

NEPHROLOGY SOCIAL WORK: *SURFING THE GREY TSUNAMI*



34TH ANNUAL CANSW CONFERENCE **TORONTO** SAVE THE DATE: OCTOBER 18 & 19, 2012

FEATURING (AMONG OTHERS):



DR. BARBARA LIU
SUNNYBROOK HEALTH AND SCIENCES CENTRE
GERIATRIC GIANTS
DEMENTIA, DELIRIUM, FALLS,
& POLYPHARMACY
(WHAT'S A RENAL SOCIAL
WORKER TO DO?)

KEYNOTE SPEAKER



DR. VANITA JASSAL
UNIVERSITY HEALTH NETWORK
DIALYZING THE ELDERLY:
TOO SOON? TOO LATE?
TO WHAT END?



GAIL ELLIOT, BSc, MA
GERONTOLOGIST & DEMENTIA SPECIALIST
MONTESSORI METHODS
FOR DEMENTIA:
THE RULES OF ENGAGEMENT



**34TH ANNUAL CANSW CONFERENCE
TORONTO - OCTOBER 18 & 19, 2012**

ACCOMMODATION DETAILS

TORONTO DELTA CHELSEA

RESERVATIONS:

EMAIL: RESERVATIONS@DELTACHELSEA.COM

MAIN LOCAL HOTEL NUMBER

PHONE: 416-595-1975

FAX: 416-585-4375

MAIN TOLL-FREE HOTEL NUMBER

PHONE: 1-800-CHELSEA (243-5732)

RATES:

REGULAR ROOM SINGLE	\$139
REGULAR ROOM DOUBLE	\$139
REGULAR ROOM TRIPLE	\$159
REGULAR ROOM QUAD	\$179
UPGRADE ROOM	\$210



CANSW Conference 2012 Call for Abstracts for Oral Presentations and Poster Presentations

We are inviting CANSW members to submit abstracts for presentation at the Annual Conference, which will be held in **Toronto, October 18 & 19, 2012.**

The conference theme this year is **“Nephrology Social Workers: Surfing the Grey Tsunami”**.

CANSW members have expressed the wish to feature the expertise within our CANSW membership. A small honorarium of \$100 is provided for all accepted oral presentations and \$25 is provided for original poster presentations.

Presentations may be in any area of nephrology social work and do not need to relate to the conference theme. Oral presentations should be limited to 30- 45 minutes. If you are interested in sharing with your peers, please submit the requested information to:

Lyle Stockwell MSW, RSW

Lakeridge Health - Kidney Care Clinic

1 Hospital Court

Oshawa, ON L1G 2B9

Tel. (905) 576-8711 x6913

Fax: (905) 433-2854

Email: lstockwell@lakeridgehealth.on.ca



ABSTRACT AND POSTER PRESENTATION

Please indicate what type of presentation you are submitting:

Oral Presentation in the area of _____

Oral Presentation in the area of patient case studies

Poster Presentation regarding _____.

Poster Presentation in the area of patient case studies.

Title:

Synopsis of the Presentation/Poster:

Handouts:

Equipment Required:

Presenter Name & Address:

The Editor



Lyle Stockwell MSW, RSW

Your feedback is welcome.

Contact me at:

**lstockwell@lakeridgehealth.on.ca
or (905) 576-8711 ext.6913**

CANSW VOICE

Table of Contents

2012 CANSW Conference	1
Message from the President	6
Meditation Study	7
Social Jerk	9
Modality Choice Issues	12
KFOC News & Views	13
Dialysis Nurse Convicted	15
Patient Resources to Share	18



The Kidney Car Program is a simple, quick and convenient way to dispose of your unwanted vehicle. You will receive a tax receipt for your car and we will tow it away for free.

Call 1-866-788-CARS (2277)

Message from the President



Angie Tuovinen BSW, RSW
President
CANSW/ACTSN

In thinking back to when I joined the world of Nephrology there have been so many changes. It appears that those days are gone when you came to work and complete the task at hand.

As Social Workers, it would seem that our days are more complicated with the demands of our caseloads, hospital restructuring, retirements of long term colleagues, and new ideas that continue to grow. The world of Kidney Disease marches on.

I would like to take the time to thank Nadine Valk and the Kidney Foundation of Canada for the continued partnership with CANSW. As we grow our membership, our caseloads grow, and the financial burdens grow, we will all need to work closely to resolve the larger societal issues.

The one thing that keeps me feeling good about the occupation of Social Work is the work that each member is doing within their own communities.

I continue to hear stories of people working on committees, ORN, steering committees, doing the Kidney March , volunteering with the KF on various events or on the National level.

Many of us have expressed a true social justice compassion.....poverty, equality, and justice for all.

I do feel blessed to work with you the village that is raising awareness. The relationships that are built through our memberships are very apparent when one of our own leaves us through death, employment change, or retirement.

Thank you to the membership for helping with my leadership. Together we can move mountains...

Angie Tuovinen

...Evidence builds that meditation strengthens the brain



Earlier evidence out of UCLA suggested that meditating for years thickens the brain (in a good way) and strengthens the connections between brain cells. Now a further report by UCLA researchers suggests yet another benefit.

Eileen Luders, an assistant professor at the UCLA Laboratory of Neuro Imaging, and colleagues, have found that long-term meditators have larger amounts of gyrification (“folding” of the cortex, which may allow the brain to process information faster) than people who do not meditate. Further, a direct correlation was found between the amount of gyrification and the number of meditation years, possibly providing further proof of the brain’s neuroplasticity, or ability to adapt to environmental changes.

The article appears in the online edition of the journal *Frontiers in Human Neuroscience*.

The cerebral cortex is the outermost layer of neural tissue. Among other functions, it plays a key role in memory, attention, thought and consciousness. Gyrification or cortical folding is the process by which the surface of the brain undergoes changes to create narrow furrows and folds called sulci and gyri. Their formation may promote and enhance neural processing. Presumably then, the more folding that occurs, the better the brain is at processing information, making decisions, forming memories and so forth.

“Rather than just comparing meditators and non-meditators, we wanted to see if there is a link between the amount of meditation practice and the extent of brain alteration,” said Luders. “That is, correlating the number of years of meditation with the degree of folding.”

Of the 49 recruited subjects, the researchers took MRI scans of 23 meditators and compared them to 16 control subjects matched for age, handedness and sex. (Ten participants dropped out.) The scans for the controls were obtained from an existing MRI database, while the meditators were recruited from various meditation venues. The meditators had practiced their craft on average for 20 years using a variety of meditation types — Samatha, Vipassana, Zen and more. The researchers applied a well-established and automated whole-brain approach to measure cortical gyrification at thousands of points across the surface of the brain.

They found pronounced group differences (heightened levels of gyrification in active meditation practitioners) across a wide swatch of the cortex, including the left precentral gyrus, the left and right anterior dorsal insula, the right fusiform gyrus and the right cuneus.

...continued next page

Continued from previous page...

Perhaps most interesting, though, was the positive correlation between the number of meditation years and the amount of insular gyrification.

“The insula has been suggested to function as a hub for autonomic, affective and cognitive integration,” said Luders. “Meditators are known to be masters in introspection and awareness as well as emotional control and self-regulation, so the findings make sense that the longer someone has meditated, the higher the degree of folding in the insula.”

While Luders cautions that genetic and other environmental factors could have contributed to the effects the researchers observed, still, “The positive correlation between gyrification and the number of practice years supports the idea that meditation enhances regional gyrification.”

Other authors of the study included Florian Kurth, Emeran A. Mayer, Arthur W. Toga, and Katherine L. Narr, all of UCLA, and Christian Gaser, University of Jena, Germany. Funding was provided by several organizations, including the National Institutes of Health. The authors report no conflict of interest.

The Laboratory of Neuro Imaging, which seeks to improve understanding of the brain in health and disease, is a leader in the development of advanced computational algorithms and scientific approaches for the comprehensive and quantitative mapping of brain structure and function. It is part of the UCLA Department of Neurology, which encompasses more than a dozen research, clinical and teaching programs. The department ranks in the top two among its peers nationwide in National Institutes of Health funding. For more information, see <http://www.neurology.ucla.edu/>.

From: ScienceBlog.com -see disclaimer below:

SITE DISCLAIMER: The opinions expressed by ScienceBlog.com bloggers and those providing comments are theirs alone, and do not reflect the opinions of ScienceBlog.com or any employee thereof. ScienceBlog.com is not responsible for the accuracy of any of the information supplied by site bloggers, commenters, or of the third-party press releases posted on this site. In other words **EVERYTHING ON THIS SITE IS LIABLE TO BE INACCURATE EITHER NOW OR AT SOME POINT IN THE FUTURE.** As you read the content on this site, keep in mind that science and medicine are moving targets. Advice you get here may cause blindness and stigmata, halitosis and loneliness. Generally, it should be ignored. If you're sick, talk to your doctor. Don't rely on what you find here for much of anything beyond entertainment.



You Gotta Fight for Your Right to Meticulously Plan

SocialJerk

Reprinted with permission from the author.

To subscribe, please visit www.socialjerk.wordpress.com

Because writing about social work can be funny, too! (Sorry Precious)

In social work, we're engaged in some pretty serious business. Assessing for safety and risk, helping people cope with crises, trying to tactfully explain why your parenting methods are a nightmare and therefore so are your kids. It doesn't seem like an atmosphere for fun. But we're also trying to help people preserve their families and hang on to their children. Sometimes a big part of this is learning to spend time with one another, and to enjoy it.

Therefore, party planning serves a therapeutic purpose. Despite the fact that it's started to drive me a little insane.

Planning a party is always stressful. Actually, coordinating any activity for more than four people is usually a pain in the ass. What time works for you? Oh, but that doesn't work for her. How about Wednesday? Oh no, she works late that day. Let's eat at this restaurant. But we need gluten-free options. Let's forget it and everyone stay home.

Here at Anonymous Agency, I enjoy throwing parties. It's fun. Families come and act like families. They eat together and meet people in similar situations to themselves. The kids can play and do arts and crafts. No one turns on a TV or video game for two hours, and the kids discover that this has not, in fact, killed them.

Of course, something always has to come up.

It's known that I enjoy the parties. Everyone else in the office is happy that we have the parties. As I mentioned, it's fun, and if their families come in, other staff members get to count that time spent making hand turkeys and snacking as a contact.

Notice that other staff members benefit from these festivities? Remember that. It will come up later.

I think it's pretty much standard in office culture that if you volunteer to do something once, you become the Person Who Does That Thing. "Oh, SJ, she's just so good at loading the printer paper." Huh? Three years ago, I offered to make an Easter party invitation. I snagged some free clip art, pasted it into a word document, wrote "You're Invited" along with the pertinent information. Now, whenever we have any kind of an event, this is my job. I am the one who knows how to do it. I'm the one who knows how to google and type.

Also print.

....continued next page

...continued from previous page

I've also found that, the more people that get involved, the worse things tend to go. Or maybe it's just that horrible people got involved in the past, I'm not sure. They got very persnickety about doing things their own way. Having the food that they wanted, budget be damned. It kind of got away from them that we were doing this for the kids. "I know you really want chicken, but we can only afford cookies and juice, and I'm pretty sure the eight year olds will be cool with that. Are you holding your breath until you get your way?"

So this Easter, a coworker and I met under cloak of darkness to make a pact to plan the party. We decided that we would dye eggs, make Easter baskets (to be filled with candy, which must be hidden from SJ until the last possible minute) and serve some simple refreshments. People were, of course, welcome to help run the party, especially since their clients would be participating, but that's what we would be doing. Nice and easy.

Nice? Rarely. Easy? Never!

First, I emailed New Director with our ideas for the party. When we would hold it, how many families would be invited, what activities we would have, and what our budget would be. Because New Director can never just say, "sure!" she approved our idea, but objected to calling it a "party." "Could we say something different? Perhaps an event, family affair, treasure hunt?"

'Event' is boring, 'Family Affair' is a 1960s sitcom, and treasure hunt makes no fucking sense because we aren't having one. I wrote "celebration" while cursing her under my breath, because I am amazing at compromise, and left it at that.

But, of course, it wasn't left at that.

My supervisor sent out an email asking that people come to me if they would like to help. We got zero responses. I have, however, had the following helpful tidbits leveled at me in the past two weeks:

"The party goes until six? But I only work until five."

Well, that is a pickle. I have no idea how to tackle that one. I mean, you could just work an extra hour and not be an asshole about it. You could even come in an hour late. Personally, I would lean towards not being an asshole, but whatever.

I can't remember the last time I left at five. Caseworkers be trippin.

....continued next page

...continued from previous page

“I don’t understand why we aren’t serving dinner.”

Did you miss that whole thing where we have no money? Like, none. I’m sitting her cutting up Easter baskets out of construction paper. People eat too much these days anyway. Fruit and crackers never killed anybody.

“Who is boiling the eggs and where will they be boiled?”

That was an email from New Director. The lady who runs the agency. Ma’am, I sincerely hope you have more important things to worry about. I also hope that you don’t think that your employees are so stupid as to not realize that we don’t have an oven here.

“What about Passover? Why is this only an Easter party? I don’t celebrate Easter, I’m Jewish!”

Well, I’m an atheist, but I’m not going to insist that the children all sit in a circle and listen to Tales of the Flying Spaghetti Monster. This isn’t about us. It’s an Easter party mostly because none of our clients are Jewish. But fine, you want to do something for Passover, go right ahead. Oh, you don’t want to do anything, you just wanted to bitch? Cool.

True story: this particular comment then led to the coworker telling me that she is personally offended by anti-Semitism (um, pretty sure we all are, because we’re not terrible people) and giving me a detailed explanation about the reasons that she is culturally, but not religiously, Jewish. I would have told her I didn’t care, but I think she would have felt that was anti-Semitic.

“Can the Easter egg baskets be bigger?”

No.

As the hours tick by until the party begins, I have a creeping feeling of dread in my stomach, along with a bunch of excitement. I mean, I love our Easter party. The kids (and the parents) get so excited about dying eggs, it’s amazing. It drives me a little crazy that such a great - event treasure hunt - celebration is tarnished with petty infighting, people being lazy, and coworkers being too quick to criticize. I also need to remember that I can be a little bit of a control freak, and I need to let it go. All of this stuff we do, which does include dressing up in bunny ears, is for the kids.

We just need to keep our eyes on the (delicious chocolatey) prize.

SocialJerk

Study shows differences between dialysis modality choice, initiation

NephrOnline

Powered by Nephrology News & Issues

www.nephronline.com/blogs

3/15/2012

Many patients start dialysis treatment with hemodialysis even though they initially had opted for peritoneal dialysis, according to a study posted online ahead of print in the *American Journal of Kidney Diseases*.

Scott E. Liebman, MD, MPH, and colleagues at the University of Rochester in New York studied 217 patients who received dialysis modality education between January 2004 and September 2009 and subsequently started dialysis.

At the time of education, 124 patients chose peritoneal dialysis, 41 chose hemodialysis, and 52 were undecided. Of the 124 patients who chose peritoneal dialysis at the time of education, 59 started dialysis therapy with peritoneal dialysis and 65 started on hemodialysis, the researchers reported online ahead of print in the *American Journal of Kidney Diseases*.

The outcome measure was hemodialysis use at initiation and day 91 of dialysis therapy in patients initially selecting peritoneal dialysis. On day 91, 60 patients were on peritoneal dialysis and 55 were on hemodialysis. Nine patients either died, undergone transplant, or not yet reached 91 days of dialysis therapy.

On multivariable analysis, nonglomerular cause of ESRD, age older than 75 years, and not being employed predicted starting with hemodialysis therapy, whereas age older than 75 years, nonwhite race, and nonglomerular cause of ESRD predicted hemodialysis use at day 91.



Nadine Valk
National Director,
Programs and Public Policy

Hi everyone. There are many things happening in Programs and Public Policy with The Kidney Foundation of Canada at the moment. Here are some of the highlights you may be interested in.

- **Transportation/The Joint Issues Working Group**
- **Updates to the Living With Kidney Disease Manual**
- **Poverty and the Financial Burden of Kidney Disease**

Transportation/The Joint Issues Working Group As most of you know, the KFOC & CANSW Joint Transportation Working Group formally requested a change to the Medical Expense Credit eligibility criteria (to include accumulated mileage) and was hoping to see this change reflected in the recent Federal budget. Unfortunately, we weren't successful this round but will re-group and continue working on this issue as well as others.

To that end, the group thought that it would make sense to broaden the mandate to include other issues of mutual interest (e.g. recommended wording change on the application form for CPP retirement, inter-provincial consistency for out-of-country reimbursement, benefits education/information package, etc.). We want this group to focus on action on the issues (and not just discussion of them) so this spring we will be developing a plan with priorities and process to help to move our shared agenda forward.

What you can do: we may need more members for this group given its expanded mandate. If you are interested in participating, please contact me or Angie Tuovinen to let one of know.

Updates to the Living With Kidney Disease Manual KFOC is planning to update the Living With Kidney Disease (LWKD) Manual this year. The manual hasn't been updated since 2006 and a 5th edition will help KFOC address current information gaps on conservative care and home hemodialysis. Promotional information about the Kidney Community Kitchen and volunteer opportunities with the Foundation will also be included.

What you can do: KFOC is in the process of developing a project plan, identifying subject areas for development and any changes that need to be made. We will be looking for reviewers once the revisions are ready so if you're interested in volunteering, please let me know. In the meantime, if there is anything that you would like us to consider or include in this update, feel free to be in touch and share your ideas.

...continued next page

Continued from previous page...

Poverty and the Financial Burden of Kidney Disease

The KFOC National Programs and Public Policy Committee met in February 2012 and part of their discussion included a review of potential public policies priorities for action. Many of the issues discussed are directly linked to poverty: costs of home dialysis, transportation, dental care, nutritional supplements and medication. It was agreed therefore that the public policy focus for the Committee would be poverty and the financial burden of kidney disease.

A background document will be developed and will include:

- A synthesis of available research and statistics on poverty and chronic disease/kidney disease and including:
 - WHO work on poverty and chronic disease
 - UN Summit on NCDs
 - Public Benefit background documents
 - Social Determinants of Health research
- Links between poverty and key issues and barriers facing people living with kidney disease
- Personal stories from across the country
- Potential action steps and public policy initiatives (National & Branch)
- Key messages

What you can do: This is something that I'll be working on over the summer and I would really appreciate receiving any information you can share that will help me to pull together the research in this area (e.g. local needs assessments, research articles on the link between poverty and chronic disease and/or kidney disease, etc.)

Many thanks to Lyle for offering this additional opportunity for KFOC to strengthen its connection with CANSW. If you have any questions or comments, please don't hesitate to contact me.

Nadine Valk

905-278-3003 x4913

1-800-387-4474 x4913

nadine.valk@kidney.ca

'I HOPE YOU BURN IN HELL'

Jury sentences Saenz to life in prison for killing patients with bleach

Posted: Monday, April 2, 2012 3:17 pm | Updated: 10:19 pm, Tue Apr 3, 2012.—By JESSICA COOLEY/The Lufkin News The Lufkin Daily News



Marisa Fernandez, right, reads an impact statement following the sentencing of convicted murderer Kimberly Saenz, left, at the Angelina County Courthouse Monday, April 2, 2012, in Lufkin. Fernandez's Grandmother Clara Strange died after Saenz injected her with bleach during dialysis treatment. Photos: JOEL ANDREWS/The Lufkin News

After being sentenced to life in prison without parole, Kimberly Saenz was addressed by family members of the DaVita Dialysis patients she killed by injecting them with bleach in April 2008.

“You are nothing more than a psychopathic serial killer,” said Wanda Hollingsworth, the daughter of murder victim Thelma Metcalf. “I hope you burn in hell.”

With her sentence read around 3:30 p.m., District Attorney Clyde Herrington informed Saenz she would be hearing from the families of her victims. She showed no emotion and at times looked down, scrawling on a legal pad as she was addressed by five more women who lost a loved one by her hand.

...continued next page

...continued from previous page

Marisa Fernandez broke down as she explained to Saenz how as a comfort she still keeps her grandmother's number in her cell phone, even though knowing she'll never answer again breaks her heart. She said she was raised by murder victim Clara Strange after her mother died when she was 7.

"When my mother died, she stepped in to raise us. Now that I have my own children I have no one to call and ask the questions that only a mother could answer," Fernandez said, sobbing. "When I go home tonight, at least, I will get to spend time with my children and you will not."



In the trial's sentencing phase, the subject of the two children Saenz will no longer see on a daily basis brought tears to her eyes. The mention of her son, who Saenz dropped out of high school to have prior to her senior year, left her sobbing. As her daughter's principal, Karen Shumaker, took the stand on her behalf, Saenz continuously wiped tears from her eyes with a tissue.

"She's a lot like her mother. She comes to school, holds her head up and has a circle of friends who will support her," Shumaker said. "It is my hope that she gets to have contact with her mom. For the development of a child, that is very important."

In the sentencing phase, jurors heard testimony from a series of character witnesses to help them determine if the 38-year-old Pollok woman should be sentenced to life in prison without parole or death by lethal injection. She leaned her head to one side, listening intently as criminal defense attorney consultant Frank Aubuchon outlined for the jury what prison life will be like for Saenz. Aubuchon, a 26-year Texas Department of Criminal Justice retiree, said she will become one of 28 women serving life in prison without parole. Defense attorney Steve Taylor said the only way Saenz is coming out of prison is in a box, as Aubuchon nodded in agreement.

...continued next page

As a highly supervised inmate on a maximum security unit, Saenz will share a cell with another woman serving at least 60 years. There are also restrictions on what type of prison job she can have, Aubuchon said, adding she can only work in the kitchen, laundry or industrial factory.

Before the defense brought out its character witnesses, the state called Lufkin Police Det. Stephen Abbott to the stand to go over documents about Saenz's past nursing history. Prior to working at DaVita, she was fired from Woodland Heights for stealing Demerol, a highly addictive narcotic painkiller, Abbott said. After being fired from DaVita, Saenz applied to work as a receptionist in a Lufkin medical office and lied on her job application. Herrington pointed out where Saenz said she had been employed at a non-medical business for seven years, leaving DaVita off her employment history.

Herrington also delved into her personal life, bringing out the details of an assault/family violence arrest from 2007 and a public intoxication charge she received the day her DaVita supervisor sent her home. Both arrests were a result of domestic disputes between she and her husband that played out at the home of his mother's boyfriend, Herrington said.

When asked if she had anything to say while being escorted out of the courthouse, Saenz said nothing, avoiding eye contact with any members of the media. Before the courthouse elevator doors closed, Saenz turned her back to the cameras, telling deputies, "I just want to get out of the camera's way."

She was then taken to the Angelina County Jail, where she will remain awaiting prison transport.

Her husband, Kevin Saenz, said there will be an appeal by her attorney, Ryan Deaton. He also said the family is planning to have a press conference soon.

Jessica Cooley's email address is jcooley@lufkindailynews.com.

.© 2012 The Lufkin Daily News. All rights reserved. This material may not be published, broadcast, rewritten or redistributed. Reprinted with permission from the author.

Patient Resources

Patient resources are included for your use if you wish.

Please retain the author/source citations on any copies that you distribute or adapt.

The CANSW Voice welcomes your submissions for any patient or social work resources you may wish to share.

Resources in this issue:

Kidney Disease and Advance Care Planning

Why is a Living Will So Important?

Advance Directives and Advance Care Planning

If illness, accident or dementia were to take away your ability to decide or communicate,

who will speak for you?

Kidney disease strikes people of any age, gender, race, and occupation. Dialysis offers you hope for maintaining a reasonable quality-of-life if you have reached end stage kidney failure. Dialysis does not fix the kidney disease, and once you need it, you will generally remain on dialysis for the rest of your life, unless transplanted.

Dialysis can allow you to feel well enough to continue with the activities you value, such as family, work, travel, hobbies, exercise and recreation.

Of course, other health problems cannot be fixed by dialysis either. Just like everyone else, people on dialysis may develop or already have any of the common problems that affect the whole population, such as, arthritis, diabetes, cardiovascular disease, cancer, pneumonia, dementia, serious accident, or “old age” .

At what point does the discomfort of illness, disability, and frequent treatment outweigh the quality-of-life benefits of dialysis?

The answer to this question is known only to you. Nobody else will know your wishes with any certainty unless you tell them. The healthcare team will always listen only to you about treatment decisions when you have the ability to make decisions and ability to communicate your wishes.

However if illness, accident or dementia takes away your ability to decide and communicate, who will speak for you about the life altering questions?

continuing dialysis?

pain control?

major surgery?

tube feeding?

resuscitation?

nursing home?

life support?

If you could not speak for yourself, you would likely prefer to ease any potential burden on your loved-ones. You can do this by discussing in advance your wishes and personal views about how you want future treatment decisions to be made.

Your renal team can help you gather the information you need to make decisions right for you, and guide you on ways to effectively communicate your wishes to family, caregivers and health professionals.

Why Is A Living Will So Important?

People of all ages and health conditions can benefit from completing a Living Will, also known generally as an Advance Directive, and Advance Care Planning.



A living will is a legal document that clearly and specifically communicates your wishes about your future health care and personal care decisions. It carries legal weight only during times when you cannot understand and appreciate treatment choices (or are mentally “incapable”). The living will is different from a *Power of Attorney for Property*, which authorizes someone to make decisions regarding your finances and property in similar situations. It also differs from a *Will*, which documents one’s wishes about finance and property at time of death.

In your living will, you can explain in simple terms, a) who you would like to make decisions on your behalf, and b) the nature of those decisions, if and when you are ever mentally incapable of making them.

The person who would make these decisions for you – your “proxy” – should be someone you know and trust, such as a spouse or partner, family member or close friend. You may name more than one person as your proxy.

Health care decisions relate to situations such as stroke, dementia, terminal illness and permanent coma, and choice of use of life-sustaining treatments such as cardiopulmonary resuscitation (CPR), ventilator, dialysis, life-saving surgery, blood transfusion, life-saving antibiotics and tube feeding. Personal care decisions relate to aspects of daily life necessary for maintaining your health and well being including shelter, nutrition, hygiene, clothing and safety.

By completing a living will you can gain control over your future health care and personal care decisions. You also relieve the burden on your loved ones of potential heart-wrenching guess-work, family conflict and guilty feelings.

For more information about how to complete your living will, please contact your social worker.

Advance Directives and Advance Care Planning

Making Your Voice Heard

“Respect for autonomy” is an important principle in health care. Autonomy is the right of each person to decide what will happen to their body. Health care providers respect your autonomy by asking for consent before starting treatment.

To give consent you must be capable (you must have decision-making capacity). You must be able to understand the information relevant to making a decision and to appreciate the reasonable and foreseeable consequences of a decision.

Unfortunately, a large number of people eventually lose their ability to make decisions. Such losses may be temporary or permanent. They may be caused by disease, injury or age-related deterioration. People who have lost decision-making capacity are described as incapable.

Many people want to retain some control over decisions even when they are incapable. They can do this by making decisions in advance — by completing an Advance Care Plan or Directive.

What is Advance Care Planning (ACP)?

Advance care planning is the process of planning your future medical care. It begins with a discussion of your values and goals, and ends with documentation of your wishes. Is it complicated?

No, but it may take a little time. There are seven steps.

1. Gather information about your health and health care options.
2. Reflect on your values, beliefs, wishes and health care goals.
3. Discuss your thoughts with your loved ones and your substitute decision-maker.
4. Reflect on any feedback.
5. Express your wishes in the format of your choice (oral, written, tape recording).
6. Inform your substitute decision-maker, family and doctor of your wishes.
7. Update your plan as your values or wishes change.

Advance Directives and Advance Care Planning continued...

What types of decisions are involved?

There are two types of decision to make. The first is “who do I want making decisions” if I become incapable. The second is “what directions do I want to give.”

Who do I want making decisions?

A substitute decision-maker is someone who makes decisions for you when you are not capable. In Ontario, you can appoint a specific person or persons to make decisions for you. An appointed person is called a Power of Attorney (POA). A POA is not necessarily a lawyer. As long as legal criteria are met, the POA can be anyone you trust.

Are there different types of POA?

In Ontario, there are two types. A **Power of Attorney for Property** is a legal document in which you give the power to make financial and other property decisions to an appointed person. This power will come into effect if you become incapable.

A **Power of Attorney for Personal Care** is a legal document in which you give the power to make health care and related decisions to an appointed person. This power will come into effect if you become incapable.

Do I need both types of POA?

Property and personal care are handled differently. Unless you and your POA hold property together (jointly), he or she will not automatically have access to your property. There is no hierarchy of substitute decision-makers for property.

If you do not appoint a POA for Personal Care health care providers can turn to the hierarchy of substitute decision makers.

Hierarchy of Substitute Decision Makers

When a patient is found not capable of making a specific decision, a substitute decision maker is asked to make decisions on that patient’s behalf. A substitute decision maker is a person authorized to give or refuse consent on behalf of a person who is incapable with respect to the decision.

Even without any written documents, everyone has a substitute decision-maker. The list of possible substitute decision-makers begins with:

Specially Appointed (S.A.)

- I. The incapable person's "Guardian of The Person", if any
- II. The incapable person's "Attorney for Personal Care", if any
- III. The incapable person's representative appointed by the Consent Capacity Board, if any.

Family

- IV. The incapable person's spouse or partner
- V. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent
- VI. A parent of the incapable person who has only a right of access
- VII. The incapable person's brother or sister
- VIII. Any other relative of the incapable person.

Last Resort

- IX. The Public Guardian and Trustee.