



Advance Care Planning Terms

Durable Power of Attorney for Healthcare: Legal document, or the POA it conveys, that names a person (the healthcare agent) to handle all medical and health-related matters when an individual (person who appoints the agent) is incapacitated. Depending on the state, the person appointed may be called a “healthcare/medical agent,” “attorney-in-fact for healthcare,” “healthcare/medical proxy,” “healthcare/medical surrogate,” or something similar.

Living Will = A written statement or directive detailing a person’s desires regarding medical treatments or interventions to be followed at a time the person is not able to express informed consent.

Advance Healthcare Directive= Several states use this term to describe a document combining the durable power of attorney for healthcare and living will.

Advance Directive= A legal document, prepared in advance of medical necessity or crisis, that goes into effect when an individual is incapacitated and unable to communicate as the result of a disease or severe injury. Both a durable power of attorney and a living will are considered advance directives.

Surrogate Decision Maker (Medical) = A person appointed (verbally or in writing) to make healthcare decisions for another person.

Default Decision Maker = In the absence of a legally binding document that appoints a healthcare decision maker or agent, state law usually dictates who can make medical decisions on behalf of an incapacitated patient. If the patient is married, then the spouse is likely the default decision maker, followed by parents, adult children, siblings, and so on. However, not all states use this “next-of-kin” hierarchy, so it is important to know how your state handles this issue. The American Bar Association tracks default decision maker and other advance care planning statutes.

Capacity= Capacity describes a person’s ability to make and express a decision. In a medical context, capacity refers to the ability to utilize information about an illness and proposed treatment options to make and communicate a choice that is congruent with one’s own values and preferences. A formal assessment of an individual’s decision-making abilities in the context of a medical decision constitutes an assessment of capacity. There are 4 decision-making abilities that constitute the ethical and legal understanding of capacity:

- 1. Understanding**
- 2. Appreciation**
- 3. Reasoning**
- 4. Expressing a Choice**



Competence = Competence refers to a legal judgment, informed by an assessment of capacity, relating to whether individuals have the legal right to make their own decisions.

Note: The terms capacity and competence are sometimes used interchangeably, but historically they have held separate although overlapping meanings. **Clinicians assess capacity in order to decide whether patients can make a specific choice about medical treatment; judges determine competence to establish rights of decision making and self-determination.**

POLST = Physician (Provider) Orders for Life-Sustaining Treatment

Utilized in some manner in all 50 states and Washington, D.C., the POLST form is a physician/provider order that specifies patient preferences for specific treatments to be given or withheld in the event of emergency. The form also defines a general scope of treatment – from “full” treatment to “comfort-focused treatment” – to govern choices not detailed on the form. The POLST is intended for patients who are seriously ill, medically fragile, or approaching the end of life. The POLST form is valid across multiple care settings and therefore “travels” with the patient. A number of states have electronic POLST registries for universal access by healthcare practitioners.

Leeway= An allowable margin of freedom to move or act in. Within the context of advance directives, leeway refers to the degree to which the agent may vary care choices away from the wishes expressed or written in the advance directive. The amount of leeway a person wants to give their agent may change over time and is generally more important when a patient has specific treatments he or she does or doesn’t want during a serious illness or at end of life.

Guardian= person, institution, or agency appointed by a court to manage the affairs of another person who cannot make decisions themselves or manager their own affairs. The guardian may or may not have medical decision-making authority, depending on the scope of the guardianship order. Healthcare providers have a responsibility to review guardianship documents to verify whether the guardian is authorized to make medical decisions. For more information on guardianship, visit the National Guardianship Association.

Ombudsman= “Long-term care ombudsmen are advocates for residents of nursing homes, board and care homes, assisted living facilities, and similar adult care facilities. They work to resolve problems of individual residents and to bring about changes at the local, state, and national levels that will improve residents’ care and quality of life.”

Components of Advance Care Planning: Understanding the Process

Through **meaningful conversations and careful documentation**, people create a framework for future decisions:

- **Plans are discussed and stored**
- **The patient’s healthcare agent is aware of the plans**
- **Plans are followed**



Glossary of Useful Medical Terms

Artificial nutrition and hydration = Clinically assisted nutrition includes nasogastric feeding (through the nose) and percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy (RIG) feeding tubes through the abdominal wall. PEG, RIG and nasogastric tube feeding also provide fluids necessary to keep patients hydrated. Clinically assisted hydration includes intravenous or subcutaneous infusion of fluids (use of a 'drip'), and nasogastric tube feeding or administration of fluid. The term 'clinically assisted nutrition and hydration' does not refer to help given to patients to eat or drink, for example spoon feeding.

Best practices = A set of guidelines, ethics or ideas that represent the most efficient or prudent course of action. Best practices are often set forth by an authority, such as a governing body or management, depending on the circumstances. While best practices generally dictate the recommended course of action, some situations require that such practices be followed.

Cardiopulmonary resuscitation (CPR) = An emergency procedure that involves breathing for the victim and applying external chest compression to make the heart pump. It can include: breathing into the mouth and pressing on the chest, electrical shock and drugs to try to start the heart, and/or a tube to assist with breathing. Abbreviated CPR, it works best if a person is healthy with no illness and is administered within a few minutes of the heart or lungs ceasing to work. "Success" rate for the chronically ill, older or weak is approximately 17% in a hospital setting and less than 3% in those living in a nursing home.

Comfort care = A model of end-of-life care, essentially synonymous with the hospice model, in which focus shifts away from life-sustaining treatment to a concentration upon relief of discomfort. In the context of comfort care, physical, emotional and spiritual needs are all given priority. As opposed to active treatment and care, a decision may be made in a comfort care situation to provide higher doses of pain medication, even if its use may accelerate approaching death.

Do Not Attempt Cardiopulmonary Resuscitation (DNR)= These advance management plans may be called DNAR orders or Allow Natural Death decisions in some healthcare settings.

End stage= The last phase in the course of a progressive disease. As in end-stage liver disease, end -stage lung disease, end-stage renal disease, end-stage cancer, etc. The term "end stage" has come to replace "terminal".

Futility of care = AKA Non-beneficial Care, it is the belief that in cases where there is no hope for improvement of an incapacitating condition that no course of treatment is called for.

Futile medical intervention = AKA Futility care or Terminal care. A medical intervention that does not lead to improvement in the patient's prognosis, comfort, well-being, or general state of health.



Hospice = The word “hospice” is used to describe both an institution providing care for people who are dying and an **interdisciplinary model of care that focuses on relieving symptoms and supporting patients and their families at the end-of-life**. Hospice care is generally offered to those with a life expectancy of 6 months or less and includes setting aside active and/or life prolonging treatment in favor of pain management and comfort care, with a focus on ensuring the best quality of life possible until the end of life. Hospice includes Palliative care for the incurably ill given in such institutions as hospitals or nursing homes, but also can be given in homes and includes support for those affected by the patient’s illness; patients, family, friends.

Heroic or extraordinary measures= Generally understood as emergency interventions normally intended to save life and restore health but seen in the context of impending death as actions that just prolong the dying process. Such measures may include CPR, forced intubation and certain surgeries. These measures themselves cause pain and trauma and are often avoided, by order of the patient and/or attending physician, at the end of life.

Life support = A therapy or device designed to preserve someone's life when an essential bodily system is not doing so. Life support may, for example, involve enteric feeding (by a tube), total parenteral nutrition, mechanical ventilation, a pacemaker, defibrillator, heart/lung machine, or dialysis.

Palliative care = The holistic care of patients with advanced, progressive, incurable illness, focused on the management of a patient’s pain and other distressing symptoms and the provision of psychological, social and spiritual support to patients and their family. Palliative care is not dependent on diagnosis or prognosis, and can be provided at any stage of a patient’s illness, not only in the last few days of life. The objective is to support patients to live as well as possible until they die with dignity.

Medical POA vs Health Care Surrogate - The main difference between a medical POA and a healthcare surrogate is that you appoint a medical power of attorney representative to make healthcare decisions for you when you become unable to make them for yourself. You can specify what healthcare decisions your medical POA can make. A healthcare surrogate, on the other hand, is someone who is appointed to make healthcare decisions for you when you become unable to make them for yourself. You may have no say in who becomes your healthcare surrogate. You can avoid having a healthcare surrogate appointed if you have appointed a medical POA representative and that representative is still willing and able to serve.

Glossary: Henry Ford Health - <https://www.henryford.com/visitors/advance-care-planning/glossary>