minor amendments to this document must be signed by you, and dated*)

(This document has been produced by the Living Wills Trust: its e-mail address is livingwillstrust@hotmail.com)

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