# Myths and Facts About Health Care Advance Directives

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**Terms to Know**

- **Advance Care Planning** – A process for setting goals and plans with respect to medical care and treatments. It requires conversations between the individual and his or her family, key health care providers, and anyone else who may be involved in decision-making. It can begin at any point in a person's life, regardless of his or her current health state and, ideally, is documented in an advance directive or recorded in your medical record, revisited periodically, and becomes more specific as your health status changes.
- **Health Care Advance Directive** – The general term for any document in which you provide instructions about your health care wishes or appoint someone to make medical treatment decisions for you when you are no longer able to make them for yourself. Living wills and durable powers of attorney for health care are both types of health care advance directives.
- **Living Will** – A type of advance directive in which you state your wishes about care and treatment you want or don't want if you are no longer able to speak for yourself. Normally, living wills address one's preferences about end-of-life medical treatments, but they can also communicate your wishes, values, or goals about any other aspect of your care and treatment.
- **Durable Power of Attorney for Health Care (or Health Care Proxy)** – A type of advance directive in which you appoint someone else to make all medical treatment decisions for you if you cannot make them for yourself. The person you name is called your agent, proxy, representative, or surrogate. You can also include instructions or guidelines for decision-making.
- **POLST/MOLST/POST** – "Physician Orders for Life-Sustaining Treatment" (also referred to by other terms, such as "Medical Orders for Life-Sustaining Treatment" or "Provider Orders for Scope of Treatment") A set of medical orders in standardized format that addresses key critical care decisions consistent with the patient's goals of care and results from a clinical process, designed to facilitate shared, informed medical decision making and communication between health care professionals and patients with advanced, progressive illness or frailty.

**Myth #1. You must have a living will to stop treatment near the end of life.**

- **False.** Treatment that is no longer helping can be stopped without a living will. Physicians will generally consult with your health care agent or close family when you cannot speak for yourself. The goal is to make the decision you would make if you had the capacity to speak for yourself. However, having an advance directive can make the right decision easier and help avoid family disputes.
    - The durable power of attorney for health care is the more useful and versatile advance directive, because it applies to all health care decisions and empowers the person you name to make decisions for you in the way you want them made.
    - Two-thirds of all adults have no living will or other advance directive.

**Myth # 2. You have to use your state's statutory form for your advance directive to be valid.**

- **False.** Most states do not require a particular form, but they do have witnessing requirements or other special signing formalities that should be followed.
    - Even if your state requires a specific form, doctors have a legal obligation to respect your clearly communicated treatment wishes in any manner or form expressed, as long as the wishes are medically appropriate.
    - Most official state forms are either worded too generally or include multiple choice options that may not adequately address the complex clinical circumstances you face in the future.
    - The critical task in advance care planning is to clarify your values, goals, and wishes that you want others to follow if they must make decisions for you, rather than trying to address every possible medical treatment. Workbooks such as *The Tool Kit for Health Care Advance Planning* can help you: www.ambar.org/agingtoolkit.

**Myth #3. Advance directives are legally binding, so doctors have to follow them.**

- **False.** Advance directives are legally *recognized* documents and doctors must respect your known wishes, but doctors can always refuse to comply with your wishes if they have an objection of conscience or consider your wishes medically inappropriate. Then, they have an obligation to help transfer you to another health care provider who will comply.
    - Advance directive laws give doctors and others immunity if they follow your valid advance directive. This is the "carrot" the law provides to them.
    - The only reliable strategy is to discuss your values and wishes with your health care providers ahead of time, to make sure they are clear about what you want, are willing to support your wishes, and they document your wishes.

**Myth #4. An advance directive means "Do not treat."**

- **False.** No one should ever presume it simply means "Do not treat." An advance directive can express *both* what you want and what you don't want.
    - Even if you do not want further curative treatment, you should always be given "palliative care" which is care and treatment to keep you pain free and comfortable by addressing your medical, emotional, social, and spiritual needs.

**Myth #5. If I name a health care proxy, I give up the right to make my own decisions.**

- **False.** Naming a health care agent proxy does *not* take away any of your authority. You always have the right, while you are still competent, to override the decision of your proxy or revoke the directive.
    - If you do not name a proxy or agent, the likelihood of needing a court-appointed guardian grows greater, especially if there is disagreement regarding your treatment among your family or between family and doctors.
    - Choosing a health care proxy is the most important decision you will make. It should be someone who knows you very well, with whom you have discussed your values, goals, and preferences, and who is capable of handling the decision-making responsibility as your spokesperson and advocate.

**Myth #6. I should wait until I am sure about what I want before signing an advance directive.**

- **False.** Most of us have some uncertainty or ambivalence about what we would want, and our goals of care change over time. A young adult may not be ready to contemplate end of life but that individual can think about and appoint a health care agent in case of serious accident or illness.
    - As one matures and faces new health conditions and family experiences, values, goals and priorities change and need to be communicated to your agent and family, and they may lead to a decision to name a new agent.
    - When one enters a stage of advanced illness, goals of care change again and as end of life approaches, greater specificity about what one wants or doesn't want becomes a greater focus of advance planning.

**Myth #7. Just talking to my doctor and family about what I want is not legally effective.**

- **False.** Meaningful discussion with your doctor and family is actually the most important step.
    - The question of what is "legally effective" is misleading, because even a legally effective document does not automatically carry out your wishes.
    - The best strategy is to combine talking and documenting. Use a good health decisions workbook or guide to help you clarify your wishes; talk with your physician, health care agent, and family about your wishes; put those wishes in writing in an advance directive; and make sure everyone has a copy.

**Myth #8. Once I give my doctor a signed copy of my directive, my task is done!**

- **False.** You have just started.
    - First, make sure your doctor understands and supports your wishes, and you understand your health state, likely futures, and options.
    - Second, there is no guarantee that your directive will follow you in your medical record, especially if you are transferred from one facility to another. You or your proxy should always double-check to be sure your providers are aware of your directive and have a copy.
    - Advance planning is an ongoing, evolving process. Review your wishes whenever any of the ***Five D's*** occur: (1) you reach a new **decade** in age; (2) you experience the **death** of a loved one; (3) you **divorce**; (4) you are given a **diagnosis** of a significant medical condition; (5) you suffer a **decline** in your medical condition or functioning.

**Myth #9. If I am living at home and my advance directive says I don't want to be resuscitated, EMS will not resuscitate me if I go into cardiac arrest.**

- **Usually False.** Your advance directive will usually not help in this situation. If someone dials 911, EMS must attempt to resuscitate you and transport you to a hospital, UNLESS you have an out-of-hospital Do-Not-Resuscitate (DNR) Order.
- A majority of states have now incorporated instructions about whether or not to attempt resuscitation in a special set of portable medical orders called POLST, MOLST, or similar name. See the definition at the beginning.
- In states with POLST programs, health care providers should initiate discussions of goals of care and care options with patients facing advanced, progressive illness or frailty.
    - They should then offer to translate those wishes into a set of medical orders (i.e., POLST) addressing key critical care decisions the patient is most likely to face, such as resuscitation, hospitalization, and artificial nutrition and hydration.

- Your health care providers are then obligated to make sure these portable orders travel with you across care setting and are regularly reviewed to ensure they conform to your wishes.

**Myth #10. Advance directives are only for old people.**

- **False**. It is true that more older, rather than younger, people use advance directives, but every adult needs one.
  - Younger adults actually have more at stake, because, if stricken by serious disease or accident, medical technology may keep them alive in a vegetative state for decades. Young adults should at least appoint a proxy decision-maker.

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# ABA Resources

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