What Would You Want?

hoag

A Guide to Health Care Decisions

This guide outlines key steps to prepare you and your loved ones when faced with a serious illness to ensure that desired treatment preferences are consistent with your values.

Follow The Five D's

STEP 1

Determine an honest assessment of your medical condition, disease trajectory and prognosis from your treating physician.

- What is the best case scenario?
- What is the worst case scenario?
- Where do you fit in that spectrum?

STEP 2

Discuss with your Support System

Many people are fearful about how their family or loved ones might react when topics related to serious health conditions are introduced, but foregoing this important conversation does not make it go away. Make sure that your health care options are discussed so that your support system fully understands your wishes.

When having this discussion, think about what is most important to you and use the below questions to guide the conversation:

- How do you define "quality of life"?
- What medical interventions would be acceptable or unacceptable to you?
- Where would you want to be if nearing end of life?
- Who needs to be involved in the conversation?
- Who will make health care decisions based on your values and preference when you cannot?
- What do you want your loved ones to know?

STEP 3

Document

Once you have made your decisions, the next step is to complete an Advance Health Care Directive and/or POLST (Physician Order for the Life Sustaining Treatment).

- Advance Health Care Directive (must be signed and witnessed OR notarized) can serve one or both of the below functions:
  - To appoint a Health Care Power of Attorney who will speak for you when you are unable
  - To provide instructions indicating your health care wishes
- POLST is a signed medical order which addresses a range of life-sustaining interventions for those with chronic progressive disease or a serious health condition
  - Allows the person to choose the intensity of medical treatments
  - A brightly colored, clearly identifiable, standardized form in California
  - Recognized and honored across all treatment settings

STEP 4

Distribute

When you've completed your Advance Health Care Directive and/or POLST, share the completed documents with your health care provider(s), your medical decision maker and other key family members.

STEP 5

Document Review

Review your documents periodically, at least once a year, or if your health status changes to ensure the documents reflect your current preferences.

For more information, visit hoag.org/advance-care or contact your physician.

FREQUENTLY ASKED QUESTIONS

What is an Advance Directive?

Advance directives consist of (1) a living will and (2) a medical (healthcare) power of attorney. A living will describes your wishes regarding medical care. With a medical power of attorney, you can appoint a person to make healthcare decisions for you in case you are unable to speak for yourself. Sometimes listing a close friend rather than a very close family member as a decision maker may be the right choice to ensure that your wishes are honored.

What is the difference between a POLST and an Advance Directive?

An advance directive is a direction from the patient, not a medical order. In contrast, a POLST form consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. POLST is a medical provider's order that gives specific instructions to the Paramedics should 911 is called and allows the treating providers to know your wishes should hospitalization be required. These orders can address things such as whether you would want to receive support from machines such as ventilators, artificial tube feedings or dialysis when you are seriously ill.

Does "Do Not Resuscitate" mean that I will not receive treatment if I go to the hospital?

No. A decision to have a "Do Not Resuscitate" order does not mean that you will not receive appropriate medical treatment if you are hospitalized. DNR is a medical order not to try resuscitation because a person does not want it or because it won't help. DNR is also called Allow Natural Death.

Resources : Prepare for your Care –
www.prepareforyourcare.org

hoag.