

Advance Directives



Answers to several commonly asked questions
which we hope will help you to understand your rights



Bermuda Hospitals Board

What is advance care planning?

Advance care planning is making decisions now about your future health care and treatment. It usually involves talking with your family or loved ones about your wishes. It may also include talking to your family doctor, others who provide your health care and your lawyer.

Advance Directives are documents written by the patient to make their wishes about medical decisions known to the health care team in the event that the patient is not able to communicate these wishes. These documents give guidance to your family, guardians and the health care team about your treatment wishes. Patients should use these documents to express their wishes about end-of-life decisions as completely and specifically as possible.

BHB supports the use of **Advance Directives**, provided they are consistent with professional standards-of-care, other BHB policies and the law. This is one important way that BHB supports open and honest communication between patients and the people who provide their health care.

Types of advance directives:

- **The Health Care Proxy** (Power of Attorney) is a document completed by the patient that allows them to designate someone to help make medical decisions for them in the event that they can no longer make medical decisions themselves. This person is called your Health Care Agent or **Substitute Decision-maker**. A blank Health Care Proxy form with detailed instructions is included in this document.
- A **Living Will** is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill.
- A **Do-Not-Resuscitate (DNR)** is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor

Why should I consider making an Advance Directive?

Having an Advance Directive helps ensure that your wishes about your health care and treatment are understood and respected when you cannot speak for yourself. It also reassures others that they are following your wishes. Making an Advance Directive gives you the opportunity to talk about what kind of health care and treatment you want with people who are close to you (such as your partner and family or loved ones) and people who provide your health care (such as doctors and nurses).

What information is usually found in Advance Directives?

Information in Advance Directives may include:

- your wishes and preferences about healthcare and treatment
- the name and telephone number of your health care agent or substitute decision-maker(s) (in the Advance Directives' proxy directive)
- a statement of personal goals or values you wish to guide decision-making
- any other information you wish those who provide your health care to have

How do I make my Advance Directives?

We encourage you to talk about your wishes to the people you are close to and the people who provide your health care. It is important to ask questions, be informed, and understand your choices when you make your Advance Directives. Please ask for assistance and any member of the hospital medical staff will be glad to help you.

Remember that Advance Directives must be:

- easy to read
- signed and dated by you
- witnessed

You are welcome to use the sample Advance Directives form provided in the appendix of this document.

Do I need a lawyer to make my Advance Directives?

You do not need a lawyer to make Advance Directives. However, it is a good idea to tell your lawyer as well as your health care agent, the people you are close to, and those who provide your health care, about your Advance Directives. This will help ensure your wishes in the Advance Directives are known and respected.

When will my Advance Directives be used?

Your written Advance Directives will only be used when you are unable to make or express your health care decisions on your own.

Where do I keep my Advance Directives? Who should have a copy?

Your original Advance Directives should be kept with other important documents in a safe place. If a health care agent /substitute decision-maker has been named, you should also give them a copy. Your family doctor should be given a copy; and a copy should be given to the hospital.

Hospital Information Management Systems or HIMS (formerly Medical Records Department) of the hospital, will keep your Advance Directives in your medical files so that it can be readily available, if needed. You may submit a copy of your Advance Directives to the Medical Records (HIMS) department or to a member of the medical staff upon admission to the hospital.

What if I change my mind about my wishes?

As long as you have capacity i.e. you are able to understand the implications, including the risks and benefits, of your decision, you can change or cancel your Advance Directive at anytime, either in writing or verbally. The people who provide your health care and your health care agent should be told about any changes you have made.

If you wish to change your advance directive, ask a member of the BHB medical staff for a new advance directive form to be completed and signed by you in the presence of a witness.

If you wish to cancel your Advance Directives you can do so by:

- writing new Advance Directives; or by providing a written statement signed by you stating you want to cancel your Advance Directives; or
- providing an oral statement to medical staff in the presence of a witness stating your wish to cancel your Advance Directives; or
- destroying your Advance Directives or directing some other person in your presence to destroy your Advance Directives.

What if I have questions about Advance Directives?

If you have questions or concerns about advance directives or end of life decisions please speak with your physician, nurse or you may contact the BHB Quality and Risk Management department at 441 239.1553.

What if I am concerned about my experience with Advance Directives at BHB?

If you need to discuss concerns about use of Advance Directives at BHB, please contact the BHB Quality and Risk Management department at 441 239.1553 or dial our Ethics Consultation Hotline 441-291-4673. If you leave your name and number, an Ethics Committee member will return your call. All consultations are confidential.

HEALTH CARE PROXY: FREQUENTLY ASKED QUESTIONS

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself.

Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form supplied, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anaesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- Whether you would want life support initiated/continued/removed if you are in a permanent coma;
- Whether you would want treatments initiated/continued/removed if you have a terminal illness;
- Whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honour the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current wform and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can my health care agent make decisions for me about organ and/or tissue donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes.

LIVING WILL: FREQUENTLY ASKED QUESTIONS

What is a Living Will?

A living will is a document that states the type of treatment you want should you be in a “terminal condition” or “permanently unconscious.” The living will tells your doctor whether you want aggressive treatment to keep you alive or whether you do not want such treatment, even if the result is your death.

We consider a patient to be in a “terminal condition” when the doctor finds that the patient has a condition which is: (1) incurable or irreversible; and (2) will result in death within a relatively short time if aggressive treatment is not provided. Also, “permanently unconscious” is considered to be a permanent coma or persistent vegetative state where the patient is not aware of himself or his surroundings and is unresponsive.

What will happen if I decide not to be fed artificially?

Many people are concerned about the withdrawal of food and water at the end of life, assuming that it would produce discomfort. Closer study, however, has shown that this is not the case. The only discomfort usually reported is dryness of the mouth, which will be remedied by regular mouth freshening. Benefits of fluid deprivation include reducing respiratory secretions, less nausea and vomiting, reducing urine output with less need for catheters or bedpan use, and reducing fluid retention and associated bed sores. Patients rarely report any sensation of hunger near the end of life; indeed, feeding the person often leads to bloating or nausea.

Will I receive “Pain Killers” if I have a Living Will?

Yes. A living will does not affect the provision of pain medication or care solely to maintain your physical comfort (for example, care designed to maintain your circulation and health of your skin). This type of care will continue to be provided as appropriate. If you have specific instructions regarding pain medication, you can write them on your living will form.

Will my Living Will be honoured by emergency medical staff or the Emergency Department?

Sometimes people who have signed living wills are surprised and upset when emergency medical staff have (unknowingly) disregarded the living will and administered life-support anyway. The reason that this may happen is that, in an emergency, the staff may not have time to read the living will, to make sure that the patient is in a terminal condition and that it is indeed appropriate to withdraw treatment. If you are already in a terminal condition and feel strongly that you do not want to be given life-support under any circumstances, you should talk to your doctor. Your doctor may be able to notify the ambulance service and the emergency room that they should not give life-support and that they should only give you treatment that will ease your pain and keep you comfortable.

HEALTH CARE PROXY / POWER OF ATTORNEY FORM INSTRUCTIONS

HEALTH CARE AGENT

Include the name, home address and telephone number of the person you are selecting as your agent.

ALTERNATE AGENT

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

EXPIRATION DATE

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

INSTRUCTIONS FOR YOUR AGENT

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent’s authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write:

I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/ don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/ don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/ don't want the following types of treatments:....

EXAMPLES OF MEDICAL TREATMENTS TO INCLUDE

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Surgical procedures
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

DATE AND SIGN

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

WITNESSES

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness



HEALTH CARE PROXY /POWER OF ATTORNEY

The Health Care Proxy/ Power of Attorney declaration is a document that designates another individual to make health care decisions on behalf of a person when they are unable to do so. The Health Care Proxy / Power of Attorney holder does not have to be the person's spouse or next-of-kin but must be an adult (18 years or older)

_____ (Name),

born _____ (Date of Birth)

hereby appoint _____
(name, home address and telephone number)

As my health care agent to make care, custody and medical treatment decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to participate in and make my own health care decisions.

Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____

_____ (name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions): _____

Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below.

I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions

(attach additional pages as necessary): _____

Your Identification (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____

Date _____

Name of Witness 1

(print) _____

Name of Witness 2

(print) _____

Signature _____

Signature _____

Address _____

Address _____

ACCEPTANCE BY THE HEATH CARE AGENT

(A) This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

(B) A health care agent shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(D) A health care agent may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the Health Care Agent is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A health care agent shall not receive compensation for the performance of his or her authority, rights, and responsibilities

(F) A health care agent shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate intent to revoke.

(H) A health care agent may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate intent to revoke.

I understand the above conditions and I accept the designation as Health Care Agent for

Signed: _____ Dated: _____



Bermuda Hospitals Board

LIVING WILL DECLARATION

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honoured as the expression of my legal right to authorize or refuse medical treatment.

I, _____ (NAME), born _____ (DATE OF BIRTH)
request that, if my condition is such that I am near death as determined by my doctor, you follow my choices below:

<p>A. CHOICE NOT TO BE KEPT ALIVE</p> <p>I do not want to be kept alive if my doctor decides that any of the following are true: 1. I have an illness that will not get better, cannot be cured, and will result in my death; OR</p> <p>2. The likely risks and burdens of treatment would be more than the expected benefits. Initials: _____</p>	<p>B. CHOICE TO BE KEPT ALIVE</p> <p>I want to be kept alive as long as possible within the limits of generally accepted health care standards in Bermuda.</p> <p>Initials: _____</p>
---	--

I have indicated my tube feeding, having water and intravenous nutrition (artificial nutrition and hydration) choices below

<p>C. FEED ME ACCORDING TO MY DECISION ABOVE</p> <p>I want artificial nutrition and hydration to be given, not given, or stopped based on the choice I have made above about keeping me alive. Initials: _____</p>	<p>D. FEED ME REGARDLESS</p> <p>I want artificial nutrition and hydration given to me regardless of the choice I have made about keeping me alive. Initials: _____</p>
---	---

I have indicated my pain relief choices below

<p>E. GIVE ME REGULAR PAIN MEDICATION</p> <p>I want treatment for relief of pain or discomfort to be given whenever necessary, even if it shortens the time until my death or makes me unconscious or unable to do other things.</p> <p>Initials: _____</p>	<p>F. SPECIAL PAIN MEDICATION INSTRUCTIONS</p> <p>These are my wishes about relief of pain or discomfort: _____</p> <p>_____</p> <p>_____</p> <p>Initials: _____</p>
--	---

My family, the medical facility, and any doctors, nurses, and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration. I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Signature: _____

Date: _____

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

<p>Name of Witness 1 (print) _____</p> <p>Signature _____</p> <p>Address _____</p> <p>_____</p> <p>Date _____</p>	<p>Name of Witness 2 (print) _____</p> <p>Signature _____</p> <p>Address _____</p> <p>_____</p> <p>Date _____</p>
--	--



Bermuda Hospitals Board

DO-NOT-RESUSCITATE ORDER

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's signature) (Date)

(Type or print declarant's full name)

(Signature of person who signed for declarant, if applicable) (Date)

(Type or print full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence.

(1) Print Name _____

Signature of witness _____

Address _____

Date _____

(2) Print Name _____

Signature of witness _____

Address _____

Date _____



“Ethics is about the ways we do, and should, treat each other.”

Quality & Risk Management Dept.: 441-239-1553

Ethics Consultation Hotline: 441-291-4673

Adapted from Advance Directives Policy and Guidelines
researched and prepared by End of Life Issues Sub-Committee

BHB ETHICS COMMITTEE

King Edward VII Memorial Hospital

Sharing hope, Seeing Reason



Bermuda Hospitals Board