



# Senior Series

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## Glossary of Terms for End of Life Planning

End of life planning involves making decisions about how you would like to be treated at the end of your life and who you would like to represent you should you become incapacitated. Communicating these decisions to your family, friends, and health care providers is an important part of the planning process. In order to make informed decisions, one needs to be comfortable with the many unfamiliar terms that are associated with preparing for the end of life. Below is a glossary of terms commonly used by medical and legal professionals who provide assistance with these matters.

***Advance care planning:*** A process that assists individuals and their loved ones in clarifying

decisions about future medical treatment. This involves conversations over time about an individual's current state of health, goals, values, and preferences. The goal of these discussions is the creation of a plan that includes specific end-of-life decisions that is understood by all participants (family, extended family, medical providers). As part of this process, the completion of advance directive documents helps communicate the plan to all concerned when the individual is unable to do so for himself or herself.

***Advance directive:*** A general term that describes two kinds of legal documents—living wills and medical powers of attorney. These documents

allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Because each state regulates the use of advance directives differently, individuals need to obtain an advance directive in the state they currently reside.

**Capacity:** In relation to end of life decision-making, a patient has medical decision-making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

**Do-not-resuscitate order:** A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital

DNR order is written for individuals who are at home and do not want to receive CPR.

**Hospice care:** A program model for delivering comfort care to individuals who are in the final stages of terminal illness. In addition to providing comfort care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

**Living will:** A type of advance directive in which an individual writes down their wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians," "health care declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.

**Medical power of attorney:** A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a "health care proxy," "durable power of attorney for health care," or "appointment of a health care

agent.” The person appointed may be called a health care agent, surrogate, attorney-in-fact, or proxy.

***Palliative care:*** A comprehensive approach to treating serious illness that focuses on the physical, psychological, and spiritual needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, controlling pain and symptoms, and enabling the patient to achieve maximum functional capacity. Respect for the patient’s culture, beliefs, and values is an essential component. Palliative care is sometimes called “comfort care” or “hospice-type care.”

***Surrogate decision-making:*** Surrogate decision-making laws allow an individual or group

of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

***Withholding or withdrawing treatment:*** Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

## Source

*Talking About Your Choices.*

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