ADVANCE HEALTH CARE PLANNING

Good Advance Planning is a Continuing Conversation

Advance planning for health care is always a work in progress. That's because circumstances change, and lives change. Even your values and priorities can change.

What are Advance Directives?

Advance Health Care Directives (also sometimes called Living Wills or Special Power of Attorney for Health Care) are documents that instruct your health care provider about:

- Who should make decisions for you if you cannot make or communicate decisions about your health care (your agent).
- What decisions your agent can make.
- When you would want or not want life sustaining care.

Utah has an **Advance Health Care Directive** form that went into effect on January 1st, 2008. If you have an old Living Will or Special Power of Attorney, you should consider completing a new Directive on the new form.

Completing an Advance Directive will help to communicate your wishes to your health care providers when you cannot speak for yourself.

You do not need an Advance Health Care Directive, Living Will, or any other document, to tell your doctor that you do not want life-sustaining or prolonging treatments. Your instructions to your doctor should be honored, even if your doctor, family members, or your health care agent disagree with your instructions. If your doctor is unwilling to follow your instructions, he or she should transfer your care to another doctor.

Remember: Do not try to complete and sign an advance directive until you have carefully thought through your options and choices.

Five Times to Re-Examine Your Health Care Wishes

1. Before each annual physical exam.
2. At the start of each decade of your life.
3. After any major life change – such as a birth in the family, marriage, divorce, re-marriage, and especially after the death of a loved one.
4. After any major medical change – such as being diagnosed with a serious disease or terminal illness. Or if such conditions worsen.
5. After losing your ability to live independently.

If Your Wishes Change

You can make a new advance directive if your wishes change.

To revoke an old advance directive, you may destroy the old one, write "revoked" across the old one, write a new one, or tell someone that you want to revoke it. If you tell someone that you want to revoke the advance directive, you should do so in the presence of an adult witness who should then sign and date a written statement confirming that you have revoked the advance directive. If you change your advance directives, it is important to notify everyone who has a copy of your old forms.

What To Do With Your Advance Directive

1. Keep the original copy of your health care advance directive and these work sheets or other notes in a place where they can be easily found. Do not lock your directive in a safe deposit box, safe, or other inaccessible location.
2. Give your agent a copy of the directive plus any worksheets or notes. Make sure your agent knows where to find the original.
3. Give your doctor a copy of your directive. Make certain it is put in your medical record. Make sure your doctor will support your wishes. If your doctor has objections, you need to work them out or find another doctor.
4. If entering a hospital or nursing home, take a copy of your directive with you and ask that it be placed in your medical record.

Medical Orders

Medical care is provided based on orders signed by physicians or other authorized medical professionals, such as nurse practitioners or physician assistants. Advance directives can serve as the basis of a medical order, but an advance directive is not, by itself, a medical order.

Utah law allows medical orders that address life-sustaining care, such as CPR, the use of antibiotics, or the use of tube feeding and IV fluids. Orders may have different names: Life with Dignity Order, Physician Order for Life-Sustaining Treatment (POLST), or Emergency Medical Services Do Not Resuscitate Order (EMS-DNR).

These orders are not relevant to most healthy people who want life-sustaining care provided in an emergency. But people who are facing a life-threatening illness or who have specific preferences about specific types of care may want an order that will be followed by emergency services personnel, emergency rooms, or health care facilities. Specifically, any person who would not want CPR must work with a health care provider to complete one of these orders

Tool #10 contains a sample POLST form. If you want a medical order to address your end-of-life care wishes, ask your health care provider to work with you to complete the POLST form.