

ABOUT THE ADVANCE DIRECTIVE FOR RECEIVING ORAL FOOD AND FLUIDS IN DEMENTIA

Introduction

There are two purposes to completing an Advance Directive for Receiving Oral Food and Fluids In Dementia. The first is to document your wishes about when to stop efforts to provide assisted oral feeding because of an advanced dementia. The second is to ensure that your appointed health care agent is empowered to honor and implement those choices if you suffer from advanced dementia.

The accompanying Directive (beginning on page 4) provides two alternatives concerning assisted oral feedings:

A. The Directive permits you to direct, in a particular clinical situation, that ALL assisted feeding of food and fluid be stopped.

B. The Directive also permits you to direct, in that same clinical situation, that comfort-focused feeding be provided.

You may sign the Directive with the directions in A **or** B, not both.

A person who is diagnosed with Alzheimer's or another incurable dementing disease may wish to have control over the circumstances and timing of his or her death. While Alzheimer's is considered a terminal disease, because the duration of the disease can be long, the terminal stage of the disease may not occur for many years, and long after decision-making capacity and the ability to self-feed are lost. The average time from diagnosis to death is 7 years, but many individuals live considerably longer. So long as those with advanced dementia receive good physical care and are assisted with eating and drinking, it can be difficult to predict when death will finally occur.

In the final, 'terminal' stage of all dementias, a person may become unable to swallow what is placed in his or her mouth, and lose the ability to ambulate, speak, recognize loved ones, and control bowel or bladder functioning. Individuals with Alzheimer's disease who contact End of Life Choices New York want to know how they can avoid the final stages of this disease. It is for those individuals, and others who fear being diagnosed with dementia in the future, that the Directive about assisted oral feeding has been created.

Appointing Your Health Care Agent

If you are age 18 or older, we recommend that you complete a health care proxy form appointing someone (and an alternate) as your health care agent who will be the advocate for your wishes. The agent will be authorized to make all health care treatment decisions for you if and when you lose your decision-making

capacity. Your agent is instructed to assume this responsibility and to make future treatment decisions as you would decide, if you were able to make that decision. Health care providers are expected to honor decisions made by an appointed health care agent.

Other Documents

You might also consider completing a MOLST (Medical Orders for Life-Sustaining Treatments) with your primary care physician. That document includes your **current** wishes about receiving cardiopulmonary resuscitation (CPR) if your heart stops or being placed on a mechanical ventilator (breathing machine) should your breathing becomes compromised.

If you complete a MOLST, be sure to add a stipulation that your instructions in your directive about assisted feeding should take precedent and be followed. You should add that stipulation in the space for OTHER INSTRUCTIONS in Section E of the MOLST form.

Although completing a MOLST is recommended, if you do not do so, you should obtain from your physician a signed Out of Hospital Do Not Resuscitate Order. You should also discuss with your physician your Advance Directive for Receiving Oral Food and Fluids In Dementia in the event that you suffer from advanced dementia. Provide a copy of this document to your primary care physician. Be sure there is no conflict between instructions in these various documents about your wishes to be fed.

Your Advance Directive for Receiving Oral Food and Fluids In Dementia does not replace your completed Health Care Proxy or MOLST form, but it is an important additional tool to empower you and your appointed agent to make decisions about receiving oral assisted feeding, in the event that you suffer from advanced dementia. Your completed Directive should be photocopied, discussed, and provided to all family members, loved ones, other health care professionals and care-givers.

Instructions for Execution of the Advance Directive

1. Sign and date the Directive when you are in the presence of two witnesses who are 18 or older. A witness may not be your health care agent or an alternate agent. The agent may not be your primary physician.
2. Have two witnesses who are age 18 or older (preferably persons who know you well) sign and add their printed names, addresses and phone numbers.
3. Executing one copy of the Directive is sufficient, but additional copies can be executed, if that is convenient for everyone. (Photocopies are generally accepted by health care providers.)

Additional Steps to Consider After the Directive is Signed

1. You might find it helpful to meet with your family attorney to review the Directive, to explain your wishes and to provide her or him with a copy of the Directive along with your concerns and your reasons for completing it.
2. You should also give a copy to your primary physician and ask him or her to make it a part of your medical records.
3. You might consider videotaping a statement explaining why you have completed the Directive, what your values and wishes are regarding this choice, and that you have made this decision without coercion. Doing so might facilitate a legal defense of the document, should the need arise. Copies of the video can also be provided to your health care agent, your physician and family members. A videotape is the most powerful way to explain why you have completed the Directive, but you can also add a separate page to the directive to explain in writing your reasons for signing it.
4. Be sure to tell all those who care about you that you are depending on them and your agents to honor your requests. Ask them to promise NOT to ignore or disregard your Directive because **they** think your quality of life is satisfactory or because you appear to be comfortable. Their job is to represent your wishes and preferences.
5. If you anticipate moving to a long-term care or memory care facility at some point, it is important to explore whether the administrators of the facility will honor your Directive before you are admitted. This may take some time as this document about limiting assisted oral feeding is currently a somewhat novel approach to advance care planning. Get help from those who care about you and your wishes.
6. Be sure that your health care agent and the alternate agent, family members, and all health care professionals know that you want to receive good symptom management and that they are aware of your directive about oral feeding. Thus access to hospice or palliative medical oversight should be provided at the appropriate time.

Please note that this Directive has not received judicial review in New York State. If you have questions or need assistance in completing the Directive, please call the End of Life Choices New York consultation service number at 212-252-2015, and we will be pleased to assist you.

To learn more about End of Life Choices New York, please go to our website at www.endoflifechoicesny.org.

**ADVANCE DIRECTIVE FOR
RECEIVING ORAL FOODS AND FLUIDS IN THE EVENT OF DEMENTIA**

I, _____, residing at _____

_____, am creating this document because I want my health care agents, medical providers, caregivers, family members, and other loved ones to know and honor my wishes regarding assisted oral feeding of food and fluids if I am in an *advanced* stage of Alzheimer's* or other incurable, advanced dementing disease and:

1. I am unable to make informed decisions about my health care, and
2. I am unable to feed myself.

Why I Am Documenting My Instructions Concerning Oral Feedings

Under the conditions that may be imposed upon me by advanced dementia, including my inability to communicate comprehensively with loved ones or care givers, and my physical dependence on others for all aspects of bodily care, continuing life would have no value for me. In those conditions, I would want to die peacefully and as quickly as legally possible to avoid a drawn-out, prolonged dying that would involve unnecessary suffering for me and for those I love.

This Advance Directive is intended to supplement any instruction I may have given in a health care proxy, living Will or other document.

Choose the provisions of either Option A OR Option B by entering your initials in the corresponding space below.

OPTION A

The provisions of this column are selected _____ (initial)

Medications and Life-Sustaining Treatments

If my appointed health care agent concludes, after consultation with my primary health care provider, that I am suffering from advanced dementia and conditions 1 and 2, above, are met, I want all medications and treatments that might prolong my life to be withheld or, if already begun, to be withdrawn,

OPTION B

The provisions of this column are selected _____ (initial)

Medications and Life-Sustaining Treatments

If my appointed health care agent concludes, after consultation with my primary health care provider, that I am suffering from advanced dementia and conditions 1 and 2, above, are met, I want all medications and treatments that might prolong my life to be withheld or, if already begun, to be withdrawn

including cardio-pulmonary resuscitation and the provision of nutrition and hydration whether provided artificially or medically or by hand or by assisted oral feeding.

Assisted Hand Feeding

If I am suffering from advanced dementia and appear willing to accept food or fluid offered by assisted or hand feeding, my instructions are that I do NOT want to be fed by hand even if I appear to cooperate in being fed by opening my mouth.

including cardio-pulmonary resuscitation and the provision of *medically* provided nutrition and hydration. I would want to receive assisted oral feedings *only* under the following circumstances:

1. So long as I appear receptive and cooperate in eating and drinking by showing signs of enjoyment or positive anticipation of eating and drinking, I want to receive assisted or hand oral feedings.
2. I would want to be fed only those foods I appear to enjoy, in any texture I prefer, and in whatever amount I readily accept.
3. I would want all attempts to provide assisted oral feedings stopped when I no longer seem to enjoy or appear willing to eat or drink, or if I begin to cough, choke or aspirate oral feedings into my lungs.
4. I do not wish to receive assisted feedings once I no longer willingly open my mouth or I appear indifferent to being fed, or spit out food or fluids.
5. I do not wish to be coerced, cajoled or in any way forced to eat or drink.

My Hygiene and Comfort

I want to receive good hygiene and other measures to assure comfort and to receive appropriate medications for relief of any signs of anxiety, agitation, insomnia, or pain, with hospice or palliative oversight. I would like my lips and inner surfaces of my mouth and gums to be kept moistened to minimize discomfort. I want to receive medications for pain or anxiety in sufficient dosages and with sufficient frequency to assure effective relief of suffering even though such medication might shorten my life.

I Hope to Die at Home

It is my wish to die at home rather than in an institutional setting, provided this does not impose an unreasonable burden on my family. If an institutional placement becomes necessary, I would like my health care agent to determine whether the facility will honor my wishes concerning hand feeding and other life-prolonging measures as written in these directions. If not, I would like not to be in that facility and instead placed under hospice care in a setting where capable staff will provide compassionate end-of-life care in accordance with these directions.

* By "advanced Alzheimer's disease" I mean stage 6 or 7 (moderate to severe) of the Functional Assessment Staging Tool (FAST) which includes severe cognitive decline and the need for extensive assistance for most activities of daily living including toileting and eating.

My Signature _____ Date _____

We, whose names are provided below, declare that the person who signed this document is personally known to us, appears to be of sound mind and acting of his or her own free will, and signed this document (or asked another to sign this document) in our presence.

Witness 1:

Signature _____ Date _____

Printed name _____ Phone _____

Address _____

Witness 2:

Signature _____ Date _____

Printed name _____ Phone _____

Address _____
