ADVANCE CARE PLANNING - ISSUES & TERMINOLOGY

Advance Care Planning

The process (rather than a single consultation or the signing of a statutory document) of discussing end-of-life care with the patient and developing a valid expression of the patient's wishes regarding future medical care. Advance care planning aims to improve the process of health care decision making and produce a better outcome of care.

Advance Directive

A person's oral and written instructions about his or her future medical care, in the event he or she becomes unable to communicate. There are two types of advance directives, instructional and designative. An instructional advance directive allows a person to write down their wishes or instructions regarding treatment when they are terminally ill or permanently unconscious. A Power of Attorney for Healthcare is a designative advance directive and allows a person to designate their agent or surrogate decision maker should they lose decision making capacity. Both are included in the California Hospital Association Advance Health Care Directive form.

A good advance directive describes the kind of treatment the patient would want if they were to become seriously ill and lost the ability to communicate their wishes. Advance directives usually tell the doctor that they don't want certain kinds of treatment. However, they can also say that the patient would wish to have aggressive life sustaining treatment no matter how ill they are.

Living Will

A type of instructional advance directive as defined above, which simply states that the patient does not wish to receive treatment that only prolongs the dying process if they are terminally ill.

Do Not Attempt Resuscitation Order

A do not attempt resuscitation (DNAR) order is another kind of advance directive. A DNAR is a request not to have cardiopulmonary resuscitation (CPR) if the heart stops or the patient stops breathing. (Unless a DNR order is in place, hospital staff will try to resuscitate all patients whose heart has stopped or who have stopped breathing.)

An advance directive form can be used to communicate this or a patient can tell their doctor that they don't want to be resuscitated. In this case, a DNAR order is put in the medical chart by the doctor. DNAR orders are accepted by doctors and hospitals in all states. A DNAR order does not impact any other treatment decisions, including admission to the ICU. Code status must be re-addressed with each hospitalization. Some patients may have pre-hospital DNAR orders, which should be honored.
**Witness Requirements**

*Two witnesses must witness the execution (signing) of the document or it may be notarized.* The witnesses must be satisfied that the patient knows what they are doing, and are doing it of their own free will. Possible witnesses may be a patient’s family or friends provided they are of legal age (have reached the age of majority in the state of execution), are legally competent, and, are unrelated to the patient, or, if related, are not named as the patient’s designated agent in the advance directive. At least one of the witnesses must not be related to the patient by blood, marriage or adoption or be entitled to any part of the estate upon their death. Employees or volunteers of a healthcare provider may not serve as witnesses.

**Who needs Advance Care Planning**

*Most advance directives are written by older people or by people who are seriously ill but, ideally, every adult should have one.* For example, a patient in the last stage of cancer might write an advance directive that says she doesn't want to be put on an artificial respirator if she stops breathing. By letting her doctor know ahead of time that she doesn't want a respirator, she may be able to reduce her suffering at the end of life and increase her control over her death. It may give her peace of mind to know that her doctor knows her wishes and that she won’t be put on a respirator if she stops breathing.

**How will Advance Care Planning effect treatment?**

*When a patient signs an advance directive, they may tell their doctor that they do not want any treatment that would only prolong their dying.* Life-sustaining treatment may be limited, or stopped completely, to be consistent with the patient’s wishes and goals of care. They will always receive treatment to keep them comfortable.

**What if the patient changes their mind?**

*A patient can change or cancel an Advance Directive at any time. This can be done in writing, or verbally.* The doctor in charge of their care should always record their wishes in the medical record. The patient’s wishes should always be re-confirmed with each hospitalization or significant change in their condition.

**Where can a patient get one?**

*A patient can be directed to the Outpatient Registration area or to the Admissions & Registration Office in the hospital.*

**What if a patient has a question?**

*Please refer patients with questions to the social worker for their hospital area.*

**Patient Self-Determination Act**

*Federal law requires that health care facilities receiving Medicaid and Medicare funds to inform patients of their right to execute advance directives.* Both federal and state laws govern the use of advance directives. All 50 states and the District of Columbia have laws recognizing the use of advance directives.