

NOTE: This resource was published in 2020 and is not being maintained. While information contained within was current when published, it may be outdated, and some links may not work.

Talking With Patients About Advance Directives During the COVID-19 Pandemic

Given all the ways that COVID-19 is affecting how medical care is provided, it is important to talk to everyone—in or out of hospital settings—about advance directives. The medical status of individuals with COVID-19, even those with seemingly benign and mild symptoms, can quickly change to the point that they may need advanced life support (e.g., a ventilator). Advance directives are written documents that communicate what medical treatments individuals want or don't want if they become unable to communicate their wishes on their own. Advance directives often include:

- Durable power of attorney for health care (e.g., naming a person to make medical decisions when someone is unable to).
- Living will (e.g., tells medical providers what treatments to use and not to use if someone is unable to do so).
- Other documents such as “do not resuscitate” (DNR) and “do not intubate” (DNI) orders or organ and tissue donor agreements.

Conversations about advance directives can be difficult, particularly if the conversation is happening without prior planning. If the patient does not have the capacity to communicate their wishes, these conversations may need to take place with loved ones, family members, or the appropriate legal representatives. In addition, some patients with disabilities may need auxiliary aids and services, such as a sign language interpreter to participate in the conversation or patients with limited English proficiency may require a language interpreter. Health care providers are required to provide these types of access under Federal civil rights laws. One way to frame a conversation about advance directives is to use **REMAP** (Childers et al., 2017):

Reframe

- Place the patient's current illness and status into a larger context.
 - “We need to have a conversation that I have with everyone who comes into the hospital, particularly as we face unusual challenges with COVID-19. I want to understand what you want for your medical care if you are unable to communicate with your medical team.”

Expect emotion and empathize

- Patients may express their emotions verbally or nonverbally. This can be a frightening conversation and patients may react with sadness, anger, and worry. Acknowledge the emotion and reflect that these are normal feelings.
 - “This can be a difficult conversation and it is normal to feel scared or worried.”

Map out the patient's values and goals

- Determine what patients want for their medical care. For example, does the patient want a ventilator if one is available; do they want you to consider the needs of others first; or would

NOTE: This resource was published in 2020 and is not being maintained. While information contained within was current when published, it may be outdated, and some links may not work.

they reject one even if a ventilator was available and prefer a “natural death” with minimized pain and suffering?

- “Let’s talk about what’s most important to you now and for your medical care moving forward.”
- Be aware that some patients may hold strong religious beliefs about what sort of medical services they must (or must not) seek in end-of-life scenarios—be respectful and accommodating of such beliefs.

Align with the patient’s values and goals

- Summarize your understanding of what is important to the patient for the sake of clarity, without imposing outside values to interpret the patient’s wishes.
 - “It sounds like you want us to take any steps that we are able to in order to save your life, as long as we control your pain and there is a reasonable chance that the treatment will work.”

Propose a plan

- Based on the patient’s values and goals, develop a plan for the advance directive elements.
- Review any crisis standards of care or modifications to practice that may exist due to COVID-19 and advise the patient on how these may relate to their wishes as they have identified them (See the TRACIE Healthcare Emergency Preparedness Information Gateway [Crisis Standards of Care Topic Collection](#) for more information on Crisis Standards of Care).
- Each State has its own requirements for advance directives. The [American Bar Association](#)¹ provides links to State-specific advance directive forms.
- Go through the required documentation or form with the patient.
 - “Let’s talk about some of the specific elements of advance directives and what you want for each one.”
- As feasible within isolation and limited visitation policies, assist the patient with obtaining necessary witnesses and/or notarization, if required.
- Tell patients to share their plan with loved ones and with the person who they designate as their medical power of attorney so everyone has a shared understanding of the patient’s wishes if they can’t communicate.

Additional Resources

National Institute on Aging [Advance Care Planning-Healthcare Directives](#)

Vitaltalk’s [Address Goals of Care](#)¹ (smoothing discussions about prognosis and treatment)

Centers for Disease Control and Prevention (CDC) [Complete Care Plan](#) and [Care Plans for Older Adults and Caregivers](#)

Agency for Healthcare Research and Quality [Making Informed Consent an Informed Choice](#)

¹ This document contains links to non-federal websites. Linking to a non-federal website does not constitute an endorsement by the U.S. government, or any of its employees, of the information and/or products presented on that site.