TABLE 10-3 STEPS IN ADVANCE CARE PLANNING

Step	Goals to be Achieved and Measures to Cover	Useful Phrases or Points to Make
Introducing advance care planning	Ask the patient what he or she knows about advance care planning and if he or she has already completed an advance care directive.	*I'd like to talk with you about something I try to discuss with all my patients. It's called advance care planning. In fact, I feel that this is such an important topic that I have done this myself. Are you familiar with advance care planning or living wills?*
	Indicate that you as a physician have completed advance care planning.	*Have you thought about the type of care you would want if you ever became too sick to speak for yourself? That is the purpose of advance care planning.*
	Indicate that you try to perform advance care planning with all patients regardless of prognosis.	*There is no change in health that we have not discussed. I am bringing this up now because it is sensible for everyone, no matter how well or ill, old or young.*
	Explain the goals of the process as empowering the patient and ensuring that you and the proxy understand the patient's preferences.	Have many copies of advance care directives available, including in the waiting room, for patients and families.
	Provide the patient relevant literature, including the advance care directive that you prefer to use.	Know resources for state-specific forms (available at *www.nhpco.org*).
	Recommend the patient identify a proxy decision-maker who should attend the next meeting.	
Structured discussion of scenarios and patient	Affirm that the goal of the process is to follow the patient's wishes if the patient loses decision-making capacity.	Use a structured worksheet with typical scenarios.
	Elicit the patient's overall goals related to health care.	Begin the discussion with persistent vegetative state and consider other scenarios, such as recovery from an acute event with serious disability, asking the patient about his or her preferences regarding specific interventions, such as ventilators, artificial nutrition, and CPR, and then proceeding to less invasive interventions, such as blood transfusions and antibiotics.
	Elicit the patient's preferences for specific interventions in a few salient and common scenarios.	
	Help the patient define the threshold for withdrawing and withholding interventions.	
	Define the patient's preference for the role of the proxy.	
Review the patient's preferences	After the patient has made choices of interventions, review them to ensure they are consistent and the proxy is aware of them.	
Document the patient's preferences	Formally complete the advance care directive and have a witness sign it.	
	Provide a copy for the patient and the proxy.	
	Insert a copy into the patient's medical record and summarize in a progress note.	
Update the directive	Periodically, and with major changes in health status, review the directive with the patient and make any modifications.	
Apply the directive	The directive goes into effect only when the patient becomes unable to make medical decisions for himself or herself.	
	Reread the directive to be sure about its content.	
	Discuss your proposed actions based on the directive with the proxy.	

Abbreviation: CPR, cardiopulmonary resuscitation.

they are constitutionally protected. Most commentators believe that a state is required to honor any clear advance care directive whether or not it is written on an "official" form. Many states have enacted laws explicitly to honor out-of-state directives. If a patient is not using a statutory form, it may be advisable to attach a statutory form to the advance care directive being used. State-specific forms are readily available free of charge for health care providers and patients and families through the National Hospice and Palliative Care Organization's "Caring Connections" website *(http://www.caringinfo.org)*.

In January 2014, Texas judge R. H. Wallace ruled that a brain dead woman who was 23 weeks pregnant should be removed from life support. This was after several months of disagreement between the woman's family and the hospital providing care. The hospital cited Texas law that states that life-sustaining treatment must be administered to a pregnant woman, but the judge sided with the woman's family saying that the law did not apply because the patient was legally dead.

As of 2013, advance directives are legal in all states and the District of Columbia either through state specific legislation, state judicial rulings, or United States Supreme Court rulings. Many states have their own statutory forms. Massachusetts and Michigan do not have living will laws, although both have health care proxy laws. In 27 states, the laws state that the living will is not valid if a woman is pregnant. However, like all other states except Alaska, these states have enacted durable power of attorney for health care laws that permit patients to designate a proxy decision-maker with authority to terminate life-sustaining treatments. Only in Alaska does the law prohibit proxies from terminating life-sustaining treatments. The health reform legislation, the Affordable Care Act of 2010, raised substantial controversy when early versions of the law included Medicare reimbursement for advance care planning consultations. These provisions were withdrawn over accusations that they would lead to the rationing of care for the elderly.

INTERVENTIONS

PHYSICAL SYMPTOMS AND THEIR MANAGEMENT

Great emphasis has been placed on addressing dying patients' pain. Some institutions have made pain assessment a fifth vital sign to emphasize its importance. This also has been advocated by large health care systems such as the Veterans' Administration and accrediting bodies such as the Joint Commission. Although this embrace of pain as the fifth vital sign has been symbolically important, no data document that it has improved pain management practices. Although good palliative care requires good pain management, it also requires more. The frequency of symptoms varies by disease and other factors. The most common physical and psychological symptoms among all terminally ill patients include pain, fatigue, insomnia, anorexia, dyspnea, depression, anxiety, and nausea and vomiting. In the last days of life, terminal delirium is also common. Assessments of patients with advanced cancer have shown that patients experienced an average of 11.5 different physical and psychological symptoms (Table 10-4).

Evaluations to determine the etiology of these symptoms usually can be limited to the history and physical examination. In some cases, radiologic or other diagnostic examinations will provide sufficient