

Death, Taxes, and Advance Directives

■ Few things in life are certain, but those that are inevitably demand attention. Seniors who haven't engaged in thoughtful advance care planning risk unnecessary suffering for themselves and their loved ones. CSAs can help them understand the planning process and the tools at their disposal. **BY JENNIFER BALLENTINE, M.A.**

Benjamin Franklin once quipped, "In this world, nothing can be said to be certain, except death and taxes." Although neither subject is pleasant to dwell on, responsible people prepare for both. With tax day gone for another year, it's a good time to turn our attention to the other inevitable event in our lives.

Many seniors have engaged in some form of advance care planning, thinking about which major medical treatments they consider acceptable in the event of a health-care crisis and which they do not want. Some seniors have also completed advance directives, which document these choices. They may have completed a living will; assigned medical power of attorney to a health-care agent; or executed a CPR directive, also known as an "out-of-hospital DNR," which is used to refuse cardiopulmonary resuscitation if the heart or lungs malfunction somewhere outside of a medical facility. However, advance care planning is a process, not just a form. It requires careful thought, courageous conversation, and repeated consideration as life events, personal circumstances, and health conditions change.

Helping clients understand the importance of ongoing advance care planning, weigh their advance directive options, and find support in navigating the maze of medical decisions

and legal forms are three important ways in which a Certified Senior Advisor (CSA)[®] can provide value to clients. (See the handout [Advance Care Planning: What You Need to Know](#) in this issue for a quick review of advance care planning options. This handout is designed for you to share with your clients.)

 For more information on advance directives, see "[Introductory Guide to Advance Directives](#)" in the Free Resources section of the SCSA website.

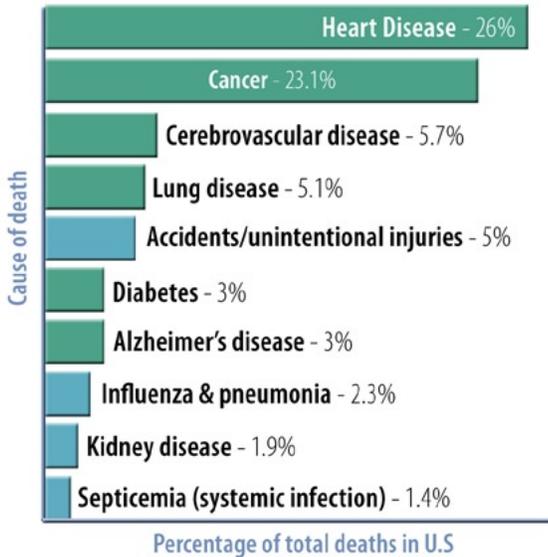
When treatments cause more harm than good

On the face of it, the idea of making medical treatment decisions long in advance of a medical crisis seems odd, especially when a person gives instructions to refuse life-sustaining treatments. Don't we all want to do everything possible to recover from illness or injury? The concept of advance care planning grew out of the recognition that some medical treatments extend biological life without offering a realistic hope of cure, or even functional recovery. For some people, just living longer is not the ultimate goal. They do not want to stay alive after they permanently lose consciousness, communication, or other basic abilities.

These days, the leading causes of death in America are chronic or progressive diseases (see *Leading Causes of Death in America* on page XX). One large-sample study found that 30 percent of seniors suffer from two

Leading Causes of Death in America

In 2006, chronic or progressive diseases caused more than half of all deaths in the United States. Here are the top 10 causes of death in America that year:



Source: Heron, M. 2010. "Deaths: Leading Causes for 2006." National Vital Statistics Reports, 58(14).

or more debilitating conditions at once (Fillenbaum et al., 2000). Our health-care system is, appropriately, set up to extend lives. Life-sustaining treatments such as artificial ventilation, cardiac support, artificial nutrition and hydration, and dialysis were originally developed as short-term, life-saving interventions. In the past three decades or so, they have become long-term maintenance measures that can deliver as much burden as benefit.

In the context of irreversible neurological injury, old age, extreme frailty, and advanced disease (or multiple diseases), these treatments may not contribute to recovery and may actually increase suffering. Nevertheless, in the absence of any instruction to the contrary, medical personnel will provide any treatments they deem necessary to preserve life. That's

the default. And our medical technologies, treatments, and professionals have gotten very good at extending life—so much so that it is actually quite difficult to die in America. There is always another treatment, another procedure, "something more we can try." One study estimates that 85 percent of deaths in America come about as a result of a decision to stop or not to start some treatment (Webb, 1997).

Just as the diseases are progressive, so are the treatments. Seniors and their families can easily get caught up in the momentum of a treatment regimen that slowly escalates over a number of years. They may never pause to consider which treatments they actually *want* to continue. They may be reluctant to question physicians' recommendations, or even be unaware that they can say "no." Thoughtful consideration of alternatives in the midst of a health-care crisis can be very difficult. That's why advance care planning conversations and documents are so important. They can guide seniors and their families through hard choices at an extremely stressful time, and they can alleviate anxiety, guilt, and conflict among family members.

Challenges in implementing living wills

The mental capacity, or competence, required for an individual to make medical decisions requires four cognitive capabilities: to understand information; evaluate the information, including pros, cons, and possible consequences of options and actions; make a choice or decision; and express that choice or decision (Beauchamp and Childress, 2001). Individuals who have all four of these capabilities are considered to have decision-making autonomy. Note that "capacity" is a clinical determination, whereas "competence" is a legal definition, but in this context the terms are interchangeable.

Determining decision-making capacity can be difficult, especially if the individual is ill. Capacity can be affected by the time of day,

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)

Fill in following these orders. If you contact physician, NP, or PA. These medical orders are based on the person's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section.

Last Name/ First/ Middle Initial _____
 Address _____
 City/ State/ Zip _____
 Date of Birth (mm/dd/yyyy) _____ Last 4 SSN _____ Gender M F

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
 Check One Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNR (Allow Natural Death)
 When not in cardiopulmonary arrest, follow orders in B, C and D

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
 Check One **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.*
 Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital if indicated. Avoid intensive care.*
 Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardiopulmonary resuscitation as indicated. *Transfer to hospital if indicated. Includes intensive care.*
 Additional Orders: _____

C ANTIBIOTICS
 Check One No antibiotics. Use other measures to relieve symptoms.
 Determine use or limitation of antibiotics when infection occurs.
 Use antibiotics if medically indicated.
 Additional Orders: _____

D ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.
 Check One No artificial nutrition by tube.
 Defined trial period of artificial nutrition by tube.
 Long-term artificial nutrition by tube.
 Additional Orders: _____

E REASON FOR ORDERS AND SIGNATURES
 My signature below indicates to the best of my knowledge that these orders are consistent with the person's current medical condition and preferences as indicated by discussion with:
 Patient Health Care Representative Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See reverse side.)
 Parent of Minor Court-Appointed Guardian
 Other _____

Print Primary Care Professional Name _____ Office Use Only _____
 Print Signing Physician / NP / PA Name and Phone Number () _____
 Physician / NP / PA Signature (mandatory) _____ Date _____

ORIGINAL TO ACCOMPANY PERSON IF TRANSFERRED OR DISCHARGED, SUBMIT COPY TO REGISTRY

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medications, and mental or physical disease processes. It is also important to remember that capacity is decision-specific. A person may be completely capable of deciding what she wants for dinner but not at all able to manage her financial affairs or consent to major surgery.

As a progressive illness moves a person toward death, that person eventually loses mental capacity and decision-making autonomy. For some, this happens only hours before death, but many people experience wavering or declining capacity over a period of weeks, months, or even years. Advance care planning enables an individual's rights of autonomy to survive her incapacity. Advance directives document choices and instructions to ensure that the individual's wishes are known after she can no longer express them. Legally, those choices and instructions are just as valid when she is unconscious as they were on the day she made them.

However, the effectiveness of advance directives—living wills, in particular—has been called into question recently. Although they have been in use for more than 40 years, and health-care facilities receiving Medicare or Medicaid funds have been required since 1990 to inform patients about their advance directive options (Ulrich, 1999), only about 25 percent of all Americans—and only one in three who are chronically ill—have any sort of advance directive.

Shortcomings in living wills themselves can also reduce their effectiveness. All states except Massachusetts and Michigan offer a living will form, but the state-authorized forms vary. In most states, living wills refuse life-sustaining treatment only when a person has a terminal condition and cannot make or express her own decisions. Some states have added “persistent vegetative state” (the condition Terri Schiavo was in) as a qualifying condition, but the circumstances in which living wills become effective are very constrained. In some states, individuals can add specific instructions

»POLST and Similar Programs, by State

- **POLST** — Physician's Orders for Life-Sustaining Treatment — California, Hawaii, Oregon, Pennsylvania, Washington, and the region around LaCrosse, Wisconsin.
- **MOLST** — Medical Orders for Life-Sustaining Treatment — New York
- **MOST** — Medical Orders for Scope of Treatment — Colorado and North Carolina
- **POST** — Physician's Orders for Scope of Treatment — Idaho, West Virginia, and Idaho

For complete program descriptions, sample forms, and detailed information, see www.polst.org.

Documents for Clarifying Treatment Choices

	Physician’s Orders for Life-Sustaining Treatment (POLST)	Living Will	CPR Directive (also known as out-of-hospital DNR)
Who should use this form?	Seriously ill or elderly adults	Any adult	Seriously ill or elderly adults
What does the document do?	Presents a summary of specific choices about key treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration.	Refuses treatment when terminally ill patient is mentally incapacitated or permanently unconscious. Can include other open-ended instructions that may or may not be relevant.	Addresses only CPR.
When should it be completed?	Contemporaneous with current medical condition and wishes.	May be completed many years ahead of need.	Contemporaneous with current medical condition and wishes.
Is it transportable?	Stays with the patient through transitions between health-care settings; honored by any health-care provider.	Needs to be retrieved from personal files or medical chart.	Must be completed anew in each facility or setting.
What is the form’s legal status?	Medical orders	Patient preferences	Patient directive

to their living wills, but such instructions are often unhelpful—either too vague (“no heroics”) or inappropriately specific (“don’t put me in an iron lung”). In some circumstances, a living will may turn out to be irrelevant to the medical needs that arise; for instance, an instruction to remove life support won’t help guide treatment for a massive stroke. In addition, an individual’s circumstances and personal viewpoints may evolve between the drafting of her living will and the medical crisis in which she’s incapacitated so that choices

outlined in the living will are no longer in line with her goals and wishes (Bravo et al., 2003; Fagerlin and Schneider, 2004; Knauff et al., 2005; Perkins, 2007; Vig et al., 2006).

Moreover, medical providers may be unaware of a patient’s living will, and even when they receive clear treatment instructions through a living will, they may not be legally required to follow them. Although specific provisions vary from state to state, living wills and other advance directives are generally not legally binding. State statutes usually protect

medical professionals from prosecution or civil suit if they follow a living will's instructions and the patient or family members don't like the outcome, but most offer little or no sanction if medical professionals fail to follow a living will's instructions. That said, some states' statutes do carry penalties for forging, defacing, destroying, or concealing a living will, and health-care providers may be professionally sanctioned for ignoring a patient's instructions. As well, one or two "wrongful life" suits have been brought against emergency responders for performing resuscitation in spite of clear and valid CPR directives.

Advance directives carry a great deal of moral weight, and medical professionals are ethically obligated to respect a patient's autonomy. Still, health-care providers are also obliged to take into account other ethical principles: doing the most good they can for patients, doing no harm, maintaining fairness among the parties involved, and using resources wisely. They may refuse to provide treatments they believe will be ineffective or harmful, and they may balk at withdrawing or withholding treatments they believe will be beneficial. If they feel strongly about the potential benefit (however defined) of a course of treatment, they may try to change the mind of the patient, or of the person making health-care decisions for the patient, if the patient has assigned medical power of attorney. Ultimately, if the patient or his health-care agent is unpersuaded, the medical professional may feel her only option is to transfer the patient to another provider who won't feel ethically compromised following his wishes.

Consider, for example, the case of a patient named Lasondra. She had a cardiac defibrillator implanted about 15 years ago, after experiencing a life-threatening heart arrhythmia. Over 15 years, the device has fired only one time, saving Lasondra from sudden cardiac death. She describes that experience as like "being kicked in the chest by a horse with

»What to Do in the Face of Conflict

When a patient's mental capacity is questionable, the patient, his family, and his health-care providers may disagree about treatment decisions. For example, if an elderly patient is dependent on a ventilator following a massive cerebral hemorrhage, his physicians may suggest withdrawing life-sustaining treatments, whereas his family insists that treatment continue. Or a patient suffering from successive systemic infections and whose arms and legs have been amputated might refuse another round of powerful antibiotics even if physicians believe she might "pull through." (See also [Case Study: When a Client's Family Faces the Toughest Choice](#) in this issue.)

Perhaps the most infamous case of conflict over life-sustaining treatments is the story of Terri Schiavo, which dramatically played out on national television some years ago. Although the emotional vortex of the story was whether removing her feeding tube constituted "murder" or "allowing natural death," the legal question focused on who had the right to make her health-care decisions. Schiavo had not assigned medical power of attorney or provided instructions about whether she would want to be kept alive if she became cognitively incapacitated. The result was a protracted legal battle between her husband and her parents.

Conflicts over medical treatment usually occur when families fail to have advance care planning conversations and individuals have no advance directives. In the absence of clear instructions from the patient, health-care providers must be guided by the patient's "best interests" (Cantor, 1987). But this standard is wide open to interpretation and dispute. Families have several options for resolving this type of conflict:

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a studded shoe.” Lasondra now has pancreatic cancer and is expected to live only a few more months. She has enrolled in hospice for expert pain management and comfort care, rather than undergoing surgery or chemotherapy. But she is concerned that when she comes to the end of her life and her body is ready to die, the defibrillator will fire, painfully shocking her and preventing her natural death. Lasondra asks her cardiologist to deactivate the defibrillator, which can be done externally by a technician with a special device. The cardiologist, however, believes that deactivation would be tantamount to physician-assisted suicide. He refuses to order the deactivation, and when Lasondra insists, he refers her to another physician who is willing to order deactivation. Lasondra dies peacefully at home six weeks later.

In contrast, individuals appointed as health-care agents by medical power of attorney have both a legal and a moral responsibility to carry out the patient’s instructions as best they can, setting aside any personal disagreements or discomfort they may have with the instructions. A health-care agent is obliged to act, always, as if he were the patient, making the decisions and choices that the patient would make. This is especially true when the patient has completed a living will. In most states, a health-care agent cannot revoke or override a living will that the patient previously completed, unless the patient explicitly gave the health-care agent that authority in the living will or in the medical power-of-attorney document.

If an incapacitated patient has not completed a living will, nor provided any instructions for her health-care agent, and if the health-care agent is not sure what choice the patient would make, the agent is obliged to make decisions according to the patient’s “best interests.” If anyone else involved with the patient’s case feels that the health-care agent is not acting responsibly on the patient’s behalf—

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- **The family meeting.** Health-care providers, family members, and other “interested persons” meet to talk through the options and come to agreement, if possible.
- **Ethics consultation.** Most hospitals have an ethics committee or ethics advisor available for consultation on conflicts involving treatment choices, communication problems between patient and provider, and advance directive disputes. Ethics committees and advisors usually make recommendations, rather than decisions, but they can be very helpful in ensuring that all voices and viewpoints are heard.
- **Elder mediation.** Professional mediators do not have the authority to make legally binding decisions, but their experience and training can help them guide families in conflict to an acceptable resolution.
- **Lawsuit.** If a conflict is completely intractable—or if it involves complex legal issues, removal of a substitute medical decision-maker, or appointment of a legal guardian—legal action may be the only option.

When conflicts arise, it could be appropriate for a CSA to take a seat at the table and assist in resolving disputes. In this role, the CSA might provide information within his area of qualified expertise, as it is relevant to the situation. An accountant could comment on the financial implications of certain decisions; an attorney could provide guidance on legal issues; a care manager might help put the crisis or conflict into context from a medical perspective; a religious advisor might discuss the spiritual, existential, or doctrinal dimension, and so on.

When patients can’t speak for themselves, and family members forcefully disagree with documented instructions or with one another,

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substituting his own preferences for treatment, for instance—the matter can be taken to court and the individual removed from his position as health-care agent.

A new approach to advance care planning

Because of concerns over living wills, an alternative approach to advance care planning has been gaining steam across the country: the Physician's Orders for Life-Sustaining Treatment (POLST). This is a standardized form that summarizes choices about CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration (see Exhibit 1 on page XX). The choices range from “Yes/full treatment” to “No/comfort measures only,” with intermediate options of limited interventions or guidelines limiting treatment to a specific time frame or goal. For instance, a person could specify that artificial nutrition and hydration can continue for a certain number of months, after which the treatment should be discontinued if recovery is not likely. Other treatments (dialysis, blood transfusions, etc.) can be addressed in annotations on the form. The POLST and its variants are now in use in 12 states and in development in 23 states (see *POLST and Similar Programs, by State*, on page XX).

The POLST is intended for people who are already seriously ill or elderly and frail, including those residing in a nursing facility. These individuals need a way to quickly communicate key treatment choices during transitions, for instance, from the nursing facility to the emergency room to a hospital stay and back to the nursing facility. The POLST is not a new form of advance directive. It does not replace a patient's living will, nor does it assign medical power of attorney (although a health-care agent may complete a POLST on behalf of the patient). It is a summary of a subset of treatment decisions which, when signed by a medical

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health-care providers may be prone to give in to the preferences of the family members. In such situations, the patient needs a strong representative, and it may be appropriate for a CSA to take on the role of an “interested person.”

professional—a physician or, in some states, an advanced practice nurse or physician's assistant—become a set of medical orders that will be honored by any health-care provider in any health-care setting.

An individual should complete a POLST in concert with a health-care provider who can fully explain the implications of the choices vis-à-vis the person's current medical condition. If the individual has other advance directives, the provider should ensure that they are brought up to date and that they are consistent with the choices documented on the POLST. (In cases of conflicting statements between prior advance directives and the POLST, the most recently executed document is typically considered to be authoritative.)

The POLST should be updated at regular intervals—as often as quarterly for residents of nursing facilities—and every time the individual experiences a major change in health status. For instance, when a patient who has a POLST and lives in a nursing facility is hospitalized, the POLST travels with him to the hospital, then returns with him when he is discharged back to the nursing facility. This ensures clear communication of his treatment choices from setting to setting. Of course, the patient and his providers must take responsibility for ensuring that the form stays with him. In states with a POLST paradigm, medical protocols are written to ensure transfer of the form. Some states have also established electronic registries of POLST forms for easy access by health-care providers.

Research has demonstrated that a POLST is much more effective than a living will in guiding care, accurately communicating relevant choices, and reducing unwanted treatments (Hickman et al., 2004; Hickman et al., 2009; Myers et al., 2004; and Schmidt et al., 2004). In part, its superior effectiveness is due to the POLST being a medical order set, rather than a statement of patient preferences. Also, the POLST tends to be more simple, clear, and current—up-to-date with the patient’s wishes and conditions—than other advance directives.

To find out whether your state has a POLST paradigm, and to find resources and specific operational details related to each state’s program, visit the [POLST paradigm website](#). If your state has a POLST program, you can recommend it to appropriate clients. However, remember that completion of the form requires the assistance of a health-care provider.

Medical power of attorney: The best option?

The best way a person can prepare for incapacity is to appoint a health-care agent who understands his wishes and will make the same decisions he would have made. This appointment is made by completing a medical durable power of attorney. Even when living wills and related documents are duly executed, family members may have difficulty agreeing to follow the instructions as written, so it’s helpful to have one person in place as “the decider.”

Consider the case of Joe, who suffers from a chronic illness. His in-town daughter, Kim, has looked after her ailing father for years. She is very familiar with the burdens of his illness and with his desire to not receive aggressive treatment. Then a crisis occurs, and her brother, Jim, flies in from out of town. He is shocked at his father’s condition and insists that the doctors do everything possible to save him. If Joe hasn’t officially appointed either child

»Questions to Jumpstart the Advance Care Planning Conversation

- Tell me about your illness: What is it? How is it affecting you?
- Can the illness be managed effectively? Is it likely to get worse?
- If your disease will get worse, has your doctor discussed what the “end stage” of the disease might be like? What concerns you the most when you think about reaching that stage of your disease? (Answers will likely focus on pain, physical or mental incapacity, unfinished financial or emotional business, and burdens placed on family members.)
- What treatments are you receiving now? Are they effective? What’s good about them (benefits)? What’s bad about them (burdens)?
- What is your goal for treatment? Are the treatments you’re receiving achieving that goal? (Note: The patient’s goal might be different from the medical aim of the treatment. The aim may be reducing inflammation in the lungs to assist breathing, but the patient’s goal may be to become strong enough to look after her grandchildren.)
- Are there circumstances in which you would prefer to stop certain treatments? Which treatments? What circumstances?
- Have you thought about who should speak to your doctors and make decisions when you can’t?

For more information on starting this type of conversation, refer to the Caring Conversations® booklet from the [Center for Practical Bioethics](#) and the book *Hard Choices for Loving People* (Dunn, 2009). In addition, the book *Choices at the End of Life: Finding Out What Your Parents*

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as his health-care agent, the situation may become messy very quickly. Even if Joe has documented his wishes, Jim may question the intention, meaning, or relevance of certain

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 For more information on medical power of attorney, see “Power of Attorney Basics” in the Free Resources section of the SCSA website.

instructions. He may doubt Joe’s capacity at the time the instructions were written. Or he may notice and dwell on conflicting statements between different advance directive documents. If Joe had appointed Kim

as his health-care agent, and included his instructions and preferences in the medical power of attorney document, Kim would have the authority to make decisions over Jim’s objections. Kim would still have to address—and hopefully resolve—Jim’s concerns, but she would have the authority to honor her father’s wishes. (See the sidebar *What To Do in the Face of Conflict*, on page XX, for more on resolving family disputes.)

Encouraging clients to assign medical power of attorney to someone they trust may be among a CSA’s most valuable contributions to their well-being. Empowering a health-care agent is better than writing the most detailed set of medical instructions, because no document can anticipate every possible medical contingency. And although many lawyers prepare medical power-of-attorney documents during the estate planning process, completing these forms does not require specialized legal knowledge or the services of a lawyer. Forms specific to each state can be accessed and downloaded from the Caring Connections website (www.caringinfo.org). This site has lots of valuable information and resources for people who are unfamiliar with advance care planning but want to assist others in the process.

A CSA, whether an estate planning attorney or not, can help clients think through whom to designate as their health-care agent. Family members are often chosen for the job, but they sometimes have trouble setting aside

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Want Before It’s Too Late (Norlander & McSteen, 2001) contains helpful information for CSAs even though it is geared toward helping adult children talk to their parents about these issues.



their own preferences. For example, an adult child may have difficulty bringing herself to remove her father from life support, even if she knows that’s what he would want. Also, because spouses are often near to each other in age, a husband appointed as health-care agent for his wife may be struggling with his own health problems or incapacity. To be effective, the health-care agent must be *informed* of the person’s wishes, goals, and preferences. She must be *available*, preferably living in the same city. She must be *willing to serve* in what can be a long and demanding job. And she must be *able to go toe-to-toe* with health-care professionals as a firm advocate for the patient.

In many states, qualified professionals can serve as health-care agents for their clients and receive payment for their services. For clients without a willing and available family member, this can be a great benefit. However, before agreeing to serve as health-care agent for a client who has capable family members, CSAs should make sure the family members are on board, then consult them scrupulously when

»Now, You Can Earn 5 CSA CE Credits

To continue exploring the CSA's role in clients' advance planning processes, turn to this issue's [Case Study: When a Client's Family Faces the Toughest Choice](#). When you have read this article and the case study, you have the option to earn 5 CSA CE credits by completing a set of online discussion questions and passing an online multiple-choice quiz. [Click here](#).

making major decisions down the road.

CSAs who are qualified professionals with training or experience in care management, social work, or health care are best suited to this role; those whose services focus on finances, property, or general legal arrangements are less suited to the role because of the potential for conflicts of interest. The concern, of course, is that receiving payment for medical decision-making might inappropriately influence the decisions being made—for instance, deciding to continue life-sustaining treatment for a client in order to continue receiving the payment. Any professional serving as the health-care agent for a client must be extremely conscientious in following the wishes of the client. Therefore, the professional should also be extremely conscientious to ensure that the client documents his wishes as completely as possible prior to losing capacity. The professional and client should also work out specific arrangements for payment—how much, how often, by whom—in detail in advance as well.

How to start the conversation

To help clients ensure they're prepared for a health-care crisis, CSAs may need to nudge them to start thinking, and talking, about these difficult issues. Choices about life-sustaining treatment are highly individual,

based on personal values, religious or spiritual commitments, cultural and ethnic characteristics, goals and dreams, past experiences, medical condition and prognosis, family responsibilities, and a host of other factors. By starting the conversation, you may provide the opening a client needs to broach the subject with family, friends, medical professionals, and others.

If you have a client who is currently receiving treatment for a chronic or potentially life-limiting disease, and she is open to your assistance, you can ask questions to help her identify her choices (see the sidebar *Questions to Jumpstart the Advance Care Planning Process* on page XX). It's important to remember that your role in this discussion is not to offer or question medical advice. Your role is to help your client identify what she knows, what she wants, what she fears, and what she needs more information to understand. By identifying questions she wants to ask at her next medical visit, you can help equip your client to have a substantive advance care planning conversation with her doctor. It may also be appropriate to help facilitate a conversation between your client and her family members. Open, honest, and in-depth discussions now can head off serious conflicts or uninformed decision-making down the road.

The advances of medical knowledge and practice over the past century have extended and improved our lives in startling ways. The dark side of medical marvels is that treatments intended to prolong life sometimes serve only to prolong dying. Almost everyone faces harsh choices at some point in their lives. The complexity and emotional tension in these situations can be eased only when family members and medical professionals know the patient's preferences, values, and goals, and are committed to honoring them. Advance care planning conversations can provide that knowledge, especially when choices are documented in forms that are readily available,

shared with family members and health-care providers, and kept current as health conditions and personal wishes change. By prompting such conversations and documentation, CSAs provide an invaluable service to their clients. Although death and taxes are certain, confusion and conflict over medical decision-making are not.



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