MAKING SENSE OF HEALTHCARE DIRECTIVES

Do you have a healthcare directive? This daunting question is posed to Emergency Room patients daily and is often received with a virtual shrug and response, “Do I need it today or may I think about it?” Being an Emergency Medicine physician, I can attest to people making and taking little time for life and death decisions. National Healthcare Decisions Day (April 16) draws attention to the importance of advance care planning. In addition, I propose taking more guesswork out of healthcare directives while lessening expectations to live forever.

Naturally, directives suggest expectations. At the end of life, preference might be to minimize expectations and optimize values; perhaps honoring the merits of free-thinking. Wishes arise from free-thinking. Decisions are determined by these wishes. However, I attend to people who are emotionally upset and unsure of their wishes and decisions. If healthcare directives actually make sense, patients could be given more reassurance and confronted with fewer trick questions regarding their interest in living. *Damned if you do and damned if you don't* is the disturbing game that plays out with those who desire to live, yet suffer the consequences of not dying.

Healthcare directives will never make sense until dying makes sense personally. At times, dying actually does make sense. As such, a futile medical condition would not incur the onslaught of a full code. End-stage heart disease would not demand the heart be resuscitated upon sudden death. Terminal cancer would not call for a continuum of heroic measures. If it makes sense to provide more dignity and less suffering through healthcare directives, people might be inclined to enact healthcare directives that seem less punitive, more compassionate and open to death.

I routinely care for near-death hospice patients and elderly patients from extended-care facilities who have directives in place to prolong their lives. I also have an internal directive that abides by the golden rule; insisting that none of what I might do for them be done to me. While I have a healthcare directive stating that I do not wish CPR, my present health is excellent. Nevertheless, if I collapse from a cardiac dysrhythmia tomorrow, someone better retrieve the AED mounted next to the public fire extinguisher. How does favoring CPR with the use of a defibrillator make sense when I have a directive against it?

To ease the decision-making process, the state of an individual’s health might determine the actual healthcare directive. As life progresses and there is a natural progression to illness, the particular phase of the illness might determine the specific care provided. To simplify these considerations, healthcare is generally delivered in four categories: Preventative care, Advance care, Palliative care, and Omega care. Omega care is my alternative term for Hospice care or comfort care. It broadens the concept of end of life care as being both empowering and affirmative.

The problem with comfort or hospice care lies in the fact that dying rarely appeases patients’ and family members’ consolation with dying. Sometimes the reverse occurs; family members feel more comfortable if the patient could be evaluated in the hospital just one more time and perhaps with the adage of *leaving no stone unturned;* perhaps averting an untoward death*.* Omega care instills certainty in death and provides for dignity being foremost to the process of dying.

As it stands now, healthcare directives typically encourage people to fight until the end; perhaps attempting to gain dignity through the conquest. Family members often prefer implementing life-sustaining measures that reflect their everlasting love. Meanwhile, I witness patients who sweat and suffer until the bitter end. Directives make sense when they anticipate both patients’ and family members’ emotional responses to dying; perhaps relying on physicians’ empathy more than their expertise to save lives. Healthcare directives make sense when they provide tender loving care.

Most people who present at the hospital have a healthcare directive that implies, “I want the physician to make me better, but I do not wish to suffer.” Ideally, Preventive care prevents unnecessary suffering; Advance care allots for suffering with prospects of becoming better; and Palliative care balances suffering with options to live longer. Omega care deters persistent suffering by drawing a finish line; creating an artful end to life before artificial life is approached. A healthcare directive could determine when to *cross my heart and hope to die.*

The finish line is located at the end of a race. Simultaneously, the heart rate begins to slow down. The finish line can be absolute or arbitrary; determined by someone having authority or by an individual claiming, “I’m done.” We can let fate and nature determine when the heart stops or enlist the use of medication and technology to prolong life. This door remains open to choice. Choice typically offers freedom which creates more options than resolutions. Healthcare directives that aspire to dignity would enlist a heart-centered resolution to death.

The arc of a reasonable healthcare directive follows the heart’s intuition as its pulse naturally determines responsiveness. The heartbeat holds steady during Preventative care and increases with Advance care. Missed beats and milestones become the pivotal point for receiving Palliative care. The ultimate downside or turn for the worse anticipates the delivery of Omega care. The normal bell-curve of illness reflects the natural upswing and downturn of life. Unorthodox thinking in both healthcare directives and life would attempt to *turn back the hands of time*.

Healthcare directives typically insist that patients are not to die hastily, readily or perhaps at all. Evidence in the medical field is that all patients die; generally, not in a manner they prefer. Patients prefer physicians give them hope but not provide unnecessary treatments. However, any hope necessitates life-sustaining measures. We need to remove hope from healthcare directives while instilling sense and sensibility into extraordinary care measures that actually respect the dis-ease process, reassure patients and provide them with fulfillment.

For instance, most people die from heart disease and a healthcare directive would warrant appropriate care. Preventive care would stress diet, exercise and smoking cessation while screening and treatment for hypertension, diabetes and high cholesterol; perhaps advising the use of aspirin, CoQ10 and Omega-3 supplements. Advance care begins when a heart attack occurs and generally involves coronary stents, more medication or surgery. Palliative care is initiated when heart disease progresses to heart failure and a heart transplant is not a viable option. Omega care is offered when quality of life ends; an important personal decision to rest in peace.

Healthcare directives make sense as the standard of care when life-sustaining measures are not granted to patients with a poor prognosis. When patients receiving Palliative care take a turn for the worse, could Omega care be automatically provided without the deliberation and coercion to save a life at all costs? Can we as a society evolve on this topic and begin to talk seriously about healthcare directives that uphold the dignity of dying patients; thus, averting senseless acts of perpetuity. Might April 16th signify a new day for healthcare directives to start making sense?

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