DOES YOUR TREATMENT PLAN **ALIGN WITH THE PATIENT'S WISHES?**

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Research shows that many patients, when surveyed at the end of their life, say they received more intensive medical treatment over their final months or years than they would have wanted. Open physician-patient dialogue can ensure a patient's treatment plan aligns with their personal values and wishes, but those conversations can be difficult.

"Goals-of-care discussions are important, but we are not initiating these conversations as often and as early enough in the care process as we should to have benefit," said **Daniel Hall, MD, MDiv, MHSc, FACS**, medical director, High-Risk Populations and Outcomes, the Wolff Center at UPMC. "Physicians should discuss goals of care and end-of-life preferences with all patients entering the last season of their life, ideally when their health is stable."

Goal planning often focuses on future conditions that patients don't consider until their health declines and they have a clear decision to make about treatment or surgery. Emotions, fear, and other factors can cloud a patient's decisions when they are faced with their own mortality.

"It's difficult to have these conversations once a health crisis arises," said Dr. Hall, who is a practicing general surgeon with additional training in moral philosophy, theology, quality improvement, and health services research.

When curative treatment is no longer an option, there is a perception that physicians and other health care providers have nothing further to offer their patient.

"Physicians are trained to do everything possible to save lives, and our cultural norm is that more medicine is better medicine. Both the health care industry and consumers have created this fictional belief that we will get out of life alive," he said.

Dr. Hall says most patients and their families want to discuss end-of-life care with their physicians and other practitioners, who they trust to allay fears, help them achieve final goals, and minimize their suffering.

"Discussing end-of-life care doesn't mean we stop treating the patient," he said. "It's having open dialogue that clarifies a patient's prognosis in a direct, truthful, and caring way, while sustaining their spirit, and identifying medical and remaining life goals."

Many health care providers have little to no formal training on end-of-life discussions, making it difficult to have these important conversations. Discussing Goals of Care: Honoring End-of-Life Preferences, taking place on **Monday, April 22**, at the Herberman Conference Center, UPMC Shadyside, will provide tools and strategies to start these conversations.

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HAVING DIFFICULT CONVERSATIONS

While many consider making health care decisions a difficult conversation, it is important to have a shared understanding of what matters most to you and your loved ones

Here are some things to consider when putting your health care decisions in place:

Health care power of attorney: A type of power of attorney in which someone appoints another trusted person to make health care decisions should the person become unable to do so.

Advanced directive/living will: A legal document that communicates wishes about life-saving medical treatment in the event a person has a terminal condition and is unable to communicate health care directives.

Documenting your wishes: There are a few ways you can make your loved ones and physicians aware of your wishes. You can prepare an advance directive or living will that states your wishes in a written document, or you can appoint a health care agent to prepare a living will.

Not sure how to get started? Use this Advanced Directive form as a guide.

Are you interested in learning more? Attend Discussing Goals of Care: Honoring End-of-Life Preferences on **Monday, April 22**, to learn from health care experts from around the country.

HAVE ADDITIONAL QUESTIONS? VISIT HALO ON INFONET OR ASK FOR MORE INFORMATION ON YAMMER.

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