Advance Directive

TALK to your family, friends, and health-care team about your values and beliefs, so they have somewhere to start should you suddenly become seriously ill or injured. Having these discussions is giving a gift to your family.

What is an Advance Directive (AD)?

- It was previously known as a “Living Will” (which has NEVER been a legal document in BC).
- It is a written document that directs your care when you are INCAPABLE and unable to communicate your choices for care and treatment.
- It must directly apply to your health and must be something that your health-care providers can translate into your medical care.
- It does NOT have to be a formal document.
- It does NOT have to be written by a lawyer or notary public.
- It can be a few sentences or a paragraph or two.
- You need to sign and date it—and revoke any previous ADs if you have made them.
- It must be witnessed by two people.
- You can change it as often as you see necessary and as your state of health changes.

Do I need an Advance Directive?

Not necessarily. Our views of what we think and believe we want now and what we want in a time of crisis can be much different.

You may not need an AD in the following situations:

- You have not been diagnosed with a life-limiting or life-ending illness, and you don’t have any views set in stone.
- You trust that your family knows what you want (and you’ve intentionally discussed it), and they are readily available should you need them.
- You trust that your doctor knows what you want and will be able to deliver that information to those who need it, when they need it.

You should consider setting up an AD in the following situations:

- You have been diagnosed with a life-limiting or life-ending illness.

- You don't want to, or feel you can't, discuss your End-of-Life wishes with family and friends.
- Your substitute decision-makers are not easy to reach by phone and/or will have to travel a great distance and/or it will be a burden for them.
- You do not have a family doctor you feel is responsive to having a discussion of this type.
- You're a planner by nature and you'd rather be safe than sorry.

Legal information:

1. You can name one person for several roles, but you will need separate documents for each role. For example, you could appoint one person as your Representative, your Enduring Power of Attorney, and your Executor for your Will, but you will need three documents.

2. We encourage you to seek counsel from a highly experienced estate lawyer to draw up your documents since it is often money well spent. Ask that they separate all your documents into individual forms. Often, lawyers will put the Representation Agreement and Advance Directive in one document. However, both are meant to be changed as your health circumstances change and having them separated is a big expense.

3. You can and should review and change your Advance Directive as information about your disease, condition or prognosis changes. You will also need to change your AD to highlight your desire to continue with any new treatments or if you would prefer to allow a natural death. You will likely need to become more and more specific about the care you do and do not want to receive.

Representation Agreements supersede Advanced Directives unless you state otherwise in your Representation Agreement:

"If a Representative must make a decision, he/she must check with the Adult first to determine their current wishes. If current wishes cannot be determined, or are not reasonable to be carried out, then any pre-expressed wishes (Advance Directive) should be considered. If these are unknown, decisions are made according to the person's values and beliefs. The Representative may make a decision based on what he/she thinks is best for the Adult (in their best interest). If there is a conflict between the AD and what is in the adult's best interest, the Representative can make the final call."

~Richard Bell, Bell Alliance LLP

Refusing Treatment:

As a competent adult under the Health Care Consent Act (HCCA), you have the right to refuse any or all treatment including CPR, antibiotics, vital sign testing, medication, and to stop eating and drinking when you choose. You also have the right to change your mind at any time.

~ Effective in BC February 2000

MOST: Medical Orders for Scope of Treatment

As of May 2017, all Provincial Health Authorities have implemented MOST (also known as Options for Care) for all adult patients admitted to a hospital or residential care facility. They are signed by a physician, and the orders will be on the front of every chart.

- Health-care providers are to ask each patient as well as Substitute Decision-Makers (SDMs) if the patient has expressed or documented wishes about future care through an Advance Directive and/or Representation Agreement.
- Your Most Responsible Provider (MRP – physician or nurse practitioner) makes the decision regarding not initiating (or removing) care or treatment based on "Expectations of Care Not Considered Beneficial".
- No-CPR orders will automatically be suspended for surgery and other procedures involving anesthesia or procedural sedation, and treatment will be provided at the discretion of the Most Responsible Physician Provider.
- MOST orders are to be reviewed upon every admission, except in extreme circumstances, such as if you are in a critical situation or if you and your Representative cannot be consulted.

Writing your Advance Directive

Understanding Resuscitation:

CPR = Cardio Pulmonary Resuscitation:

- Cardio means heart; Pulmonary means lungs; Resuscitation means to try and restart a person's heartbeat and breathing when they stop.
- CPR is the act of manual, aggressive, compressions on your chest.

When thinking about life-sustaining treatment, you should answer the following questions:

- At what stage of life are you in?
- Do you want quality of life or quantity?

Should everyone have CPR?

- No, but CPR can work for adults who are reasonably healthy.

CPR is most effective when initiated immediately after cardiac arrest. But, CPR is usually **not** effective in the following situations:

- Adults with medical conditions that have damaged their heart, lungs, kidneys, and brain.
- Adults who are at the natural end of their life.

Step 1: Deciding on Level of Care:

❖ Note: you are free to use any of the examples provided or change them to your situation.

If you want CPR, choose full CPR and resuscitation. This is considered appropriate for most adults who are otherwise healthy and without a life-threatening or life-limiting illness.

Important note:
If CPR is started, you will receive the highest level of care including being in ICU on a ventilator. No one will stop to think about your chances of survival and quality of life: that will be determined after you are stable. It is important to discuss values and beliefs and add these to your Advance Directive so your decision-makers will have your pre-determined wishes to know what you would want to happen once tests have been done to determine your current and, probable, future outcome.

Example:
I want Full Resuscitation: I am still relatively young, and at this point in my life, I am not seriously ill. I want to be resuscitated and put on life support if there is a probability that I will recover to some extent. However, if I have serious brain damage or there is little or no brain activity, I do not want to be put on life support or I want it to be removed as soon as recipients have been found for any of my viable organs.

If you do not want CPR, there are five levels of intervention to choose from:

1. **Comfort Care Only:** This is considered most appropriate for those who are in palliative care or hospice or for those in residential care who are at the natural end of their lives.

Example:
Do not resuscitate me. Do not transfer me to a higher level of care. I am nearing the end of my life. I no longer want active medical treatment. When I can no longer feed myself, please do not feed me or provide artificial nutrition or intravenous fluids. Please only provide supportive and comfort care including pain medications, oxygen if needed, regular turning, and a special bed if needed. It is important to me that (insert beliefs and values).

2. **Comfort Care & Minimal Supportive Care:** This is considered most appropriate for those at home, in palliative care, or in residential care who are approaching End of Life but whose infections or fractures are easily reversed or treated.

Example:
Do not resuscitate me. Do not transfer me to a higher level of care except to treat fractures. I am approaching the end of my life but I want any infections that are easily reversible with oral antibiotics to be given. I want adequate pain medications. Should my health continue to decline despite these measures, and/or when I can no longer feed myself, please do not feed me or provide artificial nutrition or intravenous fluids. Please only provide supportive

and comfort care including pain medications, oxygen if needed, regular turning, and a special bed if needed. It is important to me that (insert beliefs and values).

3. **Comfort Care & Transport to Hospital for a Higher Level of Care.** This is considered most appropriate for those at home, in palliative care, or in residential care and are approaching but are not at End of Life. They want to be transferred to an acute medical facility for treatment of easily reversible conditions. Risk versus benefit of treatment should be discussed thoroughly and compassionately.

Example:
Do not resuscitate me. Transfer me to a higher level of care for all treatments, including intravenous antibiotics and surgeries that are likely to improve my quality of life. Should my health decline despite these measures, do not transfer me to a critical care unit. When I can no longer feed myself, please do not feed me or provide artificial nutrition or intravenous fluids. Please only provide supportive and comfort care including pain medications, oxygen if needed, regular turning, and a special bed if needed. It is important to me that (insert beliefs and values).

Note: Discussion about Levels 4 and 5 usually take place in the hospital during rapidly deteriorating health conditions and are usually not a part of an Advance Directive:

4. **Do not resuscitate but allow transfer to critical care without ventilation.** This is considered most appropriate for those who have a life-threatening illness or where CPR would not be considered of benefit, such as end-stage organ failure, advanced cancer, severe osteoporosis, or the very elderly who want all intervention tried except resuscitation. They are willing to go to a critical care unit but do not want to be put on a ventilator if the risk or value exceeds the benefit.

Example:
Do not resuscitate me or put me on a ventilator. Transfer me to critical care for all treatments, including advanced medications, intravenous antibiotics, and surgeries that are likely to improve my quality of life. When I can no longer feed myself, please do not feed me or provide artificial nutrition or intravenous fluids. Please only provide supportive and comfort care including pain medications, oxygen if needed, regular turning, and a special bed if needed. It is important to me that (insert beliefs and values).

5. **Do not resuscitate, allow transfer to critical care, or allow a ventilator.** This is considered most appropriate for those who want all treatment and care offered to them but not CPR.

Example:

Do not perform CPR. I am willing to be defibrillated and put on a ventilator. Transfer me to critical care or intensive care for all treatments, including advanced medications, intravenous antibiotics, and surgeries that are likely to improve my quality of life. When I can no longer feed myself, please do not feed me or provide artificial nutrition or intravenous fluids. Please only provide supportive and comfort care including pain medications, oxygen if needed, regular turning, and a special bed if needed. It is important to me that (insert beliefs and values).

Step 2: Adding your Beliefs and Values

Here are a few examples of various beliefs and values. These are examples only and may not fit your personal beliefs and values. They are simply examples to help you with the process:

I believe:

- In quality of life over quantity of life.
- In being kept alive at all costs.
- It is not my choice to make decisions about the care I receive. I will leave this up to my doctors.
- My choices should be honoured.
- My brain and mind are more important than keeping my body alive.
- I should be allowed to die when I am suffering and I feel my life is no longer worth living.
- _____
- _____

I value:

- Time with family and friends.
- My pets.
- Time in my garden.
- Time reading.
- Good food.
- Independence.
- Choice.
- _____
- _____
- _____

SAMPLE

Advance Directive for
Name:
Address:
Date of Birth:
Personal Health Number:

This Advance Directive revokes any previous directives.

My wishes for my healthcare and end of life are…

_____
Your signature

_____
Date

_____
Witness signature #1
Witness printed name
Witness address (and phone number)

_____
Witness signature #2
Witness printed name
Witness address (and phone number)

I have reviewed this Advance Directive and it remains valid:

_____	_____
Date	(Signature)
_____	_____
Date	(Signature)
_____	_____
Date	(Signature)