

**FAST FACTS AND CONCEPTS #12
MYTHS ABOUT ADVANCE DIRECTIVES
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Background Written advance directives (AD) are legal in every US state. Laws and forms, however, vary state to state. There are two general types of ADs: health care agent and living will. Although, many pre-made forms combine both the health care agent with 'living will' documentation.

- **Health care agent** ('power of attorney for health care,' 'health care proxy'): a document in which the patient appoints someone to make decisions about their medical care if they cannot make those decisions. This is legally binding.
- **Living will** ('health care directive'): a written document in which a patient's wishes regarding the administration of medical treatment are described if the patient becomes unable to communicate in the setting of a persistent vegetative state or terminal medical condition.
- **POLST** (POST, MOLST, MOST): while not an AD, it is a commonly encountered portable document of clinician medical orders, often limiting (but not necessarily so) certain unwanted treatments in patients near the end-of-life. Some have referred to POLST as an "actionable advance directive." See *Fast Fact #178* for more information.

Many clinicians believe it is not appropriate to begin AD planning on an outpatient basis. Multiple studies have shown that patients want their clinicians to discuss advance care planning with them *before* they become seriously ill. Many others have shown a positive response from patients when AD discussions are held during outpatient visits.

Overcoming this barrier: When beginning an AD discussion ask, "Do you know what an advance directive is? Do you have one?" If concerned that the patient may respond negatively, perhaps saying to you "Is there something wrong with me? Am I sicker than you are letting on?" respond by saying, "I ask all of my patients this question, sick or well: the best time to start thinking about this is before something serious occurs." Note, if you practice in a hospital that receives Medicare funding, the Patient Self Determination Act of 1991 mandates that every person be asked about ADs when seen (inpatient and outpatient).

Many people believe that having a financial power of attorney means a separate medical power of attorney is unneeded. False. Most often these are separate legal documents.

Overcoming this barrier: When discussing power of attorney for health care with your patient, assess his/her understanding. Have literature in your office to clear up discrepancies.

Many clinicians and patients feel that having an AD means "don't treat." Unfortunately, ADs can be a trigger for disengagement by medical staff. Conversely, some will think having an AD means they already have a do not resuscitate (DNR) order when in fact an AD is not sufficient to ensure DNR status.

Overcoming this barrier: Make sure your patient and staff understand that ADs don't mean "don't treat me." They mean, "treat me the way I want to be treated." For patients who want an outpatient DNR order, completion of a POLST (or your state's equivalent) or a state sanctioned DNR bracelet is indicated. It is important for clinicians to know their state guidelines regarding outpatient DNR orders.

Patients often fear that once they name a proxy in an AD, they lose control of their own health care decision-making.

Overcoming this barrier: When explaining ADs to your patients, make sure they understand that as long as they retain decision-making capacity, they retain control of their medical destiny. ADs only become active when a person cannot participate in their own medical decision-making.

Many people believe (hope) that having an AD will save their family from the burden of making difficult decisions about their health care.

Overcoming this myth: Surrogate decision makers often find their role troubling and even traumatizing, even when they have AD documents to guide them. Encourage patients, especially ones with serious medical illnesses, to discuss with their loved ones what they want and would not want. For example, 'when is enough is enough?' and to give permission to their loved ones to not prolong the dying process,

assuming that is compatible with the patient's wishes. As a clinician, you should be asking your patients with serious illness these questions as well, so you can be better equipped to advocate for an appropriate plan of care when the patient is dying.

Many clinicians and policy makers believe that widespread adoption of ADs in the population will improve health care costs and other outcomes.

Discussion: ADs have come under increased scrutiny due to decades of research showing limited benefits from programs aimed at getting large numbers of patients to complete them. Data do not show that widespread adoption of ADs improves health care outcomes, reduces unnecessary medical interventions at the end-of-life, or ensures that patients receive medical treatments at the end-of-life that they allegedly would want. Importantly, the value of clinicians talking with patients about prognosis and what to expect from their illness is not being questioned, it is the population-wide implementation of costly programs aimed at getting patients to complete ADs that is under scrutiny.

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