

**FAST FACTS AND CONCEPTS #12
MYTHS ABOUT ADVANCE DIRECTIVES**

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Background Written advance directives are legal in every state; laws and forms, however, vary state to state. There are three general types of advance directives, although many pre-made forms combine both 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 his/her medical care if he/she cannot make those decisions.
- **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 serious or terminal medical condition.
- **POLST** – a portable document of physician/provider medical orders, often limiting (but not necessarily so) certain unwanted treatments in patients near the end-of-life. See *Fast Fact #178*.

The following are some common misunderstandings that create barriers to properly completing and implementing advance directives.

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

Overcoming this barrier: When beginning a discussion of advance directives simply ask, "Do you know what an advance directive is? Do you have one?" If you are afraid 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 your practice is in a hospital, the Patient Self Determination Act of 1991 mandates that every person be asked about advance directives when seen (inpatient and outpatient).

2. 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" with your patient, assess his/her understanding. Have literature in your office to clear up discrepancies.

3. Many physicians and patients feel that having an advance directive means "don't treat." Unfortunately advance directives can be a trigger for disengagement by medical staff. Conversely, some patients will think having an advance directive means they already have a 'do not resuscitate' order when in fact a living will alone is not sufficient to ensure DNR status.

Overcoming this barrier: Make sure your patient and staff understand that advance directives 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.

4. Patients often fear that once a person names a proxy in an advance directive they lose control of their own care.

Overcoming this barrier: When explaining advance directives to your patients make sure they understand that as long as they retain decision making capacity they retain

control of their medical destiny. Advance directives only become active when a person cannot speak for him or herself.

5. Many people believe that only old people need advance directives

Overcoming this barrier: The stakes may actually be higher for younger people if tragedy strikes. Use the example of the Terry Schiavo case as a trigger to enlighten the discussion. Ask – “What would you want if you were in her situation?”

6. Many people believe (hope) that having an advance directive will save their family from difficult decisions.

Overcoming this myth: Surrogate decision makers often find that role troubling and even traumatizing, even with advance directive documents. Encourage patients, especially ones with serious medical illnesses, to discuss with their loved ones what they want and would not want, e.g., ‘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 patient’s medical provider, you yourself should be asking your patients with serious/advanced medical conditions these questions as well, to be better equipped to advocate for an appropriate plan of care when the patient is dying.

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