WEBINAR
ADVANCE CARE PLANNING - ISSUES FOR LAWYERS

DATE
September 2019

PRESENTERS
Jane Goodwin
Nick Laing

Copyright reserved: This booklet or any portion thereof may not be reproduced without the express permission of NZLS CLE Ltd.
PRESENTERS

**Jane Goodwin, Canterbury Initiative Advance Care Planning Facilitator, Christchurch Hospital**

Jane, BN (1st Class Hons), MHealSc, is a registered nurse who has been in the role of Advance Care Planning (ACP) Facilitator in Waitaha/Canterbury since 2013. She has a strong involvement with ACP nationally: chairing the national ACP Steering Group; working as an L3 advanced communication trainer and L4 national advanced communication train-the-trainer with the ACP programme; and contracted to the Health Quality and Safety Commission (HQSC) as the National ACP Implementation Consultant. More recently Jane has been working with The HQSC to introduce the Serious Illness Conversation Guide (SICG) to Aotearoa.

**Nick Laing, Duncan Cotterill, Nelson**

Nick specialises in litigation and dispute resolution with a particular focus on the health sector. His areas of practice include insurance matters, health and safety, medico-legal matters, professional indemnity, commercial and business disputes. Nick’s experience includes matters relating to health practitioner discipline and negligence claims (including the Coroner, Health and Disability Commissioner, Privacy Commissioner and Ombudsmen), duty of care, patient consent, privacy and treatment issues. He recently completed a Masters in Law specialising in health law. Nick regularly advises health providers, DHBs, and primary health organisations on a wide range of medico-legal matters, including in relation to Advance Care Planning.

*The statements and conclusions contained in this booklet are those of the author(s) only and not those of the New Zealand Law Society. This booklet has been prepared for the purpose of a Continuing Legal Education course. It is not intended to be a comprehensive statement of the law or practice, and should not be relied upon as such. If advice on the law is required, it should be sought on a formal, professional basis.*
CONTENTS

1. INTRODUCTION ........................................................................................................................................ 1
   WHAT ADVANCE CARE PLANNING (ACP) IS ............................................................................................. 1
   WHO IS ACP FOR? ................................................................................................................................. 2
   WHY IS ACP IMPORTANT? ................................................................................................................... 2
   WHY ACP IS RELEVANT TO LAWYERS AND LEGAL PROFESSIONALS ........................................... 3

2. RELEVANT LEGAL FRAMEWORKS FOR ACP ......................................................................................... 5
   INTERNATIONAL LAW .......................................................................................................................... 5
   DOMESTIC LAW ................................................................................................................................ 6
   ADVANCE DIRECTIVES ......................................................................................................................... 6

3. ADVANCE DIRECTIVES – IN ACCORDANCE WITH THE COMMON LAW ............................................. 9
   CAPACITY TO MAKE A DECISION ........................................................................................................ 9
     1. Comprehending and retaining information ..................................................................................... 10
     2. Belief in the information ................................................................................................................. 11
     3. Weigh in the balance and arrive at a choice .................................................................................. 11
   INTENDED TO APPLY TO THE CIRCUMSTANCES .............................................................................. 12
   FREE OF THE UNDUE INFLUENCE OF OTHERS ................................................................................. 13
   VALIDITY .............................................................................................................................................. 13

4. ACP AND ITS INTERPLAY WITH “LIVING WILLS” AND ENDURING POWERS OF ATTORNEY ........ 15
   LIVING WILLS ........................................................................................................................................ 15
   ENDURING POWERS OF ATTORNEY ................................................................................................. 15
   WHAT IF YOU HAVE CONCERNS ABOUT A CLIENT’S CAPACITY? ...................................................... 16

5. WHERE TO DIRECT YOUR CLIENT FOR MORE INFORMATION ABOUT ACP? .................... 19
   QUALITY OVERSIGHT .......................................................................................................................... 19
   OPPORTUNITIES FOR LAWYERS AND LEGAL PROFESSIONALS TO INCORPORATE ACP INTO THEIR PRACTICE .................................................................................................................. 20

6. APPENDIX 1: MY ADVANCE CARE PLAN & GUIDE ............................................................................ 21
1. INTRODUCTION

What is advance care planning (ACP)? Why is it relevant to lawyers and legal professionals?

What Advance Care Planning (ACP) is

ACP is a process of discussion and shared planning for future health care which involves the individual, their family/whānau (if the person chooses), their health care professionals, and in some cases their lawyer. ACP encourages a person to develop and express their preferences for future care based on their beliefs and values as well as an understanding of their current and likely future health and the treatment and care options that might be available to them.

It encourages a person to think about, talk about and plan for future health and end-of-life care. It is not a process of facilitating or directing euthanasia, or assisted suicide.

An ACP conversation and the creation of an advance care plan can happen unbeknownst to the lawyer. Discussions might be initiated by the person, encouraged by whānau or introduced and supported by the health care team. For others, the process of ACP may well begin at a lawyer’s office. Thoughts, preferences and directives for care may be formulated and articulated by a client as they create or update their will or prepare an enduring power of attorney or living will. As with a will, or an attorney, the process of creating an advance care plan may be prompted by a wish to ensure affairs are in order, a desire to reduce any burden on loved ones, a health crisis (either their own, or that of whānau, a friend or an acquaintance), or worries about how their estate arrangements might look should they die.

Conversations are central to effective ACP. People engaging in the ACP process are encouraged to speak with whānau, friends, significant others and the health care team about the things that are important to them in relation to their health care and end of life.

Advance Care Planning

These conversations may be formalised into an advance care planning document, such as My Advance Care Plan and Guide (Appendix 1) and include details of the person’s values, beliefs, concerns, hopes, goals, priorities if time were limited, preferences for decision making, information about where they might like to be cared for during their final days and
the ways those caring for them can look after spiritual, cultural or emotional needs. It may also cover what sort of funeral a person would like, their wishes regarding organs, tissue or body donation, whether they would want to be buried or cremated and the location of important papers.

These details provide context to any goals of care and advance directives the person may choose to incorporate into their ACP (e.g., s 6 of the My Advance Care Plan & Guide) or document separately in a living will.

**Who is ACP for?**

ACP conversations are for everyone. All competent adults are encouraged to think about, talk about and create their own advance care plan. You never know when you may have a health crisis and be unable to speak for yourself.

The population who will get the most immediate benefit from ACP are those with life limiting conditions and/or those with progressive cognitive conditions whose competence is expected to reduce in the future. A number of DHBs across Aotearoa offer subsidies and/or funding to support ACP conversations in these populations.

**Why is ACP important?**

The benefits of ACP are varied and considerable. Research tells us that ACP:

- helps a person achieve a sense of control as illness progresses and death approaches
- has a positive effect on mitigating patients’ existential distress
- can positively enhance a patient’s hope in the face of progressive disease
- reduces fear and anxiety
- facilitates end of life wishes to be known and followed
- reduces stress, anxiety and depression for family members when a patient dies
- reduces time spent in hospital in the last year of life

---

6. See above n 5.
increases patient satisfaction with their health care$^{8,9}$

To hear people share their ACP stories and hear what the process has meant to individuals and their whānau, please use the link below to the Advance Care Planning pages on the Health Quality and Safety Commission New Zealand website.


**Why ACP is relevant to lawyers and legal professionals**

ACP is relevant to lawyers and legal professionals as it allows for a focused, practical and pragmatic discussion about their client’s preferred future health care and ideally between their client, their whānau, and their client’s health professionals.

ACP facilitates the autonomy of a person to express, in advance, their treatment preferences, including to refuse particular treatments or to specify their preferences for particular treatment (to the extent it is clinically indicated). This means that when a person loses the mental capacity to make decisions for themselves, their treatment preferences can be given effect. In this seminar paper, we will explore the legal framework that enables ACP, and the formulation of advance care plans including advance directives.

An effective ACP process can mean that a client’s underlying preferences about their future treatment can be consistent with, and more easily incorporated in, the legal documents lawyers prepare for their clients. The information gathered as part of the ACP process gives valuable context, as conversations are usually guided by health professionals rather than by lawyers. It can also help inform treatment preferences and broaden treatment options by discussing scenarios, and weighing up the benefits and drawbacks of particular treatment options and preferences.

**Example:** Joe has recently retired. He is preparing a living will with his trusted long-time lawyer. While the lawyer is not a medico-legal specialist, the lawyer has drafted countless wills including living wills. Joe wants to refuse a specific medication being administered. Joe has read in one of his favourite online forums and on Dr Google that while it is proven effective in treating a stroke, it can have some side effects that sound nasty to Joe. Joe’s lawyer includes his refusal of this medication in his living will – but Joe doesn’t talk to his GP to help understand that refusing this medication could leave him with permanent and irreversible nerve damage, and the side effects are pretty minor.

**Takeout:** Joe should discuss this treatment preference – and his living will – with his GP, so he can be informed about and weigh up his treatment options.

---

$^{8}$ See above n 5.

2. RELEVANT LEGAL FRAMEWORKS FOR ACP

The relevant legal frameworks in New Zealand allowing for ACP – and in particular allowing a person to make an advance directive – derive from international law, domestic law and the common law.

At its most basic level, an advance directive can refer to any communication that sets out a person’s wishes as to their healthcare. An advance care plan can include such a directive. There are various descriptors of advance directives in literature and a lack of precision as to their definition. They could be labelled as advance statements, advance agreements, living wills, advance decisions, advance treatment authorisations, future treatment plans, crisis plans and advanced care plans. Their essence is that they formally convey the person’s wishes about treatment decisions and preferences to be applied, including once a person loses decision-making capacity.

In general in New Zealand law, the terms “capacity” or “competence” are interchangeable. In this paper, we use the term “capacity”, being a concept that refers to a person’s ability to make a decision with legal consequences for the person, or for others.\(^\text{11}\)

**International law**

The first key international instruments of relevance are the “International Bill of Rights”: the 1948 Declaration of Human Rights; the 1966 International Covenant on Civil and Political Rights; and the 1966 International Covenant on Economic, Social and Cultural Rights. These instruments continue and affirm the fundamental rights of the person, in particular the right to life, liberty and security of the person. They also affirm the right not to be subject to torture or to cruel, inhuman or degrading treatment or punishment. These rights crystallise a person’s right to autonomy over their own body, together with the right to choose what medical treatments they wish to consent to and those they wish to refuse.

---

\(^\text{10}\) Nick Laing would like to acknowledge with thanks the University of Auckland and in particular his lecturers – Kris Gledhill and Alex Ruck Keene – for their guidance and input into a paper upon which these sections are based in part, completed as part of the requirements of an LLM in Litigation and Dispute Resolution (First Class Honours).

These rights are transposed into domestic law through the New Zealand Bill of Rights Act 1990 (BORA), which affirms the rights and freedoms set out therein, and is “subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”. The rights include the right not to be deprived of life, the right not to be subjected to torture or cruel treatment, and the liberty of the person. It also affirms a right to refuse to undergo medical treatment.

The second key international instrument is the 2006 Convention on the Rights of Persons with Disabilities (CRPD). The purpose of the CRPD is to:

- promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity (Article 1).

The CRPD has been ratified by New Zealand, and also transposed into New Zealand domestic law under the Disability (United Nations Convention on the Rights of Persons with Disabilities) Act 2008. Under the CRPD a “disability” has a broad definition and can encompass a person with a learning impairment as well as a person who has lost functional decision-making capacity, for example, due to dementia.

The CRPD promotes a supported decision making framework; this stands in contrast to New Zealand’s existing legislation under the Protection of Personal and Property Rights Act 1988 (the PPPR Act) – which embodies a substitute decision-making model. In other words, under the PPPR Act, when a person loses capacity, a substitute decision-maker steps in to make decisions for them. What the CRPD requires instead, is that a person who has lost capacity has the right to equal recognition before the law, and the ability to enjoy legal capacity on an equal basis as others in all aspects of life (art 12). Accordingly, ACPs – including an advance directive – are a key tool in ensuring a person’s human rights are respected, including in the case where a person has lost mental capacity because of a disability (and whether that is permanent or transient).

**Domestic law**

As discussed above, the BORA sets out a number of fundamental human rights. Relevantly for ACP, the two of relevance are Right 9 – that “Everyone has the right not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment” and Right 11 – that “Everyone has the right to refuse to undergo any medical treatment”. These two rights echo the requirement that any person receiving medical treatment must provide informed consent to that treatment, and further that a person has the right to refuse to medical treatment.

**Advance directives**

New Zealand has a very limited legislative framework providing for ACP, including for advance directives.

However, that framework is supported by the common law, meaning that *advance directives are valid and legally binding.*

They must meet certain requirements (which are discussed further below). The Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights)
Regulations 1996 (the Code of Patient’s Rights or the Code), a regulation made under the Health and Disability Commissioner Act 1994, confirms the common law legal framework for advance directives in New Zealand.

An advance directive is defined in cl 7(4) as:

- a written or oral directive—
  1. by which a consumer makes a choice about a possible future health care procedure; and
  2. that is intended to be effective only when he or she is not competent.

Further, the Code restates the common law position that allows a health consumer to use an advance directive:

7(5) Every consumer may use an advance directive in accordance with the common law.

**Example: HDC case – surgical patient who refused blood (11HDC00531, 30 June 2014)**

This case was about a person (Ms A) who was diagnosed with gallstones and placed on the waiting list for a gallbladder removal surgery at a public hospital. Four days prior to her surgery, Ms A confirmed, and it was subsequently recorded in her clinical notes, that she did not consent to the use of blood and blood products (Ms A’s advance directive). The anaesthetist was aware of Ms A’s advance directive, but the matter was not raised during the surgical “Time Out”, when any issues of concern are brought to the attention of the theatre team. The surgeon did not become aware of Ms A’s advance directive until her condition began to deteriorate following her first operation when he instructed that Ms A was to be given blood. The surgeon determined that Ms A should be transferred to a facility better equipped and staffed to manage the situation, however her condition rapidly deteriorated and Ms A died before the transfer could be safety conducted.

The hospital was held to be in breach of Right 4 of the Code of Patient’s Rights – being the right to services of an appropriate standard. In particular, the hospital breached Right 4(1) – “that every consumer has the right to have services provided with reasonable care and skill”, and Right 4(5) – “every consumer has the right to co-operation among providers to ensure quality and continuity of services” of the Code.

The breach was on the basis that the arrangements and systems in place at the hospital did not support the timely communication of the information relating to Ms A’s advance directive. Both the surgeon and the anaesthetist were required to know about Ms A’s advance directive prior to her first surgery in order to have the appropriate plans and preparations in place. The surgeon was held to be in breach of Right 4(1) for failing to provide services with reasonable care and skill. The anaesthetist was held to be in breach of Right 4(5) for failing to take reasonable steps to co-operate with his colleagues to ensure quality and continuity of services.
3. ADVANCE DIRECTIVES – IN ACCORDANCE WITH THE COMMON LAW

The common law has established four key elements for an advance directive to be binding and effective:

1. The person must have had *capacity* when they made the directive.
2. The directive must have been intended to apply to the particular *circumstances* that have arisen.
3. The directive must have been made *free* of the undue influence of others.
4. There must be an appropriate standard of evidence to substantiate the *validity* of the advance directive.

**Capacity to make a decision**

The ability of a person to give consent to medical treatment, or refuse that treatment, rests on the person having the capacity to do so. Capacity is a legal test, established by the common law.

However, it is also a factual consideration for clinicians to assess at the time of considering a clinical procedure for a patient. A person may only make a decision when they have the capacity to do so: “Every human being of adult years and sound mind has a right to determine what should be done with his own body.”

---

12 *Schloendorff v Society of New York Hospital* 211 NY 125, 105 NE 92 (1914) at 130, 93 per Cardozo J.
It follows there is a fundamental, albeit rebuttable, presumption at common law that every adult has capacity.\(^\text{13}\) Importantly, the presumption is not that the person has capacity only to make reasonable or sound decisions in the eyes of the person’s health practitioners.\(^\text{14}\)

Traditional common law approaches to assessing capacity consider a “functional” approach: an objective consideration of whether a person can understand and come to a decision about what is involved. In \(\text{Re C (Adult Refusal of Treatment)}\),\(^\text{15}\) Thorpe J considered a functional definition of capacity as a person having a sufficient understanding of “the nature, purpose and effects of the proffered [treatment]”.

The three key aspects to this understanding are considered according to whether the person could firstly, comprehend and retain information; secondly, believe the information and, thirdly, weigh the information against other factors in order to reach a decision. In \(\text{Re C}\), because the patient demonstrated these three aspects, the Court considered the person had capacity to consent to refusing the amputation of a gangrenous leg, even while affected by schizophrenic delusions that he was a doctor. These three tests have become known as “the Re C test”.

---

**The Mental Capacity Toolkit**

Dunedin Barrister Alison Douglass has made an outstanding contribution New Zealand legal scholarship in the area of capacity, in her Law Foundation report of July 2016. As part of the report, Ms Douglass co-authored (together with consultant psychiatrist Dr Greg Young and an ethicist Professor John McMillan) a *Toolkit for Assessing Capacity*, which includes practical guidance for doctors and lawyers when assessing the capacity of their clients. Given that having capacity is a critical consideration for the validity of an advance directive, it is important for legal and medical practitioners to consider.

The “Toolkit”, applies the functional “Re C” test of capacity. It is available at Ms Douglass website www.alisondouglass.co.nz and is also explored in a forthcoming work *Assessment of Mental Capacity: A New Zealand Guide for Doctors and Lawyers*, due out late in 2019.

---

1. **Comprehending and retaining information**

The first requirement is that a person can comprehend and retain information. As part of this test, it is suggested that best practice is for a clinician to assess whether the person is able to understand firstly the broad nature and purpose of the proposed treatment. This is a context-specific consideration of fact, having regard to the treatment in question. If a person can understand the broad nature and purpose of the proposed treatment, the person will be considered competent to consent to the treatment. Secondly, the person should understand the material risks associated with the medical treatment. This would allow a clinician to then undertake a functional assessment of whether the information is understood, and also to consider whether it is retained.

---

\(^{13}\) Re T (An Adult: Consent to Treatment) [1993] Fam 95 at 112 per Lord Donaldson MR.

\(^{14}\) Smith v Auckland Hospital Board [1965] NZLR 191 (CA) at 219 per Gresson J.

\(^{15}\) [1994] 1 WLR 290 at 295.
2. **Belief in the information**

The second requirement is that the patient believes the information being provided, in addition to understanding and retaining the information. Delusions may present a challenge to satisfying this criterion; the facts of *Re C* provide a useful factual example to consider this aspect. Mr C’s leg would have become gangrenous if it were not amputated. Despite Mr C having a delusional personality disorder that he was a world class doctor, he believed the information provided to him about the benefits of treatment. His worldview was such that he did not value continuing living with only one leg. On this basis, he would meet this second requirement and be considered to have the capacity to refuse treatment.

3. **Weigh in the balance and arrive at a choice**

The third requirement is that a person is able to weigh the information presented, after first understanding and retaining, and believing, the information. This requirement necessitates an evaluation of a person’s cognitive ability to reason a premise, rationally process that premise in relation to the proposed treatment, and consider an outcome.

Arriving at a choice needs to be communicated to the treating clinician; insufficient evidence of an ability to communicate choice has resulted in patients being deemed incompetent. For example, in *Auckland Area Health Board v Attorney-General*, the patient in question had Guillain-Barre syndrome, a relatively rapid onset autoimmune disease which paralyses the body but the mind remains unaffected. The Court held because the person was in a persistent vegetative state and unable to communicate their choice, this “living dead” status meant that under this third requirement the patient would fail this test and be deemed to lack capacity.

The above *Re C* functional capacity test has been applied in New Zealand law, in *Chief Executive of the Department of Corrections v All Means All*, a case involving a prisoner on a hunger strike at Rolleston Prison refusing artificial nutrition and hydration. We refer to this case later. The functional capacity test has also been adopted more recently as part of a threshold test in compulsory treatment in compulsory substance addiction treatment legislation Substance Addiction (Compulsory Assessment and Treatment) Act 2017, at ss 7 and 9.

---

*Chief Executive of the Department of Corrections v All Means All* [2014] 3 NZLR 404

This case is one of the most recent statements confirming both the entitlement of a person to make an advance directive in accordance with the common law, as well as endorsing the *Re C* functional test for capacity.

This case concerned Mr All Means All (Mr A), a 57 year old serving prisoner who refused both food and liquid to strike against a detective he believed lied in giving evidence at his trial. On several occasions when admitted to Christchurch Hospital, Mr A consented to hydration and nutrition, but on return to prison, continued his hunger strike. The Department of Corrections (*Corrections*) and the Canterbury District Health Board (*the DHB*) sought declarations to establish their rights and duties in relation to the medical treatment of Mr A. Specifically, *Corrections* sought a declaration that Mr A may receive medical treatment by way of artificial hydration and nutrition when his health or

---

17 [2014] 3 NZLR 404 at [17] per Panckhurst J.
life is in peril in the judgment of a clinician, and he no longer is able to indicate whether he consents to treatment. Alternatively, both Corrections and the DHB sought a declaration that they have lawful excuse for not providing medical treatment so long as Mr A continues to refuse consent to treatment.

The Court considered ss 11 (the right to refuse to undergo medical treatment), 8 (the right not to be deprived of life) and 13 (freedom of thought, conscience and religion) of the BORA. The Court also considered ss 7(1), 7(5) and 7(7) of the Code – which set out the right to make an informed choice and give informed consent.

The Court confirmed that a person must have capacity and the competence to make an informed and rational decision to refuse treatment. Mr A had been examined by four psychiatrists, and the Court held that there was no doubt as to Mr A’s capacity to make a decision refusing medical treatment (at [17]). The Court referred to the “desirability of simplicity and certainty”, stating that BORA and the Code are well understood and are applied routinely in practice in New Zealand (at [60]). The Court also said that to limit s 11 of BORA would give rise to an ethical dilemma for medical practitioners and may invite prisoners to become involved in “manipulative conduct” (at [61]).

### Intended to apply to the circumstances

The second step a Court must consider is whether the scope of the advance directive applies to the present circumstances, primarily to address situations of “changes in mind”. This is particularly relevant where there may have been a long time between the advance directive being made, or material changes in the person’s circumstances such as entering a new relationship or the recent death of a loved one.

Previous challenges to the validity of advance directives have been successful where interpreting the advance directive indicates remote, general, spontaneous or casual comments, compared with an analysis yielding detachment, consistency, and thoughtfulness of any statements or documents. Reliable witnesses that are available to attest to cogent and serious decision-making can support a valid advance directive, and similarly from an evidential perspective, having the directive in writing means it is much more likely to be effective.

#### Two UK case examples:

**HE v A Hospital NHS Trust [2003] EWHC 1017 (Fam)**

In this UK case, a young woman, raised a Muslim but who converted to Jehovah’s Witness, made an advance directive after her conversion (relating to the refusal of blood products in accordance with her religious beliefs), but some years later, promised to convert to Islam after getting engaged to a Muslim man.

In the meantime she was injured in an operation and became seriously ill and required a blood transfusion. Her father sought an urgent declaration that the advance directive was invalid while her mother sought a declaration it was deemed valid.

Munby J held that, on the evidence (and after the briefest of hearings given the urgency), the promise to convert to Islam was an “essential and ultimately compelling aspect” for
finding the advance directive was not intended to apply to the intended circumstances, and was therefore declared invalid.

*Kings College NHS Foundation Trust v C and V* [2015] EWCOP 59

This case concerned an advance directive by a person, Mrs C, refusing consent to renal dialysis treatment following her attempted suicide. Without the treatment it was almost inevitable that Mrs C would die. Balanced against this was the likelihood that if treated, Mrs C would live, but the with an appreciable and increasing possibility that Mrs C would require dialysis for the rest of her life. In this case the family supported Mrs C’s decision, in particular her elder daughters G and V. This stood in contrast with two psychiatrists who deemed she did not have capacity, and the independent expert engaged by the hospital trust and the family who determined she did have capacity.

The Court held that Mrs C did intend the directive to apply to these circumstances, and commented that while the decision reached by Mrs C was certainly what many in society would consider “unreasonable, illogical or even immoral”, the “the ongoing discomfort of treatment, the fear of chronic illness and the fear of lifelong treatment and lifelong disability are factors that also weighed heavily in the balance for [Mrs] C”.

**Free of the undue influence of others**

The third step for the court to consider is whether the decision was made free of the undue influence of others.

The test is a subjective one, and seeks to ascertain whether the decision made in an advance directive is the patient’s true choice. The subjectivity arises from two aspects: the person’s wishes and their relationship with the person who is influencing them. First, in terms of the patient’s own personality, in considering whether their own free will is being challenged by a stressful situation, pain, tiredness or the influence of medication. If these external factors are present, it may be that a person’s susceptibility to being influenced by others may be reduced from that which would ordinarily be the case than under ordinary circumstances. Second, the degree of the relationship with the influencing person is relevant, in terms of proportionality considerations. If a person enjoys a very close relationship with the person influencing them, the likelihood that they will be overborne is increased when compared with a persons with a less strong relationship.

**Validity**

The relevant civil standard is the balance of probabilities.\(^{18}\)

While the standard does not vary, the evidence it requires may be more or less extensive depending on the context and the nature of the allegation.\(^{19}\)

*Sandman v McKay* [2019] NZSC 41

---

\(^{18}\) *Hohipa v R* [2015] NZCA 73 at [71].

\(^{19}\) *Re H (Minors)* [1996] AC 563 per Lord Nicholls.
In the parallel context of preparing a will, the Supreme Court has recently confirmed that where there may be some doubt as to the capacity of a person making – in this case – a will, a lawyer:

“… should carefully document the advice given and the steps taken. In this regard, it would be prudent for a solicitor to suggest that a medical certificate be obtained. It would also be prudent to document the reasons for the provisions of the will and the process involved in taking instructions and in ensuring that the instructions had been correctly understood”.

In a practical sense, Dixon J focused on three relevant factors the Court should consider when determining whether it is reasonably satisfied that an issue has been proved to the standard: the seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding. These factors militate toward a requirement for the Court to ensure it scrutinises the evidence as closely as may be necessary to, in these circumstances, determine whether the directive is valid. Munby J (in *HE v A Hospital NHS Trust*) noted this is a requirement for “convincing and inherently reliable evidence”.

It follows that where an advance directive was made by a person who has capacity, intends it to apply to the circumstances, was made free from the undue influence of others, and it is evident on the facts that it is valid, binding and should be followed.

A UK example highlights the potential risks for failing to follow a valid advance directive.

Brenda Grant suffered a catastrophic stroke in October 2012 that left her unable to walk, talk or swallow. She had made an advance directive stating she should not be fed nor given treatment to prolong her life in the event she was no longer of sound mind. Unfortunately the advance directive was hidden in the middle of a thick pile of medical notes. Ms Grant was then artificially fed – against her wishes – for 22 months.

The George Eliot Hospital Trust was sued for failing to follow the advance directive. It settled out of court and paid the family £45,000. Other cases involving advance directives have tended to focus on the validity of a known advance directive, rather than for failing to follow one that was valid. Reportedly it is the first UK case involving a negligence claim against a hospital for failure to follow a valid advance directive.

---

20 *Briginshaw v Briginshaw* [1938] 60 CLR 336 (VSC) at 363.
4. ACP AND ITS INTERPLAY WITH “LIVING WILLS” AND ENDURING POWERS OF ATTORNEY

Living wills

As discussed above, “living wills” are effectively the same as advance directives. They are not like wills which are formally made under the Wills Act 2007 (or its forerunner the Wills Act 1837 (Imp)), and dispose of a person’s property once they die. For a living will containing an advance directive to be valid, it will need to meet the same requirements as discussed in part 3 above.

Enduring powers of attorney

An enduring power of attorney (an EPOA) is an instrument where a person (the donor) appoints an attorney to act on their behalf, in respect of their property or personal care and welfare matters if the donor loses capacity (or some cases under an EPOA for personal care and welfare, while the donor still has capacity). An EPOA is a creature of statute and is governed by the PPPR Act. There are strict requirements for executing an EPOA, including in their format, and also in executing them, including that the donor must be independently advised.

Relevant to the ACP context is the role of an attorney for personal care and welfare (under s 98 of the PPPR Act). Such an attorney may act on behalf of the donor in relation to personal care and welfare matters generally, or specifically, subject to the wording of the EPOA and the PPPR Act. Section 98A of the PPPR Act expressly states that in the exercise of the role of attorney:

…

(2) The paramount consideration of the attorney is the promotion and protection of the welfare and best interests of the donor, while seeking at all times to encourage the donor to develop and exercise his or her capacity to—

(a) understand the nature and foresee the consequences of decisions relating to his or her personal care and welfare; and

(b) communicate such decisions.

(3) Without limiting the generality of subsection (2), the attorney must—

(a) encourage the donor to act on his or her own behalf to the greatest extent possible; and

(b) seek to facilitate the integration of the donor into the community to the greatest extent possible.

This section makes it clear that an attorney is required to not only have regard to any advance directive the person has made, but also be an advocate for that person’s advance directive or an ACP that the person has.

Notably one of the most significant limitations in the PPPR Act on such an attorney is that they may not refuse consent to the administering to the donor of any standard medical treatment or procedure intended to save that person’s life or to prevent serious damage to that person’s health (ss 18 and 98(4)). However, in the event that the person’s ACP contains
an advance directive refusing consent to particular treatment, even where that treatment is lifesaving, the attorney should be an advocate for the donor. This accords with the requirements under art 12 of the CRPD, to ensure that the donor retains the ability to enjoy legal capacity on an equal basis as others in all aspects of life – including the legal capacity to plan their preferred treatment options in advance.

It is therefore important that clients ensure that they make their attorney under an EPOA aware of an ACP or any advance directive they may have.

What if you have concerns about a client’s capacity?

The Supreme Court’s comment in Sandman v Mackay reinforces the importance of documenting any concerns about capacity. Alison Douglass advises that where a lawyer has any doubt as to their client’s mental capacity to make a decision, they should refer the client to a health professional for assessment. In addition, her practical suggestions about a lawyer’s role are:

1. Look for “triggers” or warning signs that raise the issue of a client’s capacity or undue influence;
2. Making an initial, preliminary assessment of capacity by way of an interview with the client – identifying the relevant legal test and applying a functional approach to assessing a client’s abilities in the [Mental Capacity] Toolkit: understand, retain, use or weigh or communication;
3. If doubts arise, organising the referral for a formal clinical assessment of capacity, with client consent, if possible, in relation to the particular decision or action required; and
4. Making a final legal judgment about capacity for the particular decision or action required (for example initiating a legal proceeding) and acting on it.

It is suggested that helpful indicators of a client’s capacity can also come through casual conversation and interaction with the client – including trying to greet them at the door, asking about past and future events in their lives, discussing the potential impact of the decisions they are making, and seeking the views of, for example, the receptionist and other staff about their interactions with the client.

In the ACP context, this illustrates that ACP discussions should ideally involve a health practitioner – likely including that person’s GP or practice team.

Example of a living will drafted by a lawyer who did not have an understanding of the medical treatments his client would be offered.

Mrs S was a 57 year old with terminal lung cancer. She had a life expectancy of around six months. Several weeks before her current admission, she had visited her lawyer and drafted a living will. This stated that if she was in a situation where she had been on life support for more than three months, she requested an assessment by two independent physicians. If both deemed her condition to be non-recoverable, she asked that her life support be discontinued and she be supported to have a natural death.

---

On face value this seemed a reasonable directive and it appeared that Mrs S had made provisions for her future care. The challenge however, was that it had been drafted without medical oversight or an understanding of the treatment options that would be offered to Mrs S at this stage of her disease process. Her condition was palliative. Intensive Care and life support would not be treatment options offered in New Zealand. As such she would never be in a position where she was on life support for three months for her directive wishes to come into effect, ie her directive could not be applied in practice and did not provide direction or guidance for the situations she was likely to encounter.

Takeaway point: The creation of the living will should have included discussions with Mrs S’s oncology and/or palliative care teams to ensure it was an informed advanced directive. The health care team would have provided guidance on the clinical situations she may expect to encounter in the future and what anticipatory decisions would be relevant to guide future care.
5. WHERE TO DIRECT YOUR CLIENT FOR MORE INFORMATION ABOUT ACP?

Comprehensive information about ACP in New Zealand can be found on the ACP website: https://www.hqsc.govt.nz/our-programmes/advance-care-planning/about-acp/

The majority of District Health Boards across New Zealand have programmes in place to support ACP conversations and advance care plan creation in their communities. Most use the national ACP template to capture wishes – *My Advance Care Plan & Guide* (Appendix 1).

This document contains 7 sections:

- **Section 1**: My Advance Care Plan (person lead)
- **Section 2**: What matters to me (person lead)
- **Section 3**: Why I am making an Advance Care Plan (person lead)
- **Section 4**: How I make decisions (person lead)
- **Section 5**: When I am dying (person lead)
- **Section 6**: My treatment and care choices (completed with the support of registered health care professional)
- **Section 7**: After my death (person lead)

Hard copies of the *My Advance Care Plan & Guide* booklet can be ordered directly from the Health Quality and Safety Commission or downloaded from the HQSC ACP website.22

Approaches for sharing ACP information in New Zealand vary from district to district. Some systems rely on paper copies, others scan PDFs into the health record, while others have a fully integrated electronic approach, enabling advance care plan and advance directive wishes to be created and viewed across the health system (primary care, acute hospital, palliative care and hospice, age residential care and the ambulance service).

For information about processes in your district, please refer to the interactive map on the ACP pages on the HQSC website.23

**Quality oversight**

Several regions have instigated additional quality processes to support robust advance care plan and advance directive creation. The South Island, for example, has adopted a process where electronic advance care plans remain in draft on the electronic health record, until they have passed an administration and clinical review.

The administration review ensures the version on the electronic system matches the version the person (and their trusted health care professional) has signed. And that the advance care plan has been signed by the person (not on their behalf).

The clinical review ensures the content of any directive is clinically interpretable and does not contain contradictory information, for example a request to be not for resuscitation (NFR) in one section and to attempt resuscitation if it was thought the person might recover, in another. In such situations the advance care plan is returned for clarification.

**Opportunities for lawyers and legal professionals to incorporate ACP into their practice**

*Case Study:* A South Island law firm working in a small community, has taken an active approach to ACP.

They introduce the concept of ACP to all clients drafting an EPOA for personal care and welfare. Clients are provided with a hard copy of the *My Advance Care Plan & Guide* booklet and encouraged to consider completing an advance care plan in parallel with their EPOA (this includes sharing with their general practice team to lodge their plan on their electronic medical record, as per the local processes).

The same practice has introduced a policy of requesting an advance care plan be completed and electronically lodged for any clients who record the firm as their EPOA (care and welfare). Their rationale for this is twofold:

- The plan provides context and information to help guide the attorney’s decision making.
- It also reduces the volume of out of hours calls the firm receives from medical teams, as the key details of the person’s wishes and goals of care are available electronically 24/7.
6. APPENDIX 1: MY ADVANCE CARE PLAN & GUIDE
My Advance Care Plan & Guide

Plan the healthcare you want in the future and for the end of your life

Name:

Date:
The conversations you have with your whānau and loved ones in thinking about your advance care plan are important, even if you never write down an actual plan.

If you do complete an advance care plan, it needs to be shared with your healthcare team and anyone else you want to have access to it.

It is important your whānau and loved ones know you have a plan and where it is kept.

It is also important you review your plan on a regular basis – maybe every year around your birthday or some other significant date.

As I work through this plan, these are the questions I have and the things I need to know:

The white spaces throughout this booklet are for your choices.
This is my advance care plan and contains my choices. Please follow this plan if I am unable to tell you what I want.

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth:</td>
<td>NHI:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>Mobile:</td>
</tr>
</tbody>
</table>

Or attach patient label if you have one.
2 What matters to me

Here are some questions to help you work out what matters to you:

• What makes you happy?
• What brings you pleasure and joy?
• How do you like to spend your time?
• What are your hobbies and interests?
• Are there routines you really like? for example, how do you like to start or end your day?
• What makes each day meaningful?
• Who do you like spending time with?
• Do you have cultural, religious, spiritual rituals or beliefs?

Here are some other things that might be important or meaningful to you:

• being able to talk to and be close to people
• being aware of who and where you are
• being able to feel the love and concern of others
• being able to live a life that is meaningful
• being close to a pet
• being able to attend to your spirituality or religion
• being part of your culture
• being able to contribute to society
• being hugged or having your hand held
• being able to walk and/or move around by yourself.

This is what I want my whānau and loved ones and healthcare team to know about who I am and what matters to me:

________________________________________
________________________________________
________________________________________
________________________________________

My cultural, religious and spiritual values, rituals and beliefs:

________________________________________
________________________________________
________________________________________

To honour these beliefs I want my whānau, loved ones and healthcare team to:

________________________________________
________________________________________
________________________________________
2 What worries me

Are there things that worry you when you think of your future?

For example, do you worry about:

- how your health might affect your future plans
- how your health might affect your loved ones
- where you will be cared for
- how you will manage pain if it occurs
- being unable to communicate
- being a burden
- going into care
- dying alone
- how your whānau and loved ones will manage without you
- being stuck in bed
- your whānau or loved ones over-riding your wishes
- a clash between traditional and modern cultural ways
- finances?

This is what I want my whānau, loved ones and healthcare team to know about what worries me.

I worry about:

- **my loved ones because:**
  - 
  - 
  - 

- **suffering. To me this means:**
  - 
  - 

- **not being able to talk or communicate.**

- **not doing things such as:**
  - 
  - 

- **other things that worry me are:**
  - 
  - 

- **nothing worries me.**
Why I’m making an Advance Care Plan

This is why I am making my advance care plan:

- I am well.
- I am receiving care and treatment for the following:

Some things to think about:

- What illnesses have your whānau and family had, and could that happen to you?
- Does your health stop you doing some day-to-day activities?
- Do you have any health conditions you are getting care or treatment for?

To understand what impact your current and future health might have talk to your doctor or healthcare team.

You may need to discuss the following:

Could your illness change:

- how you live your life
- how independent you are
- what you need to plan for?

What might your illness mean for the people who may need to care for you?

I understand this may happen to my health in the future:

- I am well.
- I am receiving care and treatment for the following:

   - 
   - 
   - 
   - 

   - I understand this may happen to my health in the future:
3 Why I’m making an Advance Care Plan

Facing my future makes me think about:


Facing my future makes me feel:


If my time were limited my priorities would be:


4 How I make decisions

Think about the decisions you might need to make about your health.

Think about how you like to make decisions.

Do you need time? Do you like lots of information and options or do you prefer to let others decide?

Sometimes you might be faced with having to make a healthcare decision in a crisis (such as an accident or when you are really sick). This can be made easier for you if you have already thought about how you like to make decisions and who you want involved.

Who can make decisions on your behalf when you are unable to?

If you are too unwell to speak for yourself others will need to help make the decisions for you. Talk to them about what matters to you and what you want or don’t want to happen while you still can.

If you want a person to have the power to make decisions for you, consider appointing them as your enduring power of attorney for personal care and welfare (EPOA). This means they can be involved in most decisions about your care. This person will not make decisions for you unless you can no longer decide for yourself.

For more information, contact the Citizens Advice Bureau, a solicitor or the Public Trust.

These scales might help you think about how you like to make decisions and how you prefer your medical information is shared. Mark along the scale what you would want:

**I like to know...**

<table>
<thead>
<tr>
<th>only the basics</th>
<th>all the details about my condition and my treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
</tbody>
</table>

**As doctors treat me, I would like...**

<table>
<thead>
<tr>
<th>my doctors to do what they think best</th>
<th>to have a say in every decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
</tbody>
</table>

**If I had an illness that was going to shorten my life, I prefer to...**

<table>
<thead>
<tr>
<th>know my doctor’s best estimate for how long I have to live</th>
<th>not know how quickly it is likely to progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
</tbody>
</table>

**How involved do you want your loved ones to be?**

<table>
<thead>
<tr>
<th>I want them to do exactly as I have said, even if it makes them uncomfortable</th>
<th>I want them to do what brings them peace, even if it goes against what I have said</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○</td>
</tr>
</tbody>
</table>

**When it comes to sharing information...**

<table>
<thead>
<tr>
<th>I don’t want my loved ones to know anything about my health</th>
<th>I am comfortable with my loved ones knowing everything about my health</th>
</tr>
</thead>
</table>
4. If I am unable to make decisions

If you appoint an enduring power of attorney for personal care and welfare, include them in any discussions about your future care and treatment options.

Talk them through your advance care plan and give them a copy.

If you do not have an enduring power of attorney, it is a good idea to name someone to help your healthcare team make the best decisions for you.

Talk to this person about what is important to you and how you feel.

For both your enduring power of attorney for personal care and welfare or your nominated person choose someone who:

• knows you well
• cares about what is important to you
• helps you without taking over
• listens to you and is respectful
• will tell people about your wishes and try to make sure they happen.

When I am unable to make decisions, I would prefer them to be made like this:

- I want my enduring power of attorney for personal care and welfare to make decisions using the information in this advance care plan.
  My EPOA’s name is:
  Relationship to me: Phone:

- I don’t have an enduring power of attorney.
  Using the information in this advance care plan, the following person will help my healthcare team make the best decisions for me.
  Name:
  Relationship to me: Phone:

In addition, the following people know me well and understand what is important to me. I would like them included in discussions about my care and treatment.

Name:
Relationship to me: Phone:
Name:
Relationship to me: Phone:
Name:
Relationship to me: Phone:
Name:
Relationship to me: Phone:
5 When I am dying

When you are dying you will be made comfortable.

The dying process is different for everyone and will be affected by your age, general health or illnesses and can happen very quickly or it may take several days.

For example, you might need:
- pain-relieving medicines and treatments
- medication to ease breathing difficulties
- medication to manage nausea.

Consider what quality of life may mean to you at this stage of your life:
- being aware and thinking for yourself
- communicating with the people who are important to you
- something else?

What do you think will be important to you when you are dying:
- What would your ideal death look like?
- When you think about dying, what situations worry you?
- Who do you want with you as you die?
- When you are nearing death, what do you want or not want?
- What kind of spiritual care do you want at the end of your life?

As I am dying, my quality of life means:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

Other details I would like you to know:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

I understand that when I am dying my comfort and dignity will always be looked after.
This will include food and drink if I am able to have them.

In addition, I would like you to:

- Let the people who are important to me be with me.
- Take out things, like tubes, that don’t add to my comfort.
- Stop medications and treatments that don’t add to my comfort.
- Attend to my religious, cultural and/or spiritual needs, as I described in section 2.
5 When I am dying

Where would you like to spend your last few weeks or days?
  • What would be needed for this to happen?

Who should be contacted when you are dying?
  • Where do you keep their contact details?
  • Who knows to do this for you?

If your condition meant you couldn’t be cared for in your preferred place, where else might you like to be?

What things would be important?
For example, having my loved ones around, maintaining my privacy, etc.

The place I die is important to me:  ○ Yes  ○ No

When I am dying I would prefer to be cared for:
  ○ at home, which for me is:

................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................

  ○ in hospital
  ○ in a hospital level care facility (residential care)
  ○ in hospice
  ○ I don’t mind where I am cared for

Other details I would like you to know:

................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
................................................................................................................
6 My treatment and care choices

This section is best completed with help from a doctor, nurse or specialist.

There are medical procedures that keep you alive or delay death. These may include resuscitation (CPR), life support, getting food and drink through a tube, and kidney dialysis.

Sometimes treatments can be both helpful and harmful. They may keep you alive, but not conscious, or make you a bit better for a short time, but cause you pain.

You need to decide if this is what you want. Your healthcare team will only offer treatments that you will benefit from, this includes the offer of CPR.

Think about what is important to you.
For example, quality of life (how good your life is) or quantity of life (how long your life is)?
Are there circumstances in which you would want to stop being kept alive and be made comfortable so you can have a natural death?

If I am seriously ill and I am unable to make decisions for myself, the following best describes the care I would like to receive. I understand this does not require the healthcare team to provide treatments which will not be of benefit to me.

Seriously ill to me means:

Choose only ONE of these five options.

I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the healthcare team think are appropriate to my situation.

The exceptions to this would be:

If required and appropriate I would want CPR to be attempted:

- [ ] YES
- [ ] NO
- [ ] I will let my doctor decide at the time.

I would like my treatment to focus on quality of life. If my health deteriorated I would like to be assessed and given any tests and treatments that may help me to recover and regain my quality of life, but I DO NOT WANT TO BE RESUSCITATED. For me, quality of life is:

I would like to receive only those treatments which look after my comfort and dignity rather than treatments which try to prolong my life. I DO NOT WANT TO BE RESUSCITATED.

I cannot decide at this point. I would like the healthcare team caring for me to make decisions on my behalf at the time, taking into account what matters to me and in close consultation with the people I have listed in Section 4.

None of these represent my wishes. What I want is recorded in my Advance Directive on page 11.

I choose Option Number: [ ]
If you have treatment and care preferences for specific circumstances or you want an advance directive please write the details below.

An advance directive is a way of choosing beforehand specific treatments you would or would not want in different circumstances if you were no longer able to speak for yourself.

If you can't speak for yourself, it is the responsibility of your healthcare team to apply your advance care plan and any advance directive. When applying the advance directive, they must be confident that you:

1. fully understood what you were asking for,
2. were free from influence or duress from someone else, and
3. meant this to apply to the current situation.

<table>
<thead>
<tr>
<th>In the following circumstances:</th>
<th>I would like my care to focus on:</th>
<th>I would accept the following treatments:</th>
<th>I would wish to refuse or stop the following treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Severe stroke, unable to recognise anyone</td>
<td>Example: Allowing a natural death</td>
<td>Example: Comfort measures</td>
<td>Example: Artificial feeding</td>
</tr>
</tbody>
</table>

○ If I have left this section blank, I am happy with the choice I made on the previous page and have no other preferences.
Your health care team has a responsibility to follow your wishes. Signing this section is optional, but it helps show your healthcare team you fully understand what you are stating. The doctor leading your care will be more confident about using your plan if you sign and date it.

The healthcare professional who helped you complete your plan is also asked to sign it and provide their details.

Remember to share copies of your completed plan with your GP, nurse or specialist, your enduring power of attorney for personal care and welfare or your nominated spokesperson and important whānau and loved ones.

Your rights
Your rights as a patient are set out in the New Zealand Code of Consumer Rights.

- Under the Code advance directives and advance care plans do not need to be formal, written documents.
- They can include any treatments, not just life sustaining treatments.
- Your right to refuse treatment is set out in the New Zealand Bill of Rights Act (Section 11).
- If a healthcare provider violated this right, they would be guilty of a criminal offence.
- A person cannot demand a specific treatment or ask for anything that is illegal.

By signing below, I confirm:

- I understand this is a record of my preferences to guide my healthcare team in providing appropriate care for me when I am unable to speak for myself.
- I understand treatments that would not benefit me will not be provided even if I have specifically asked for them.
- I agree that this advance care plan can be in electronic format and will be made available to all healthcare providers caring for me.

Name
Address
Phone  Signature  Date

Healthcare professional who assisted me

By signing below the healthcare professional confirms that:

- I am competent at the time I created this advance care plan.
- We discussed my health and the care choices I might face.
- I have made my advance care plan with adequate information.
- I made the choices in my advance care plan voluntarily.

Healthcare Practitioner
Facility/organisation
Designation
Phone  Signature  Date
After my death

Have you considered organ and tissue donation?
Donated organs and tissues can help others to live and to have an improved quality of life. For further information go to: Organ Donation New Zealand: www.donor.co.nz

Have you considered leaving your body to medical science?
There are specific processes and forms that need to be completed. For further information contact the Auckland or Otago School of Medicine.

Do you have any body parts that need to be returned to you?

Immediately after death or in the time between death and your funeral, are there any rituals you would like performed?

Is it important where your body is kept?

For your funeral or farewell:
• Do you have preferences for your death announcement?
• Do you have any ideas or preferences for your funeral or farewell?
• Do you already have a prepaid funeral or life celebration plan. If so, with who?
• Are there songs you would like sung or things you wish people to know?

After I die I would like to be:  ○ Buried  ○ Cremated

For my funeral or tangi I would like:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

I would like my last resting place to be:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

This is important to me because:

________________________________________________________________________
________________________________________________________________________

○ I don’t mind. I would like the decision to be made by:
7 After my death

Final questions to think about.

Is there anything important you want your whānau and loved ones to know?

Are there any financial records or bank account details that need to be managed?

Have you thought about your social media or Facebook accounts and how these should be managed?

In the years after your death, are there ways you would like to be remembered?

Do you have any final words for your loved ones?

We recommend everyone has a will. If you have a will, who is it with? If you need advice on making a will go to the Citizens Advice Bureau, a solicitor or the Public Trust.

<table>
<thead>
<tr>
<th>Things I would like my loved ones to know:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

My will and other important things can be found:

<table>
<thead>
<tr>
<th>Document/item</th>
<th>Where it is</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>My will</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© ACP Cooperative 2016.
Kete woven and gifted to the New Zealand ACP Programme by Nga Kaitaki Kaumatau, Gerontology Nursing Service, Waitemata District Health Board.
Photography by Kara Manson.