



FOSTERING END OF LIFE CONVERSATIONS

## Your Conversation Starter Kit

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care.

We know that no guide and no single conversation can cover all the decisions that you and your family may face. What a conversation can do is provide a shared understanding of what matters most to you and your loved ones. This can make it easier to make decisions when the time comes.

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

Date of birth: \_\_\_\_\_

Today's date: \_\_\_\_\_

**the conversation project**



This Starter Kit doesn't answer every question, but it will help you get your thoughts together, and then have the conversation with your loved ones.

You can use it whether you are getting ready to tell someone else what you want, or you want to help someone else get ready to share their wishes.

Take your time. This kit is not meant to be completed in one sitting. It's meant to be completed as you need it, throughout many conversations.

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## Step 1: Get Ready

There are a million reasons to avoid having the conversation. But it's critically important. And you can do it.

### Consider the facts.

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**90%** of people say that talking with their loved ones about end-of-life care is important.

**27%** have actually done so.

Source: The Conversation Project National Survey (2013)

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**60%** of people say that making sure their family is not burdened by tough decisions is extremely important.

**56%** have not communicated their end-of life wishes.

Source: Survey of Californians by the California HealthCare Foundation (2012)

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**80%** of people say that if seriously ill, they would want to talk to their doctor about wishes for medical treatment toward the end of their life.

**7%** report having had this conversation with their doctor.

Source: Survey of Californians by the California HealthCare Foundation (2012)

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**82%** of people say it's important to put their wishes in writing.

**23%** have actually done it.

Source: Survey of Californians by the California HealthCare Foundation (2012)

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**One conversation can make all the difference.**

**Remember:**

- You don't need to have the conversation just yet. It's okay to just start thinking about it.
  - You can start out by writing a letter—to yourself, a loved one, or a friend.
  - You might consider having a practice conversation with a friend.
  - Having the conversation may reveal that you and your loved ones disagree. **That's okay.** It's important to simply know this, and to continue talking about it now—not during a medical crisis.
  - Having the conversation isn't just a one-time thing. It's the first in a series of conversations over time.
- 

**What do you need to think about or do before you feel ready to have the conversation?**

**Do you have any particular concerns that you want to be sure to talk about?**

(For example, making sure finances are in order; or making sure a particular family member is taken care of.)

## Step 2: Get Set

What's most important to you as you think about how you want to live at the end of your life? What do you value most?

Thinking about this will help you get ready to have the conversation.

### Now finish this sentence:

What matters to me at the end of life is...

Sharing your “what matters to me” statement with your loved ones could be a big help down the road. It could help them communicate to your doctor what abilities are most important to you—what’s worth pursuing treatment for, and what isn’t.

### Where I Stand Scales

Use the scales below to figure out how you want your end-of-life care to be. Select the number that best represents your feelings on the given scenario.

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#### As a patient, I'd like to know...

- 1                       2                       3                       4                       5
- Only the basics about my condition and my treatment                      All the details about my condition and my treatment

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#### As doctors treat me, I would like...

- 1                       2                       3                       4                       5
- My doctors to do what they think is best                      To have a say in every decision

---

#### If I had a terminal illness, I would prefer to...

- 1                       2                       3                       4                       5
- Not know how quickly it is progressing                      Know my doctor's best estimation for how long I have to live

**Look at your answers.**

What kind of role do you want to play in the decision-making process?

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**How long do you want to receive medical care?**

1

2

3

4

5

Indefinitely, no matter how uncomfortable treatments are

Quality of life is more important to me than quantity

---

**What are your concerns about treatment?**

1

2

3

4

5

I'm worried that I won't get enough care

I'm worried that I'll get overly aggressive care

---

**What are your preferences about where you want to be?**

1

2

3

4

5

I wouldn't mind spending my last days in a hospital

I want to spend my last days at home

---

**Look at your answers.**

What do you notice about the kind of care you want to receive?

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**How involved do you want your loved ones to be?**

1

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable

2

3

4

5

I want my loved ones to do what brings them peace, even if it goes against what I've said

---

**When it comes to your privacy...**

1

When the time comes, I want to be alone

2

3

4

5

I want to be surrounded by my loved ones

---

**When it comes to sharing information...**

1

I don't want my loved ones to know everything about my health

2

3

4

5

I am comfortable with those close to me knowing everything about my health

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**Look at your answers.**

What role do you want your loved ones to play? Do you think that your loved ones know what you want or do you think they have no idea?

**What do you feel are the three most important things that you want your friends, family and/or doctors to understand about your wishes for end-of-life care?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Step 3: Go

When you're ready to have the conversation, think about the basics.

**Mark all that apply:**

**Who** do you want to talk to?

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Mom            | <input type="checkbox"/> Sister/Brother                                     | <input type="checkbox"/> Doctor       |
| <input type="checkbox"/> Dad            | <input type="checkbox"/> Faith leader (Minister, Priest, Rabbi, Imam, etc.) | <input type="checkbox"/> Caregiver    |
| <input type="checkbox"/> Child/Children |   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Partner/Spouse | <input type="checkbox"/> Friend   |                                       |

**When** would be a good time to talk?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> The next big holiday          | <input type="checkbox"/> Before I get sick again                         | <input type="checkbox"/> At the next family gathering |
| <input type="checkbox"/> Before my kid goes to college | <input type="checkbox"/> Before the baby arrives                         | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Before my next trip           | <input type="checkbox"/> The next time I visit my parents/adult children |   |

**Where** would you feel comfortable talking?

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> At the kitchen table     | <input type="checkbox"/> On a walk              | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> At a favorite restaurant | <input type="checkbox"/> Sitting in a park      |                                       |
| <input type="checkbox"/> In the car               | <input type="checkbox"/> At my place of worship |                                       |

**What** do you want to be sure to say?

If you wrote down your three most important things at the end of Step 2, you can use those here.

## How to start

### *Here are some ways you could break the ice:*

- “I need your help with something.”
- “Remember how someone in the family died—was it a ‘good’ death or a ‘hard’ death? How will yours be different?”
- “I was thinking about what happened to \_\_\_\_\_, and it made me realize...”
- “Even though I’m okay right now, I’m worried that \_\_\_\_\_, and I want to be prepared.”
- “I need to think about the future. Will you help me?”
- “I just answered some questions about how I want the end of my life to be. I want you to see my answers. And I’m wondering what your answers would be.”

## What to talk about

- When you think about the last phase of your life, what’s most important to you? How would you like this phase to be?
- Do you have any particular concerns about your health? About the last phase of your life?
- What affairs do you need to get in order, or talk to your loved ones about?  
*(Personal finances, property, relationships)*
- Who do you want (or not want) to be involved in your care? Who would you like to make decisions on your behalf if you’re not able to? *(This person is your health care proxy.)*
- Would you prefer to be actively involved in decisions about your care? Or would you rather have your doctors do what they think is best?
- Are there any disagreements or family tensions that you’re concerned about?
- Are there important milestones you’d like to be there for, if possible?  
*(The birth of your grandchild, your 80th birthday)*

- Where do you want (or not want) to receive care? (*Home, nursing facility, hospital*)
- Are there kinds of treatment you would want (or not want)? (*Resuscitation if your heart stops, breathing machine, feeding tube*)
- When would it be okay to shift from a focus on curative care to a focus on comfort care alone?

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*This list doesn't cover everything you may need to think about, but it's a good place to start. Talk to your doctor or nurse if you're looking for more end-of-life care questions.*

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### **Remember:**

- Be patient. Some people may need a little more time to think.
- You don't have to steer the conversation; just let it happen.
- Don't judge. A "good" death means different things to different people.
- Nothing is set in stone. You and your loved ones can always change your minds as circumstances shift.
- Every attempt at the conversation is valuable.
- This is the first of many conversations—you don't have to cover everyone or everything right now.

### **Now, just go for it!**

Each conversation will empower you and your loved ones. You are getting ready to help each other live and die in a way that you choose.

## Step 4: Keep Going (A Colorado Resource)

### Congratulations!

Now that you have had the conversation, here are some legal and medical documents you should know about. Use them to record your wishes so they can be honored when the time comes.

**Advance Care Planning (ACP):** the process of thinking about your wishes—exactly what you have been working on here.

**Advance Directives (AD)** include the following:

**Medical Durable Power of Attorney (MDPOA):** The document in which you appoint a health care agent (decision-maker) and alternates (if the agent is not available). Your agent makes and communicates healthcare decisions for you if you cannot. If you are competent to speak for yourself, your spoken wishes will be honored. If you are not, your agent should make decisions according to his or her understanding of what your wishes and preferences would be. There is space on the form to document your wishes or you may make wishes known in some other way (a conversation). (THIS IS THE MOST IMPORTANT DOCUMENT TO COMPLETE.)

**Living Will (also referred to as Advance Directive for Surgical/Medical Treatment):** tells your doctors to stop or not start life-sustaining treatment if you are in a terminal condition and cannot make decisions for yourself or if you are in a persistent vegetative state (PVS). A Living Will goes into effect 48 hours after two doctors certify that you are terminal or in PVS.

**CPR Directive:** alerts emergency and health care personnel that you do not wish to have cardiopulmonary resuscitation in the event that your heart and/or lungs stop or malfunction. It must be signed by your physician and is usually reserved for people who are seriously, chronically or terminally ill.

**Medical Orders for Scope of Treatment (MOST):** converts your end-of-life wishes into actual medical orders, indicating interventions that you DO want, as well as interventions that you DO NOT want. It is primarily used for seriously, chronically or terminally ill persons and requires a health care provider signature. Treatments addressed include CPR, general scope of treatment, antibiotics and artificial nutrition and hydration. This document should be honored by medical providers across care settings.

**Note:** All of these documents are available at [www.ColoradoAdvanceDirectives.com](http://www.ColoradoAdvanceDirectives.com). While not necessary, you may choose to utilize legal counsel for completion of the MDPOA or the Living Will documents. The MOST and CPR Directives are available online but require health care provider consultation and signatures.

If you need help accessing these documents or support in beginning the conversation, contact us at [www.theconversationprojectinboulder.org](http://www.theconversationprojectinboulder.org).

Completion of the Starter Kit and conversations with family will help clarify your values before filling out these documents.

**Who do you want to talk to next time? Are there people who should hear things at the same time (like siblings who tend to disagree)?**

**How did this conversation make you feel? What do you want to remember? What do you want your loved ones to remember?**

**What do you want to make sure to ask or talk about next time?**

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**We hope you will share this Starter Kit with others.**

You have helped us get one conversation closer to our goal: that everyone's end-of-life wishes are expressed and respected.