END OF LIFE Ireland

ADVANCE HEALTHCARE DIRECTIVE

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 voluntary assisted dying, or euthanasia is not part of the Advance Healthcare Directive. 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 or assisted death.

These directives are not yet legally-binding documents in Ireland, it is up to next-of-kin to make decisions around end of life care should you not be able to communicate your preferences. Since AHDs 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 minimised, 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.

NB: This form can be edited digitally but needs to be printed and signed.

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 on 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 (*e.g. your GP, Health Care Proxy, Spouse, Best Friend, Solicitor*):

Name: Telephone:

Address:

Name: Telephone:

Address:

Name: Telephone:

Address:

GENERAL MEDICAL TREATMENT

Two specific medical circumstances are set out below, 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) nor (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 little 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 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 (named in the next section)

I (*name*) ☐ want to be given all necessary palliative care to control pain, respiratory distress and other severe symptoms arising even if this might shorten my life.

I realise that if I do not specifically indicate my preferences regarding any of the forms of treatment listed here, 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 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 respected.

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 the 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 (*name*)

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 expectation 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 on 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 persons who act in good faith and in accordance with what I have requested in this Advanced Healthcare Directive.

In the following space, you can write whatever you think is relevant to the directives you have requests 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 purpose I have initialled below:

☐ Any organs or part	☐ Eyes	☐ Liver	☐ Heart
☐ Bone and connective tissue	☐ Kidney(s)	☐ Lung(s)	☐ Pancreas

For the purposes of:

☐ Any purpose authorised by law	☐ Transplantation	☐ Research	☐ Medical education

Your signature _____ *Date* ☐

Signature of your next-of-kin _____ *Date* ☐

SIGNATURES

This Advanced 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* _____

Your signature _____ *Date* _____

Your signature _____ *Date* _____

Your signature _____ *Date* _____

Your signature _____ *Date* _____

You have the right to change or cancel this 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 documents must be signed by you, and dated.