

# Taking Control

*Advance Care Planning Guide for  
When You Become Seriously Ill*



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## **Preface**

The freedom to choose how to live one's life is a quintessential American value. It has been my experience that among patients' greatest fears is losing this control when they are sick or when they have a grave illness and are near the end of life. Having that control, to live as you wish and to die as you wish, gives a great sense of comfort and inner peace. The desire to help you achieve this type of peace prompted Dr. Linda Stehling and me to share our insights on the important topic of Advance Care Planning, and it is why I have worked with her to bring this information to your attention. The formalities of the process, and that there is a "process", is what puts people off from addressing

this important topic. This barrier delays beginning the process, and the uncomfortable aspect of discussing this topic with friends, family, and your physician perpetuates the inertia. It is the purpose of this simple guide to help you overcome your reticence and to address these issues in your life, and in so doing reassert your control over your destiny. What is the meaning of life...what is its purpose? This is something we all ponder throughout our lifetimes. Is it the poet's answer..."to love and be loved"? Is it "the call to action and engagement" as some philosophers have surmised? In thinking about the end of our lives, we can express our beliefs and feelings in tangible ways that have important consequences. To avoid doing so leaves this important task to others or leaves it undone completely and creates unintended consequences that can burden family and friends.

With this short book, we encourage

you to begin the process of making your thoughts known. Begin informally with “The Conversation” and then progress to formal legal documents, so you can have the control you desire over your life both in health and sickness.

Dr. Lakin





# *1*

## **Advance Care Planning**

### **The Process**

Advance care planning is a process whose ultimate goal is to relieve anxiety and worry about end of life issues. It involves three simple steps:

The conversation: Thinking about and talking over with family and friends your goals for care should you become seriously ill.

Memorializing: Creating some document or representation, in written or video form, that expresses your wishes.

Documenting: Formalizing your wishes with

legal forms that provide an objective basis for putting your wishes into action.

Advance care planning is not a one-time event and is not just for the older patient. The Institute of Medicine recently published a report entitled *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. In it they recommend the process begin at a key maturation point such as turning 18, leaving home to go to school or into the military, or marriage.

### **Barriers to Advance Care Planning**

About 75% of patients say they would like to talk with their doctor about treatment options at the end of life; however, 90% say their physician has never mentioned it. Most of us avoid the topic of death and illness, and this accounts for the major reason, in my mind, why there is a disconnect between the desire for control over our care and formalizing that process. Other

barriers include:

- Who should initiate the discussion?
- Patients who believe doctors, not patients, should make all decisions
- Discussions only initiated when life-threatening illness or injury occurs
- Physicians not trained to discuss topic
- Medical system oriented to life-prolonging treatment, not comfort care
- Patients unaware of complications, side effects of treatments and interventions
- Complex and inconsistent state laws regarding required legal documentation

### **Goals of Advance Care Planning**

The ultimate goal is for you to receive the care you want at the end of life and to avoid unwanted treatment. It has been my general experience in medical practice that even without formal planning, most people have their overarching wishes followed; however, documenting this

information formally can assure you that this will happen. Having your wishes documented in a living will, and naming a health care agent ensures you receive appropriate treatment if you are incapacitated and unable to express yourself.

A secondary goal is to minimize anxiety, stress and guilt that may accompany decision making by family members when there has been no discussion of patient preferences or designation of who should make decisions. A complicated, prolonged bereavement process may result.

If no health care agent is available, the default decision in an emergency is to treat diseases and conditions, no matter how hopeless or painful. Decisions may be made by the legal next of kin or a group of family members and clinicians. The hospital ethics committee also may be consulted. In more extreme cases, a guardian may be assigned by the court if there is no designated health care agent or next of kin, or if first-degree relatives cannot agree on decisions.

The surrogate(s) will make decisions for you by:

- Following the treatment decisions you legally documented when you were mentally and physically competent
- Putting themselves in your place and attempting to choose what you would want—*substituted judgment*
- Using *good faith to decide best interests* to determine what would be best for you under the circumstances

If you did not prepare an advance directive, they will rely on the following:

- Did you ever talk about what you would want at the end of life?
- Did you ever express an opinion about how someone else was being treated?
- What were your values in life? What gave meaning to your life?

The absence of advance directives makes it less likely you will receive the care you want. Do your best to ensure you do not receive burdensome

interventions you do not want: begin advance care planning now. *It's always too early, until it's too late!*

### **Plan of Implementation**

Once you decide to proceed with advance care planning, it is important to be organized. A logical sequence of actions to follow is:

- Review the purposes and goals of advance care planning, your medical treatment options, and legal forms
- Discuss your health status and medical treatment options with your doctor
- Elicit participation of family and close friends in “The Conversation” regarding your preferences for care
- Document the matters discussed
- Select a health care agent and back-up
- Seek legal assistance if necessary
- Sign your Living Will and Durable Health Care Power of Attorney in the presence of the

required witness(es)

- Store the original documents in an accessible place and provide copies to your health care agent, physician, and select relatives and friends
- Carry a wallet card indicating you have advance directives and the person(s) to contact for copies
- Review the documents periodically and update if necessary

*See Appendix A at the end of this book for a checklist for completing your Advance Directives.*





# 2

## **What Things Are Most Important to You?**

### **Determinants of Preferences**

An individual's values, religious and cultural beliefs, ethnicity and race, life experiences, and knowledge about available care options determine the choices they make in life and for care at the end of life. Decisions are significantly influenced by the way options are presented, the willingness of health care professionals to answer questions, and input from family, friends, and advisers.

## Questions to Ask Yourself

- What gives your life purpose, meaning?
- What does quality of life mean to you?
- Is quality of life or length of life more important to you?
- What concerns you most about the end of life?
- How would you like to spend your final days and weeks of life?
- Where would you prefer to die?
- Are there any types of medical interventions you do not want?
- Are there medical conditions, physical or mental limitations that would make you prefer death to living with them?

Most people say quality of life is more important than length of life. Some want everything possible done to preserve life, regardless of how painful or unpleasant.

Among the things most cited as important at the end of life are:

- Being with family and friends
- Not being a burden for others
- Being treated as a “whole person”
- Maintaining dignity, a sense of purpose
- Being able to contribute, helping others
- Cognitive ability, mental alertness
- A caring health care team, caregivers
- Being kept clean, free of pain, anxiety
- Feeling prepared to die, not dying alone

Most patients say they would prefer to die at home. Although there is significant geographic variation and the number is increasing, only about 25% of patients older than 65 die at home. Approximately two-thirds die in hospitals or nursing homes. It is estimated that the percentage of patients dying in long-term care facilities will rise to 40% by 2040.

Medical interventions many patients don't want include cardiopulmonary resuscitation (CPR), endotracheal intubation (insertion of a breathing tube), mechanical ventilation, kidney

dialysis, and artificial nutrition via a feeding tube. Medical conditions, physical, or mental limitations patients say might make death preferable to living with them are:

- Severe pain not easily relieved by pain medications
- Inability to recognize family and/or communicate with them
- Inability to control bowel and bladder functions
- Being confined to bed all the time
- Needing a caretaker 24 hours a day

# 3

## Treatment Options

### Types and Goals of Treatment

The types of treatments patients want and do not want may differ with their health status. Knowledge of the three general approaches to care is particularly important when considering end of life care.

***Life-prolonging care*** includes the use of all available medical interventions to extend life as long as possible. Options include, but are not limited to:

- Cardiopulmonary resuscitation (CPR)
- Endotracheal intubation and mechanical

ventilation (insertion of a breathing tube through the mouth or nose and use of a breathing machine)

- Intravenous medications to maintain blood pressure and heart rhythm
- Care in the intensive care unit (ICU)
- Artificial nutrition (food) through a feeding tube
- Kidney dialysis

***Limited medical care or selective treatment***

aims to treat medical conditions and restore or improve health while avoiding burdensome treatments. It may include hospitalization and administration of intravenous fluids and medications. CPR, intubation, and care in ICU are avoided.

***Comfort care*** includes relief of pain and measures to maximize comfort and quality of life. It excludes measures to delay death. Hospitalization is avoided unless required to provide comfort, such as pain relief.

## Palliative and Hospice Care

Palliative and hospice care both focus on comfort care and measures to relieve pain and symptoms due to serious illness. However, there are differences between the two types of care in terms of patient eligibility, where care is delivered, types of concomitant treatment administered, and payment for services rendered. Both utilize teams of physicians, nurses, social workers, therapists, and counselors.

***Palliative care*** characteristics include:

- Appropriate for patients of any age with serious illness (heart failure, Parkinson's disease, chronic obstructive lung disease, cancer, renal failure, etc.)
- Not dependent on prognosis or life expectancy
- May be continued any length of time
- Curative treatments permissible
- Care delivered in physician's office, clinic, hospital, home, nursing home



- Medicare, Medicaid, private insurers cover some aspects of care, copays may apply, services may be billed separately for individual providers

**Hospice care** programs were initiated in the 1970s and now number over 6,000 non-profit and for-profit organizations. Hospice of the Valley, established in 1977, was one of the first hospices in the country. Although hospice care is appropriate for patients of all ages, about 85% of the patients are 65 years of age or older. Consequently, the primary funding mechanism is the Medicare Hospice Benefit. In order to be eligible for it, a patient must be:

- Eligible for Medicare Part A
- Certified by the patient's physician and hospice physician to have a life-limiting illness that, in the normal course, leads to death in six months or less
- Receiving care by a Medicare-approved hospice

Medicare pays on a per diem basis for hospice care for a terminal illness and related conditions. It will continue to pay for services longer than six months if the provider certifies a patient is still close to dying. The services may be discontinued and later reinstated. Patients may withdraw from hospice at any time.

The focus of hospice care is comfort, not cure. Patients must be willing to forgo treatments aimed at curing their illness or prolonging life.

Most care is delivered in the patient's home. Inpatient care in a hospice facility is usually limited to about a week. Medicare defines a set of core services that must be available to patients:

- Physician services
- Nursing care
- Case management services
- Medical equipment (wheelchairs, walkers)
- Medical supplies (bandages, catheters)
- Drugs for pain relief, symptom control
- Social work and counseling services

- Physical, occupational, speech therapy
- Dietary and nutritional counseling
- Hospice aides and homemaker services
- Grief support for patient and family
- Short-term inpatient care for pain and symptom management
- Short-term respite care to give the usual caregiver(s) a rest

Hospice does not provide round-the-clock care. Nurses visit periodically and medical personnel are available for consultation 24 hours a day. Personal patient care must be provided by family, friends, paid caregivers.

### Cardiopulmonary Resuscitation

Cardiopulmonary resuscitation (CPR) involves several maneuvers to restore heart function when an individual's heart has stopped (cardiac arrest). It involves manually compressing the chest rapidly and may include defibrillation (administration of an electric shock), artificial

ventilation, and administration of medications. The aim of CPR is to restore cardiac function and breathing and thereby reduce the chances for neurologic injury due to decreased blood flow to the brain. This discussion is limited to in-hospital cardiac arrest and out-of-hospital cardiac arrest in patients with known life-threatening conditions.

The chances a hospitalized adult will survive a cardiac arrest are related to the patient's age, underlying illnesses, and health status at the time of the arrest. The average survival-to-discharge rate is about 10% to 20%. The rates are lower in the elderly and those with serious diseases, including cancer. Many resuscitated patients have prolonged hospital stays and still do not survive. Statistics dealing with the functional status of discharged patients show about 25% will be newly placed in a rehabilitation or skilled nursing facility.

Complications of CPR include fracture of the

sternum (breastbone) and ribs, pneumothorax (collapsed lung), damage to internal organs (heart, liver, spleen) and bleeding secondary to the damage. These complications occur most often in elderly, frail, debilitated patients, but may occur in any patient.

### **Do Not Resuscitate (DNR) Orders**

In the absence of a DNR order, the default position in the case of cardiac arrest is to perform CPR and institute measures to prolong life. There are two types of DNR orders. Those for hospitalized patients relate to the actions of hospital personnel. Non-hospital or out-of-hospital DNR orders instruct emergency medical personnel, emergency room staff, and nursing home personnel not to perform CPR. In Arizona, the document is called a Prehospital Medical Care Directive. It must be on letter sized paper or wallet sized paper on an orange background to be valid. A recent photograph or physical

description of the individual is required. It must be signed in the presence of a witness and also signed by a licensed health care provider.

## **Medical Orders for Life-Sustaining Treatment**

Physician Orders for Life-Sustaining Treatment (POLST), also known as Provider Orders for Life-Sustaining Treatment, and Medical Orders for Life-Sustaining Treatment (MOLST) convert patient treatment goals into legal medical orders. Characteristics include:

- Intended for people who are seriously ill or frail
- Signed by physician or other medical provider and patient or health care agent
- Applies to all health care professionals, including emergency medical service personnel
- Followed in all health care facilities in the state where it is legal

- Specifies exact wishes about certain medical treatments and interventions
- Options include *full treatment* with goal of prolonging life by all effective means; *selective treatment* for some conditions while avoiding burdensome measures; or *comfort-focused treatment* only
- Portable, goes with patient to home, hospital, long-term care facility
- Placed in patient chart or file
- Written in simple language and typically printed on bright neon color paper
- Neither an advance directive nor a replacement for advance directives

Forms exist or are in development in most states. Arizona is in the development stage at this time and cannot recognize forms from other states.

# 4

## **The Conversation**

### Purpose

While we refer to “The Conversation”, it is not a one-time event. Preparing for the end of life is an on-going process throughout life. The purposes of having the initial discussion with your family and close friends are to:

- Introduce the concept of advance care planning
- Present information about the types of treatment you want and do not want to receive at the end of life
- Explain the reasons for your choices



- Allow those present to comment, ask questions, and express their feelings about your preferences for care
- Reassure loved ones they will benefit by knowing exactly what type medical care you want and what decisions to make if you are incapacitated
- Select the person you want as your health care agent
- Identify potential problem interactions and disagreements among those present and attempt to resolve them
- Record your wishes so there will be no doubt about your preferences

### **Conduct of the Meeting**

It is not necessary to have a formal agenda. However, you should have a mental or written list of the major issues you want to discuss. Select a place such as your home where participants are comfortable and feel at ease. Dr. Angelo Volandes,

author of *The Conversation: A Revolutionary Plan for End-of-Life Care*, suggests the topic of advance care planning be introduced during a family gathering or following the death of a friend or relative. When conducting the meeting:

- Keep the discussion friendly, focused.
- Discourage discord, hostile interactions.
- Do not allow the conversation to continue too long. Schedule a follow-up meeting if necessary.
- Remember to thank the participants.

### Follow-up

If a video was made during the meeting, share it with those in attendance. If not, follow up with a summary letter or e-mail. When available, provide copies of your advance directives to appropriate family members and friends. Be sure to send them updated copies if you revise your living will or change your health care agent.



# 5

## **Terminal Illness**

### **Definition**

Terminal illness refers to a condition or disease for which there is no cure and from which a patient is expected to die within a relatively short period of time, often arbitrarily defined as six months or less. When informed of a terminal illness, the first question a patient usually asks is “How long do I have?” In some cases (solid-tumor metastatic cancer) the clinician is able to offer a relatively accurate estimate of life expectancy. For many diseases (heart failure, chronic obstructive lung disease, stroke, Parkinson’s disease) it

is difficult to provide a reliable prognosis. A patient's prognosis has multiple implications:

- Personal, affecting the patient's state of mind, decisions about how to spend the remaining time, relationships with loved ones
- Financial, regarding resources and allocation of funds
- Family caregiver(s), regarding who will provide care and for how long
- Clinical, decisions regarding treatment options and where care is delivered
- Legal, preparation of advance directives
- Hospice care, determines eligibility under Medicare Hospice Benefit

### **Patients' Fears and Concerns**

The things patients fear most at the end of life are influenced by their spiritual, religious, philosophical and cultural beliefs. Previous experiences with dying loved ones, particularly patients who had a so-called "bad death"

characterized by pain and suffering, can have a profound influence. Things most dying patients fear include:

- Loss of independence and control
- The unknown, non-existence
- Eternal punishment
- Pain and suffering
- Isolation and dying alone
- What will happen to loved ones

Many patients fear the process of dying more than being dead. While death cannot be prevented, you can do things to make the process easier:

- Prepare advance directives to ensure you receive the care you want and avoid unwanted treatments.
- Seek care from palliative care teams experienced in managing the physical, emotional, spiritual and psychosocial needs of patients and their families.
- Discuss your fears and concerns with family

and health care providers.

- Enter a hospice program early when eligible, not just at the end of life.
- Insist on adequate pain relief.

### Coping Mechanisms

Dr. Elisabeth Kubler-Ross in her book entitled *On Death and Dying* defined a series of coping mechanisms exhibited by most terminally ill patients. Although presented as the five stages of death, they do not necessarily follow in the order presented. The stages are:

- Denial and isolation
- Anger
- Bargaining
- Depression
- Acceptance

### Reconciliation

Patients nearing the end of life often recognize the need for reconciliation with family and

friends from whom they are estranged and for strengthening troubled relationships. Harboring feelings of anger, resentment, or regret for prior actions may prevent them from being at peace with themselves and others. In his book *The Four Things That Matter Most* Dr. Ira Byock, a palliative care physician, emphasizes that our relationships are our most precious possessions. By caring and taking time to express affection, gratitude and forgiveness it is possible to renew and revitalize these precious connections. The four most important things to say are:

- I love you
- Thank you
- I forgive you
- Please forgive me

These simple, meaningful statements apply throughout life and should be repeated frequently. They can be especially beneficial in helping to get rid of emotional baggage and restoring relationships near the end of life.





# 6

## **Advance Directives**

This section will cover the nuts and bolts of creating the two advance directives you require: A Living Will and a Health Care Power of Attorney.

### **Living Will**

A living will specifies the types of medical care and treatments you want and do not want under specific conditions (e.g., terminal illness, dementia, irreversible coma) if you are unable to express your wishes. It deals with medical conditions while you are alive. (In contrast, a will and testament deals with issues related to your

estate after death.)

Each state has a different form and requirements for who must witness you signing the form. Some, including the Arizona Living Will (End of Life Care) form only require checking a few options. Others are quite lengthy. You also have the option of attaching additional provisions or limitations on medical care. It is not necessary to use the form provided by the Attorney General of Arizona. Other resources for documents are listed at the end of this publication. Although an attorney is not required, your personal attorney can provide guidance and suitable legal forms.

### **Durable Health Care Power of Attorney**

Approximately 70% of adults will at some time be incapable of making decisions about their health care. A Durable Health Care Power of Attorney is a legal document identifying the person you have selected to make medical decisions for you if you are unable. Most, but not

all, states allow use of a universal form such as the one prepared by The Commission on Law and Aging of the American Bar Association. The Office of the Arizona Attorney General includes a form in its Life Care Planning Packet.

A Durable Mental Health Care Power of Attorney document also is available in Arizona. The decision whether an individual is incapable can only be made by an Arizona licensed psychiatrist or psychologist who evaluates whether the individual can give informed consent.

### **Health Care Agent**

A health care agent, also called health care proxy or surrogate, makes decisions about your medical care if you are incapacitated and unable to make your wishes known. Your spouse or a relative may be the best choice, but not necessarily. If your spouse's cognitive ability is questionable or declining, another person should

be selected. A friend may know your health care preferences better than a relative in another city. You also should have a back-up agent in case the chosen agent is not available when needed. The agent must be someone who:

- Knows your values and priorities
- Meets legal criteria to act as agent
- Is willing to discuss sensitive issues, listen to your preferences for care, and will honor your wishes even if they conflict with their beliefs and values
- Will honor your wishes even if family and medical staff object to them
- Lives near or is willing to travel to be with you if needed
- Is likely to be available in the future
- Will be a strong advocate if medical and facility personnel are reluctant to provide information about your medical condition or treatment options
- You trust with your life

It is possible to combine a Living Will and Durable Health Care Power of Attorney in one document. If you have two documents, you must attach the Living Will to the Durable Health Care Power of Attorney.

### **Document Storage and Distribution**

Where the documents are stored is as important as preparing them. They must be:

- Portable, wherever you are in the world
- Available in a timely manner
- Not in a safety deposit box

Make several copies and provide copies to your health care agent, physician, and select relatives and friends. The Patient Self-Determination Act requires Medicare and Medicaid funded hospitals, nursing homes, and home health care agencies to ask patients whether they have advance directives and to incorporate them into the patient record. Be prepared to provide a copy if you seek care from such facilities.

Copies can be registered in the Arizona Advance Directive Registry. The Arizona Secretary of State oversees filings, security, and operations of the Registry. Private companies also provide storage services.

If you spend a significant amount of time in more than one state, it is wise to have legal documents in each state.

### Reviewing and Updating

The American Bar Association suggests review when any of the “Five D’s” occur:

- Decade—when you begin a new decade
- Death—when a loved one dies
- Divorce—or other major family change
- Diagnosis—of serious health condition
- Decline—or deterioration of your health condition, especially if it affects your ability to live independently

It is common for patients’ preferences for care to change as health status changes. If so, new

documents should be prepared incorporating the type care desired and specifying the health care agent. Retrieve or have recipients of previous documents destroy their copies, and provide copies of the revised documents to them. This is facilitated by keeping a list of recipients with your copies of your advance directives.





# 7

## **Additional Sources of Information**

### **Your Physician**

As your primary care physician, I know you and am familiar with your medical history. This book is evidence of my interest in advance care planning and my willingness to be involved as you navigate the process.

The Centers for Medicare and Medicaid Services (CMS) recently recognized the importance of advance care planning by approving payment for voluntary end of life counseling for Medicare beneficiaries. Medicare will reimburse physicians and other

qualified health professionals for advance care planning sessions which may be scheduled when you are healthy, following the diagnosis of a serious illness or chronic disease, or if you have a terminal illness. Ideally, they will occur in a primary care setting where you have a longstanding relationship with your physician and can engage in a planning session at a time of your choice. They may occur on the same day as your annual wellness visit, another medical visit, or at a separate time. A team-based approach is appropriate for some patients, particularly those who are receiving palliative or hospice care.

### **The National Institutes of Health**

The National Institutes of Health (NIH) has an extensive list of publications on advance care planning and end of life issues. Access the advance care planning document at: [nia.nih.gov/health/publication/advance-care-planning](https://nia.nih.gov/health/publication/advance-care-planning). Discussions, videos and a long list of

frequently asked questions (with answers) about end of life care are available at: [nhseniorhealth.gov/endoflife](https://nhseniorhealth.gov/endoflife).

### State Publications

The Life Care Planning Packet: Advance Directives for Health Care Planning is available from the Office of the Attorney General of Arizona. It contains information on advance care planning and the necessary forms for advance directives. Access it at: [azag.gov/seniors/life-care-planning](https://azag.gov/seniors/life-care-planning).

### Professional Associations

The Commission on Law and Aging of the American Bar Association has a Consumer's Tool Kit for Health Care Advance Planning available at [abanet.org/aging](https://abanet.org/aging).

CaringInfo, a program of the National Hospice and Palliative Care Association, provides several resources on advance care planning and links to each state's requirements at [caringinfo.org](https://caringinfo.org).



## Appendix A

### Checklist for Completing Advance Directives

- Read this book
- Consult your physician, lawyer, others for additional information if necessary
- Have “The Conversation”
- Select health care agent(s)
- Obtain Living Will and Durable Health Care Power of Attorney forms<sup>1</sup>
- Complete the forms, preferably with

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1 Download the forms (sections 3 and 5 of The Life Care Planning Packet) from the Office of the Attorney General of Arizona at [azag.gov/seniors/life-care-planning](http://azag.gov/seniors/life-care-planning) or obtain copies from Dr. Lakin’s office. Forms are available from several other sources or your lawyer can prepare them for you.

assistance of a family member or friend

- Sign forms in presence of witness(es)<sup>2</sup>
- Store original forms in secure, accessible place (*not safety deposit box*)
- Give copies to Health Care Agent and other appropriate individuals
- Place copy of wallet card in wallet
- Relax. You have taken control!

---

2 In the State of Arizona, one witness OR a Notary Public must witness the signing of the forms and then sign them. The witness CANNOT BE anyone under the age of 18; related to you by blood, adoption, or marriage; entitled to any part of your estate; currently designated as your health care agent; involved in providing your health care. (Note: The number of witnesses and the conditions for eligibility are not the same in all states. Follow the guidelines of the forms you sign.)

## **Appendix B**

### **Wallet Card Indicating You Have Advance Directives**

#### **I HAVE ADVANCE DIRECTIVES**

My name: \_\_\_\_\_

Contact for Copies

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Care Agent

Name: \_\_\_\_\_

Phone: \_\_\_\_\_





## **Disclaimer**

This book is not designed to and does not provide medical or legal advice, professional diagnosis, opinion, treatment or services to you or any other individual. Through this book and linkages to other sites, the authors provide general information for educational purposes only. The information is not a substitute for obtaining medical care or legal advice. The authors are not liable or responsible for any medical or legal advice, course of treatment, diagnosis, or any other information, services or product you obtain through this book.



Dr. Lakin is a graduate of Barrett, the Honors College at ASU. He received his medical degree from Johns Hopkins School of Medicine and completed a residency in internal medicine at The University of Iowa Hospitals and Clinics. In 1990, he joined his father, Dr. Mervyn Lakin, in practice. He continues to practice in the tradition of his excellent training and to provide the quality of patient care established by his father.

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