

My Way Cards[®] for Natural Dying[®]

*Sort them now to obtain your personal
NATURAL DYING—LIVING WILL*

*...to let others know **EXACTLY** what
treatment you will, or will not want, if
you are too sick to speak for yourself.*

Plan Now, Die Later[®] to Live Longer

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Completing Your “Natural Dying Living Will” using “My Way Cards”

My Way Cards for Natural Dying®

These cards help make a **Living Will** to tell others what treatments you **DO** or do **NOT want** — if you become too ill to speak for yourself.

Two important examples:

→ **DO** you want total relief from pain and suffering as you die?

→ Do you **NOT** want to die very slowly after you reach the stage of Advanced Dementia?

A Living Will is a “gift” for your loved ones. They may feel **less grief** if they can feel **more certain** that they knew what you really wanted.



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This 12-condition DEMO has the complete Introduction

Begin the “Natural Dying Living Will”

– the Easy Way

What is a living will? Why do you need one?

Someday, you may have an illness from which you will die (a terminal illness). All illnesses cause clinical problems called **conditions**. Conditions can cause you and your family or others pain and suffering. As your illness progresses, you may lose your ability to speak for yourself. You will not be able to make sound (good) decisions. You will not be able to tell others that you are suffering. If so, you might live a long time as you and others suffer.

Living wills can help prevent unwanted prolonged dying with severe suffering. That is, if they work. Some living wills do a good job of **telling** others what you want, but fail when it comes to **getting** what you want. That takes some explaining. But first, what is a living will?

Living wills are medical documents. They also need to be legally verified by witnessing or notarizing your signing. Living wills let you make important treatment decisions for your future self—now—in case you are unable to decide when it's time to put your decisions into action. A common example: “If I have advanced cancer and then my heart or lungs stop working, DO NOT attempt to restart them.”

This instruction can save you physical trauma from breaking your ribs, when CPR is not likely to work.

Note how the instruction was worded: “If I reach **this condition**, then I do not want **that treatment**.”

Attorney Luis Kutner used this wording when he created living wills in 1969. It did not change until May, 2025. That's when Caring Advocates started asking this different question for each condition in its living will:

“If I reach **this condition**, this is how much **suffering** I would **judge** it would cause me and my loved ones.”

Each condition is on a card. It has a drawing and words. In the past, planning principals (people completing living wills) and counselors viewed and sorted real cards. Now, you can view cards on a computer.



This wording works because when Caring Advocates' computer program prints your living will, it replaces your "how much suffering" judgments with specific treatments that fit.

Why did we make this change? Because it is easier to judge suffering than to decide on a treatment. Medical treatments are complicated. All have various risks and benefits. They may be hard to understand. You have four choices for judging how much suffering, Here they are:

- **No or mild suffering**
- **Tolerable suffering** (meaning life is still good)
- **Severe suffering** (bad suffering until you die)
- **Exceedingly severe suffering** (very, very bad suffering from which you want relief soon)

This living will also asks you to judge how much your loved ones would suffer. Alzheimer's and other dementias can cause huge burdens to loved ones and caregivers.

Caregiving can cause family members to become physically exhausted, emotionally drained, and financially bankrupt.

But making good decisions is just the beginning of what is called Advance Care Planning (ACP).

To SUCCEED, your living will must help you persuade your future treating physician to write the medical orders you need. Your proxy/agent can help give consistent instructions. It can take a lot to convince physicians to comply (agree to go along). Before they write orders, physicians have a right to ask five questions: (A) What did you really want—for sure? (B) Why did you want it—so much? (C) Is it legal? (D) Is it ethical? And, (E) is it moral? This living will helps you answer these questions. That can make the difference between success and failure. In turn, that can determine whether you suffer for years or have a peaceful and timely dying, with minimal suffering to you and your loved ones.

In contrast, most living wills ask planning principals (the person completing the living will) to sign a document printed on paper after checking some boxes or writing some “Yeses” to indicate what they want.

Most living wills have no way to make sure the planning principal understood what they checked or signed. —A possible dealbreaker for patients who have a “little” dementia. Furthermore, pieces of paper cannot explain “Why” with passion.

This living will takes several times longer to complete than others. Why put in so much time, effort, and funds?

Because it **works**. Read on. As you complete your own living will, you’ll begin to understand how. Then, you can decide if the Natural Dying Living Will is for you.

Caring Advocates, a non-profit organization, has been developing the “Natural Dying Living Will” since 2006. Several significant were introduced in Sept. 2023. We recommend updating your living will if done before then.

How can you JUDGE suffering?

Judge how much suffering each condition would cause based on your lifelong personal values and treatment preferences.

Examples of lifelong personal values:

- “I do not want to experience severe pain most of the time.”
- “I do not want my illness to burden my family or society.”

Examples of treatment preferences:

- “I do not want to be connected to a machine until I die.”
- “I do not want to spend all the hours that I am awake getting medical tests and treatment.”

All living wills face six challenges

1. It's rarely easy to get other people to do what you want them to do.
2. It's harder, if you want them to do it in the future.
3. Harder still, if in the future, you no longer can speak for yourself to argue or explain why.
4. Harder still, if several professions are want to be heard. Examples include medicine, law, religion, philosophy, and bioethics.
5. Harder still, if you need to argue that common ways of thinking do not apply as you are dying. Examples: In the bible, Matthew 25 teaches to feed the hungry and give drink to the thirsty. For most of our lives, feeding is a way of loving. If you want to refuse assisted feeding, some will oppose (be against) this.

6. Harder still, if those in power insist on proof that your living will is legal, ethical, and moral in their opinion.

- Success is possible, but it can take much effort. Your advance care planning counselor can be your coach; for example, help you explain why you want what you want with passion.

This “Natural Dying Living Will” was written so most people could understand and use it. The words on all 50 conditions (cards) are easy to understand and the drawings show what people are feeling. This makes your task of judging suffering easier.

This Introduction starts out easy. But eventually, it must explain more complex things. Some people want help to understand later parts of the Introduction. Others will skip the harder parts and ask their counselor to explain.

Suppose living wills are new to you, you know few medical words, you're not much of a reader, and/or your mind is

not working as well as it used to because you are in early-stage dementia. Then, you can choose either one or both of these options:

1. You can skip ahead to the task where you judge the suffering of conditions. Double click when you see, “**click here (N).**” There are **3** of them, so you can also continue reading until you see the next “**click here (N).**” When you talk to your counselor, he or she can explain what you skipped—if and when you need to know it.
2. You can ask someone to help. This person should know you well. You should trust them. Your “helper” could be a member of your family or close friend. Ideally, it will be the person you named as your proxy/agent in your durable power of attorney for healthcare decisions.

Helpers must be comfortable with medical words and ideas. Their minds must work well. They should read the whole Introduction. They must try **not** to influence your decisions. This can happen even if don't mean to. They should listen to *your* values, *your* goals, and *your* wishes—not their own.

Before you begin, you (and your helper, if you have one) can view a 14-minute YouTube video. Part of it is about **hidden pain**. The rest shows what it is like to **live with advanced dementia**—for patients, family members, and caregivers. [Click here](#) to view it. If you have any questions, write them down. You can talk to your counselor about them in Step 2 →

Four Steps to complete your living will

Step 1: TO LEARN. In Step 1, you go through about **50 My Way Cards** on a computer one or more times—by yourself or with your helper. (You will meet your advance care planning counselor in Step 2.)

In Step 1, you **need not decide or judge anything**. You'll do this in Step 2. Just **learn** about the conditions. What clinical problems are common as life is ending? Or, after you live with dementia a long time? Also **learn** how this living will works.

During Step 1, **write down** the numbers of all conditions/cards you want to talk about with your advance care planning counselor. The numbers are 0.0, 1.1, 1.2, until 8.6. (Condition 9 is the 50th condition. It is more complicated. You can talk about “9” later.)

You can write down a condition's number for any reason.

The two most common reasons are:

- You want help to make sure you **understand** a condition.
- You want help to **judge** how much suffering a condition would cause.

Living with dementia a long time can cause suffering in ways that many people have not thought about before. Some ways of suffering may be new to you. They may even be new to physicians. So, they many are not in other living wills. But you will still suffer from them.

Here are some examples: your feelings that others cannot see, how much your loved ones are suffering, and your future suffering. The longer you live with dementia, the worse will the memories be that others will have for you.

Physicians are just now learning that many **more patients** suffer—and **suffer more**—than they had

thought before. Why does this make a big difference? If a living will does not ask about a type of suffering, but you later are suffering from it, it could take you longer to die as you suffering more. Also, suffering that can be felt but not seen. To summarize, living wills that omit types of suffering that are hard to observe can lead to much longer suffering. Dr. Stanley Terman has published articles on this topic. They are available upon request.

You now have the basics to start.

If you want, you can [click here \(1\)](#) to skip to Step 1 or Step 2 to read about the conditions or to **judge** the conditions with your counselor.

You can also continue reading and learning more.

(Note: if you are the patient's "helper," please continue reading this Introduction.)

What makes living wills successful?

Suppose your goal as your life ends is a peaceful and timely dying. Peaceful means causing you and your loved ones as little suffering as possible. To attain your plan, you are relying relies on your living will.

Then, your future physician must promptly write and implement (put into action) the medical orders that you need—based on what your living will says you want.

These orders will usually be written on a form called “**POLST**.” It was previously called, “Physician Orders for Life Sustaining Treatment.” (“Sustaining” means to let life go on.) **POLST** is the most powerful document to successfully attain your end-of-goals. The “**Natural Dying Living Will**” was written to work with “**Future POLSTs**.” You can complete POLSTs during advance care planning. Each of the 4 levels of suffering has its own Future POLST. See the Table on the next page
→**The next table shows this connection** →

How your judgment of suffering can someday lead to specific treatment

How much suffering would this condition cause you and your loved ones? →	Based on your judgment, you will get the treatment below: (POLST = physicians orders)
Exceedingly severe suffering Very, very bad suffering	MA-POLST = Moderate Anesthesia = put into a deep sleep so you don't feel suffering
Severe suffering Bad suffering until you die	ND-POLST = Natural Dying = No assisted feeding by mouth
Tolerable suffering Some suffering but life is still good	SLT-POLST = Selective/Limited Treatment = Only gentle treatment
No or mild suffering , but you will still die from your illness	CPRL-POLST = 1 last CPR, and then only gentle treatment

(Modified from Dr. Terman's slides from his 6/3/2025 Zoom presentation. They are available upon request.)

Step 2: Your initial judgments of suffering

In Step 2, you will go through about 50 conditions with your advance care planning counselor. You will judge how much suffering each condition would cause. **Your judgments must make sense.** They must also fit with each other. Your future physician must believe your judgments. Otherwise, your living will is likely to fail. Here's an example of judgments for two conditions of suffering that will **not** work with future physicians:

- (A) “I judge needing help to take a shower would cause me **mild** suffering.”
- (B) “I judge needing help to get dressed would cause me **severe** suffering.”

Decision (B) has two problems. First, it doesn't fit with decision (A). Second, your proxy/agent will not likely be able to persuade your future physician why needing help to get dressed would cause you severe suffering.

IMPORTANT: You may loathe (hate) the idea of needing another person (relative or caregiver) to feed and hydrate you as you live in an advanced stage of dementia. But if you judge every condition would cause severe suffering or exceedingly severe suffering, then future physicians may NOT consider your judgments CREDIBLE. They may view your judgments as “crying wolf.” Then, they may not write the orders you want when you reach a condition that *really* causes you severe or exceedingly severe suffering. You might be left suffering when you really need relief. So, do not judge suffering is severe if a condition still lets you enjoy living in some moments.

Physicians will rarely honor your autonomy (what you said you wanted) if their orders would cause you great harm. Possibly dying in two weeks is a great harm. This amount of harm does **not** fit the condition, “I need help to get dressed.”

So, make judgments about suffering that are consistent and credible (believable). Otherwise, you may **not** get what you want. Your effort in advance care planning might not succeed. At worst, you might suffer a very long time.

As you talk to your counselor, he or she will input your responses in the computer. After your talk, your counselor will send you a printout. This will be a PDF of your “Initial Natural Dying Living Will.” You can discuss the printout with your counselor in Step 3.

The next section is important, but hard to understand. Also ask your counselor to explain these points to you, especially if you click below to skip ahead after you read, “**7 points to keep in mind.**”

You can [CLICK HERE \(2\)](#) to go to Steps 1 and 2. Step 1 is reading the conditions by yourself, or with your helper. Step 2 is judging how much suffering conditions would cause. Do this with your counselor.

Keep these 7 points in mind in Step 2, as you judge, “How much suffering would each condition cause?”

1. You have a terminal illness that cannot be cured.
2. Your suffering cannot be treated. Reasonable treatments were tried, but failed to give you relief.
3. You lack decision-making capacity. Your disease caused you to lose DMC just when you most need to make a life-or-death decision. You cannot talk about, explain, or advocate for the treatment you want.
4. Rarely will physicians write orders that may allow you to die soon if you can still enjoy living or your suffering is tolerable to almost everyone . Do not think of other conditions or future possible worsening. Just judge your current suffering.

5. Consider each condition—as if it were the only condition. You can separately give your proxy/agent the power to “Decide Later.” Then, they can add up the suffering from several conditions. While each condition causes only tolerable suffering by itself—when combined with suffering from others, all cause severe suffering.

6. Demonstrate Diligent Deliberation in Decision-making (DDDD) is a fancy way to recall this goal: You must prove you appreciate different conditions cause different amounts of suffering. This makes make your responses credible. It makes it more likely that your future physician will write and implement the orders you need to fulfill your end-of-life goals.

6. Your task is to persuade your future physician to comply. So, when you record your interview in Step 4, do a good job of explaining why. Be Credible, Clear, Consistent, and Convincing (CCCC).

➔ Your advance care planning counselor can help!

Why brain diseases make it very hard for you to die how and when you want

It's hard to die from some terminal illnesses. For Alzheimer's, other dementias, and any disease that damages your brain, it is especially hard to die.

These diseases destroy your brain's ability to work. You cannot think clearly. Your judgment is not sound (good). You cannot clearly tell people what you want. Your mind will lose the ability to make treatment decisions. You will then lack what is called, "decision-making capacity" (**DMC**).

Worse, you can lose **DMC** several years before you die. Losing your ability to tell others that you are suffering can be extremely hard. That's because if others do not know you are suffering, you could suffer for years before you die.

Avoiding severe suffering after you lose **DMC** is one main reason to complete a living will.

You need an effective living will that covers all types of suffering. You also need added strategies (actions you put in place ahead of time to make your plan successful). Otherwise, it could take years for you to die while you are suffering. Even a decade.

Living wills may not succeed in two ways. A physician or other authority (such as a judge or an administrator at a nursing home) can promptly refuse to do what your living will says. That happened to Margaret Bentley, whose photograph you may view later. (See Condition 8.2.)

Second, conflicts can emerge that last a long time. This results in ***To Delay is To Deny***. During the delay, you will suffer just as much as if authorities had said, “No.”

Conflicts can last a lifetime. That is, until you die of another disease. Most common are infections, heart attacks and strokes. But they may not happen for years.

What diseases are challenging?

The **Natural Dying Living Will** is for any illness that can cause you to die. It is especially for brain illnesses. They **usually damage your mind**. Alzheimer's is the most common. Yet there are almost a dozen other types of dementias.

Other diseases can also cause your mind to lose its ability to make decisions. They include strokes, the persistent vegetative state, toxins from end-stage liver or kidney disease, and high doses of pain killers like morphine you may need someday to reduce pain from advanced cancer.

The Natural Dying Living Will was written to deal with all these and other challenging end-of-life situations.

Step 3. Connecting treatments with the amount of suffering you judged

Your counselor will print and show or email you, your “Initial Natural Dying Living Will.” It will show **one of four levels of treatment** based on the amount of suffering you judged. The computer program will have automatically printed corresponding treatments. You can talk about treatments for all conditions with your counselor. You can change any decision you want in your living will—if your mind can still make sound (good) treatment decisions.

Two of 4 treatments are not controversial

This living will does **not** offer the “Full treatment” choice, where physicians try everything to cure a disease. The living will is only for terminally ill patients. But it does offer treatment that tries to help patients feel better so they can enjoy life again.

It offers gentle treatments that are not burdensome; that is, not hard to go through. These treatments are not controversial. You will not be sent to a hospital's intensive care unit. You will not be connected to a machine to breathe for you. You won't have surgery to place a feeding tube into your stomach.

But you will get treatment like antibiotics, and extra oxygen and fluid—if you get pneumonia. The goal is for you to recover so you can enjoy life again.

There are two gentle treatments. They differ in only one way. One gives you a “last chance” CPR. Physicians will try to restart your heart and lungs. This treatment is named “**CPRL**.” If CPR works, then you will get Selective/Limited Treatment, which is named “**SLT**.” SLT is for patients whose “code status” is DNR. DNR means “Do Not Resuscitate.”

The other two types of treatments are controversial. Some may say, “No.”

The other two treatments are called, “treatments of last resort.” These treatments are only for severe or exceedingly severe suffering that cannot be relieved in other ways. They treat suffering that will likely last the rest of your life and not let you enjoy living. But in trying to reduce your suffering, you might die sooner **than if you did not receive this treatment.**

Both treatments are for patients who have “**no plug to pull.**” They do not need any devices, machines, or medications to live. There is no easy way to allow patients to die naturally—by just stopping them.

Two treatments are for **two kinds of patients.** They differ in one way: whether or not they can eat and drink without assistance from anyone, like a caregiver.

The two controversial treatments

One treatment of last resort is called **Natural Dying (ND)**. This treatment is for patients who need another person to put food and liquid in their mouth, their suffering is severe, and suffering will last until they die. It is **legal** to refuse assisted feeding and hydrating in advance. ND is a **peaceful** way to get relief from severe suffering.

Caring Advocates adds a second order to “Cease assisted feeding.” It is, “Always place food and fluid within the patient’s reach.” This makes it clear that you did not die by the active withholding of food and fluid. This could be viewed as euthanasia and it is **not** legal.

If food and fluid were available, what caused you to die?
Here are two possibilities:

One is that your brain could no longer recognize food and fluid. The second is that your brain could not send signals to your hands to put food and fluid into your mouth.

We may not learn which. But either reason let's you make this argument: you died of your underlying disease. This is what makes it possible to view the treatment Natural Dying (ND) as being **moral**. In turn, this can help convince people in power to accept Natural Dying.

Moderate Anesthesia (MA) works even if you can still eat and drink without assistance. MA stops your being aware of your suffering. You will be put into a very deep sleep. You will be unconscious. You may not wake up again before you die, and you may die sooner. You need to agree to let your physician wake you up after about 4 days. Then, your physician can ask you, "Has your rest let you regain your strength? If so, do you now want to continue living as an awake person?"

This question shows that the goal of treatment was to decrease your suffering—not to hasten your dying. This makes it possible to argue that MA can be viewed as **moral**.

Note: Moderate Anesthesia is more controversial than Natural Dying. So, if you judge a condition would cause exceedingly severe suffering (very, very severe suffering), but in the future, you **do** need help with feeding and hydrating, your physician can order Natural Dying instead of Moderate Anesthesia.

You can learn **more details** about these two treatments of last resort if you read on. But you can choose instead to [click here \(3\)](#). Then, you can skip to reading about and judging how much suffering about 50 conditions would cause.

More details about Natural Dying

What is *Natural Dying*? Is it really *peaceful*?

Natural Dying is when...

- 1) You refuse another's *ASSISTANCE* with hand-feeding and drinking;
- 2) Food & fluid are always *OFFERED*;
- 3) You refuse all high-tech medical treatment that tries to keep you alive;
- 4) You get all the Comfort Care you need—so you suffer as little as possible.

Dying is usually peaceful and ends within two weeks. Some people are surprised: a total fast is quite peaceful. Yet patients who can still talk say that they feel *more comfortable with less fluid*.



Important: Others ALWAYS place food and fluid in front of the patient and within his/her reach.

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If you CAN feed yourself...

You can *always* be OFFERED food & fluid. They can be placed in front of you. But if it is time for *Natural Dying*, then NO ONE will ASSIST you with oral feeding & drinking.

Will you be comfortable? Yes
Hunger is not a problem. Sprays, swabs & gels can relieve thirst.

Why choose *Natural Dying*?
To avoid a prolonged dying with more suffering and pain, especially if you cannot tell others that you hurt.

Can you be comfortable if **NO ONE HELPS** you with feeding & drinking?



Yes, the "Thirst Reducing Aid Kit" (TRAK) provides Comfort Care.

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Dr. Ganzini asked nurses about the quality of dying for *alert competent* hospice patients who refused all food and fluid. Nurses rated these patients as having a “good death.” On their scale, “9” was the best possible dying. The average rating of these patients was “8.” ^{ref.1}

Dr. Pasman observed patients with *Advanced Dementia*. If they got no, or almost no food and fluid, most died within 2 weeks—and they seemed to become more comfortable. ^{ref.2}



1. Ganzini L, Goy ER, Miller LL, Harvath TA, Jackson A, & Delorit MA. 2003. Nurses' experiences with hospice patients who refuse food and fluids to hasten death. *N Engl J Med.* 349(4): 359-365.

2. Pasman HR, Onwuteaka-Philipsen BD, Kingsman DM, Ooms ME, Ribbe MW, & van den Wal G. 2005. Discomfort in nursing home patients with severe dementia in whom artificial nutrition and hydration is forgone. *Arch Intern Med.* 165(15): 1729-1735.

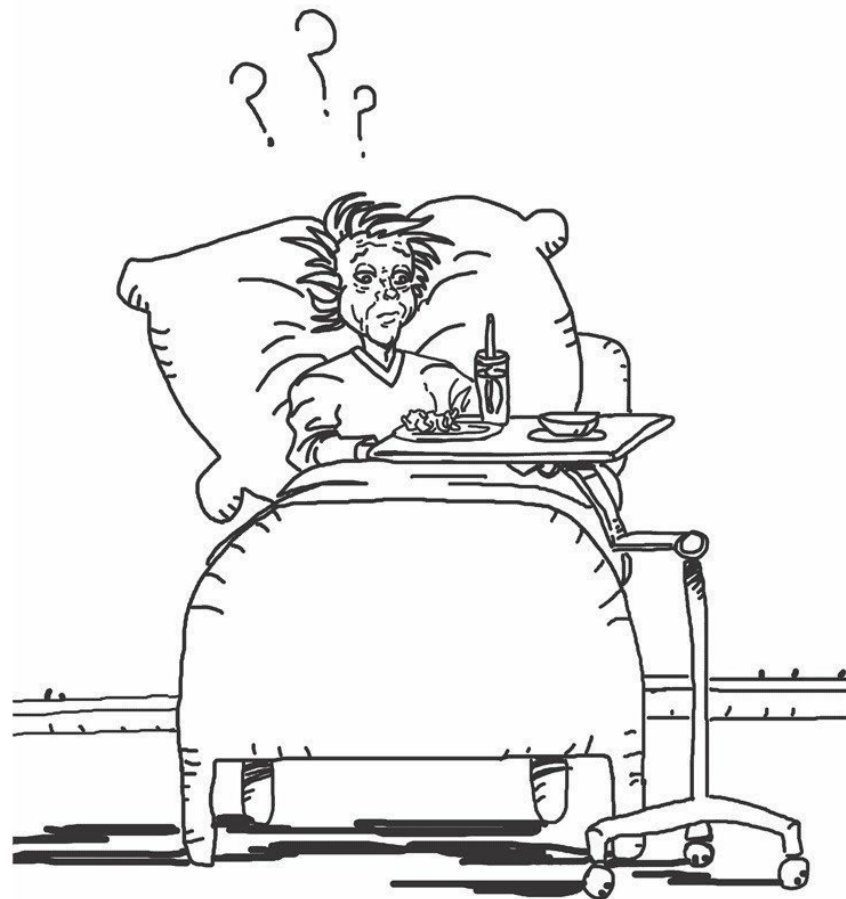
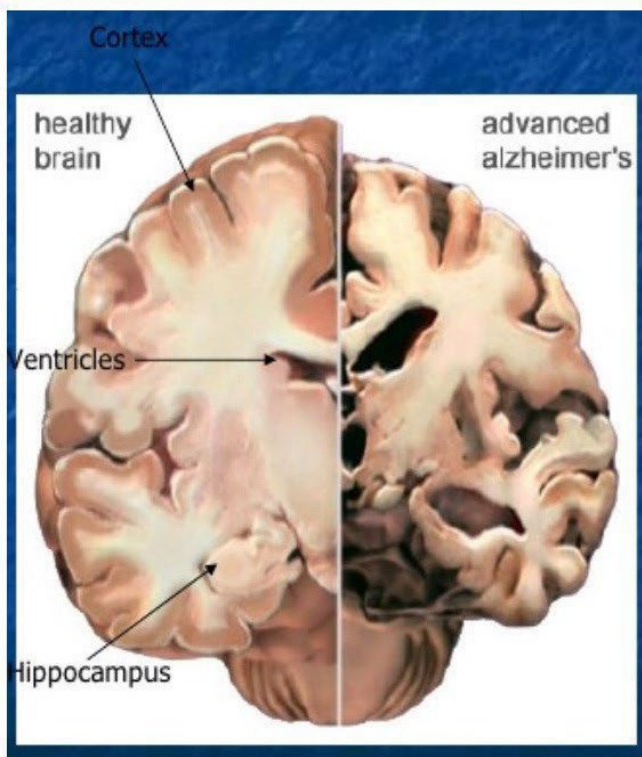
Natural Dying is surprisingly peaceful. Unlike starvation that only stops food but continues fluid, hunger is usually mild and can be easily treated.

Many dementia patients have a bad dying because their bodies cannot absorb the food that others put in their mouths. So, they slowly starve to death. (See for example, the tragic photo of Margaret Bentley that illustrates Condition 8.2.)

Many people think continued attempt to feed a patient that is not helping them is a terrible idea. Many patients want to make sure that does not happen to them.

To receive Natural Dying, you must have irreversible brain damage and be suffering

A brain disease can cause irreversible impairment of brain functioning that is so severe that patients no longer can put food and fluid into their mouth without another's help.



An explanation of Natural Dying in words for physicians and providers:

Treatment Options	Brief Description
<p>Natural Dying (ND-POLST): Indicated for patients whose suffering is refractory to treatment, if they need assistance with feeding and hydrating. They die of their underlying disease since food and fluid are placed within their reach, but their brains either cannot recognize them as food and fluid, or cannot direct their hands to put the food and fluid in their mouth.</p>	<p>Provide all needed comfort care including medications and treatments to reduce dryness especially to the mouth—with minimal fluid so that dying is not prolonged + DNR + Comfort-Focused Treatment</p>
<p>The goal/benefit/purpose of ND: To prevent unwanted, prolonged, severe suffering from any terminal illness.</p>	

The second type of patient can still eat and drink without others' assistance.

Moderate Anesthesia might be necessary if you do **not** need any assistance to eat and drink—but you still experience exceedingly severe suffering.

Until the 2023 revision of the Natural Dying Living Will, this type of patient had been mostly ignored. They were trapped in a terrible situation. They could not complain and let others know they were suffering. Even if they did, no treatment was widely accepted.

Caring Advocates describes them as living in the "Dementia Gap." Dr. Terman estimates over a half-million Americans now live in the Dementia Gap. Over a dozen new living wills were written for patients living with dementia in the last decade. But **none** can help reduce their suffering as long as they can still eat and drink without assistance.

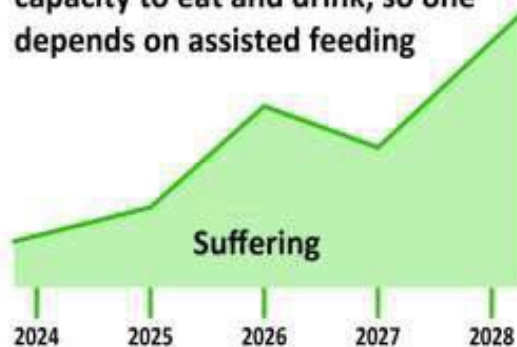
The “Dementia Gap” is a period of time. It **begins** after patients lose decision-making capacity so they no longer can legally decide to die by Voluntarily Stopping Eating and Drinking (often called **VSED**).

The period of time patients spend in the Dementia Gap will **end** when they lose their ability to self-feed and self-drink. At that point, they will qualify for Natural Dying.



The Dementia Gap

The time between having sufficient capacity to Voluntarily Stop Eating and Drinking (VSED)... and losing capacity to eat and drink, so one depends on assisted feeding



There is no way to predict how long a patient will live in the Dementia Gap.

Yet Caring Advocates has experience with helping patients who likely would have lived a few years while their suffering was exceedingly severe.

The Natural Dying Living Will is part of the Strategic Advance Care Planning protocol that tries to prevent the nightmare of suffering a long time as patients live in the Dementia Gap.

Dr. had been working on this living will for almost two decades before he realized he needed to revise it so it could overcome two kinds of challenges: Some patients may suffer a lot but their suffering is hard or impossible to observe. Other patients are living in the Dementia Gap from which there was no widely agreed upon exit strategy. Of course, some patients who live in the Dementia Gap have suffering that's hard to observe.

More details about Moderate Anesthesia

Moderate Anesthesia (MA) to Unconsciousness is a new term. It can be implemented only if: (A) patients' suffering is exceedingly severe, (B) no less-sedating way can relieve patients' suffering, and either (C) patients can eat and drink without assistance, or (D) it is urgent to treat their exceedingly severe suffering.

When physicians start MA, they will usually prescribe just enough sedating medication to calm the patient down. They try not to make them unconsciousness. They hope psychiatric and other symptoms or behaviors can be reduced with low doses of medication. But if this is not possible, deeper anesthesia is needed so patients are not aware of suffering—or anything else. Patients may never wake up before they die, and they may die sooner. Patients must sign a consent form to show they understood these two risks. Then, MA can be their future possible treatment.

To receive Moderate Anesthesia, you must have irreversible brain damage and your suffering must be either exceedingly severe or be severe and urgent to treat.

[6.6]

My decisions for “MA” means I CONSENT to be put into a deep sleep (moderate anesthesia) as the treatment of last resort — if no less-sedating treatment can relieve my exceedingly severe suffering — even though I might not wake up until I die.



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An explanation of Moderate Anesthesia in words for physicians and providers:

Treatment Options	Brief Description
<p>Moderate Anesthesia (MA-POLST): Indicated if exceedingly severe suffering is refractory to all non-sedating treatments and achieving relief is urgent, or if patients can still eat and drink without assistance</p>	<p>Use sedating medications to directly reduce the source of suffering if possible; if not, reduce consciousness so patient is unaware of (dissociates from) suffering + DNR + Comfort-Focused Treatment</p>
<p>The goal/benefit/purpose of MA: To prevent unwanted, prolonged, exceedingly severe suffering from any terminal illness.</p>	

Step 3: Review Your JUDGMENTS

You may have heard the expression, “Put a cap on it.” It means you’ve finished something well. That’s why Step 3 is called your “**Deliberative Capstone Review**.” (“Deliberative” means you thought about it deeply.)

In Step 3, you and your advance care planning counselor review the printout of your Natural Dying Living Will from Step 2. As already mentioned, this document does **not** print your **judgments** about suffering. Instead, it prints the corresponding **treatments**. These treatments will determine your fate.

Step 3 has this goal: to make sure you feel confident that your living will says exactly what type of treatment you want for each condition.

The next printout will be named, your “Final Natural Dying Living Will.” (Don’t worry about the word, “final.” You can change your mind about any treatment for any condition if you still have decision-making capacity.)

Just in case you need a reminder, here again is the table that connects “how much suffering” with different treatments in the Strategic Advance Care Planning protocol:

The Judged Intensity of Suffering that a Condition Would Cause Determines →	Which Treatment the SACP Protocol Prints in Your “Natural Dying Living Will”
Exceedingly severe suffering	MA-POLST (Moderate Anesthesia)
Severe suffering	ND-POLST (Natural Dying)
Tolerable suffering	SLT-POLST (Selective/Limited)
No or mild suffering but terminally ill	CPRL-POLST (1 last CPR, then SLT)

Step 4: Record your living will on video

Your advance care planning counselor will interview you. He or she will also record the interview on video.

This interview can legally prove the treatment you want. It has authority since viewers can see your face and hear your voice. Your counselor may have recorded his or her professional opinion about your decision-making capacity.

The interview will be based on your “Final Natural Dying Living Will” from Step 3. You will be asked to “**Read, Describe, Decide, Explain**” for each condition:

First, you **READ** the words.

Next, you **DESCRIBE** what is going on in the drawing—including how the people are feeling.

Then, you **DECIDE** what treatment you want. This was printed to match the suffering you **JUDGED**.

Finally, and very importantly, you **EXPLAIN** why.

EXPLAIN why the condition would cause the amount of **suffering** that you judged. Or you why you want this **treatment**. Give your best EXPLANATION, so your efforts at advance care planning can SUCCEED.

Choose words to persuade your future physician to write and implement the orders you need. Your words may be printed for your counselor or physician to review.

The video of the interview also allows other physicians and providers to later evaluate how well your brain was working as you were interviewed.

Two examples of important questions to answer:

“Did you have decision-making capacity?” And,

“Were you very depressed?”

If you lacked DMC or were very depressed, others could question whether oral testimony was valid (true). If others do not believe what you said, your living will could fail.

Optional Recap: How to your advance care planning success by following the protocol, and trying hard during the interview

In order for your proxy/agent to persuade your future treating physician to implement the clinically appropriate POLST, you must DEMONSTRATE that you DILIGENTLY made a DELIBERATIVE advance treatment DECISION (judgment) about how much suffering each of about 50 conditions would cause. (This is the “DDDD” strategic approach.)

When you record a video of your living will interview, you should try to be CREDIBLE, CLEAR, CONSISTENT, and CONVINCING. Then, your future treating physician will be likely to implement the orders you need to fulfill your end-of-life goals. (This is the “CCCC” interview approach.)

(Optional reading) To explain the rationale about this narrative style to sophisticated patients

This Introduction to the patient decision aid “**My Way Cards**” strives to explain complex medical, legal, and ethical concepts and still reach patients whose comprehension is less than grade 5. The words that describe the conditions are written at grade 3. Conditions are the most important part of your living will. You want to express your own judgments and decisions—with no influence by others’ explanations. Some helpers may tell you what they think is best without meaning to.

Why the goal is to reach as many people as possible:

Living wills have been long criticized for not being accessible to the very patients for whom they are intended; for example, patients who delayed

completing their living will until they experienced some impairment in cognition due to early dementia.

But advance care planning is too important to be accessible only to those with higher education and high-level healthcare literacy. A second form just for such individuals could be more succinct. But the goal was to write a living will that **all** patients can understand. Screening patients as a preliminary step to selecting one of two patient forms seemed impractical. For example, the same patient might want to revise their Natural Dying Living Will after they have had some cognitive decline but still have decision-making capacity.

To conduct meaningful research (such as to evaluate the effectiveness of the patient decision aid, My Way Cards), identical questionnaires must be given to all participants. Standardization helps ensure data collection is valid so that reliable comparisons can then be made across populations with varying characteristics.

Some early-stage dementia patients may fear completing a form they do not understand, but could determine their fate. Writing simple explanations may reduce their feeling intimidated and overcome their fear-based avoidance of completing a living will. If so, the neediest sub-population can be well served.

The format of 50 conditions, each of which asks the same key question, is a systematic approach to advance care planning that has been under development and testing since 2006.

Caring Advocates therefore asks for your patience with the simple wording and occasional definitions. Please recognize the importance of helping and gathering research data from patients who are less sophisticated, or whose diagnoses have already affected their cognition.

This is the page where “click here” lands. You can now begin the main task to complete your living will on the next page →

You can first go through the conditions by yourself (or with your “helper”) as you write down which conditions you want to talk about with your counselor. If so, you will be taking Step 1 for your first time through.

If you wish, you can get help from your counselor right away. Then you (and your “helper,” if you have one) may start talking with your counselor about how much suffering each condition would cause.

This will be Step 2. (You will have skipped Step 1.) Either way, you will now start reading about the conditions/cards →

I cannot eat in the usual way. I forget to swallow so food stays in my mouth. Helpers place very soft food at the back of my tongue—so that I SWALLOW by REFLEX. This is forced-feeding. [8.3]



o
a

10. For Condition 8.3, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

No longer can I understand, discuss, or add to what I did in my life—in my job or profession or hobby, or as a spouse, parent, or grandparent.

[1.2]



11. For Condition 1.2, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

I cannot remember my basic values, or my life's goals, or what I felt was important for my life to be good. [1.4]



Ca

12. For Condition 1.4, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

The way I act shows that I forgot my life-long ideals. If I could see my future actions *now*, I would feel shame and I'd feel sorry since my actions would hurt my husband or my wife, and others, like children. [1.5]



Ca

13. For Condition 1.5, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

**I cannot make
sounds or move
parts of my body
so others are
really sure I
mean “Yes” or
“No.” [2.2]**



Ca

14. For Condition 2.2, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

I very often have severe pain. But I cannot say what bothers me.

Doctors don't see my pain. They do not treat my pain.
[2.6]

Ca



15. For Condition 2.6, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

When I see my close family members or best friends, I do not know who they are. I cannot enjoy them. I do not respond. I just sit there. [3.2]



o
a

17. For Condition 3.2, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

**When I see my
close family
members or best
friends, I do not
know who they
are. Yet I can
still do things
with them. I can
still enjoy them.**

[3.3]



18. For Condition 3.3, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

I fear something horrible will happen to me. I see things or hear things.

I may know that what I see or hear is *not real*—but still, I feel very scared. [5.4]



o
a

19. For Condition 5.4, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

So I do not hurt others or myself, doctors must give me a lot of medicine. This way, they will not need to tie me down. Otherwise if I get angry, I may hit people — even loved ones and others who are nice to me. [5.6]



o
a

20. For Condition 5.6, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

**Helpers try hard
to feed me and
use many skills.
But they cannot
get enough food
in me.**

**I am very thin.
I will starve to
death—slowly.
[8.2]**



21. WARNING. Next is a horrific photo of Margaret Bentley, after five years of force-feeding that you can skip, if you wish.

- I am willing to view this photo
- I want to skip viewing the photo



22. For Condition 8.2, how much suffering do you judge it would cause you and those you care about? (For now, consider it as the only condition you're in.)

- No or Mild Suffering Tolerable Suffering Severe Suffering
 Exceedingly Severe Suffering Not Applicable or Don't Know

This living will lets you indicate how strictly you want others to follow your requests --if you reach a condition for which you decided you want Natural Dying.

The most popular choice is illustrated below.

Other choices are:

- A) Let my physician decide.**
- B) Let my proxy/agent decide.**
- C) Let my "future demented self" decide.**

My Choice "D"

Let my **PAST SELF's LIVING WILL** decide if others' help with hand-feeding and hand-hydrating should **STOP**—if I reach a condition I judged would cause "severe enough suffering"—even if my "future demented self"* clearly asks for help to **CONTINUE**.

Example reason: I do not want my dying to take a long time and risk more pain and other types of suffering.

o
a



*or terminally ill, incapacitated self

The full program includes detailed description of the four My Choice Cards.

Each Choice was reviewed to make sure its reflection was correct.

Thaddeus Mason Pope, JD, PhD, agreed “My Choice D” is the best choice. He is Professor of Law and Director of the Health Law Institute at Mitchell Hamline School of Law. He works to improve medical decision making and protect patients' end-of-life rights.

Karl E. Steinberg, MD, CMD, who was past chair of Public Policy, is current VP, and will be President of The Society for Post-Acute and Long-Term Care Medicine, considered the statement choosing your treating physician as accurately reflecting The Society's recommended policy, which resulted from their adopting Resolution A19 in 2019.

Professor Emeritus Guy Micco, MD, wrote the statement choosing your proxy/agent, which is the choice that he prefers. Dr. Micco is the former Director of Academic Geriatric Resource Center and former Co-Director of the Joint Program for the Medical Humanities, both at University of California, Berkeley.

Professor Ladislav Volicer, MD, wrote the statement for his choice, which is to let the advanced dementia patient decide. Dr. Volicer is at the School of Aging Studies, University of South Florida. He is the former Director of Geriatric Research

and Education, E.N. Rogers Memorial Veterans Hospital, Bedford, Mass. His leadership in the area, palliative care for dementia, began three decades ago.

In contrast to this DEMO, the full program lets you... Judge **50** conditions instead of 12. They include brain diseases such as: strokes, locked-in state, Lou Gehrig's disease, brain cancer, and the Persistent Vegetative State. It also covers serious medical illness such as those that cause severe pain, and those for which treatment no longer provides much, if any benefit. (Note that this "Natural Dying Living Will" can be used as a **complete** living will. It is **not** an add-on to a traditional living will.)

The full living wills **strategically warns** your future treating physicians about **three legal risks** if they fail to write orders that comply with your known wishes.

You will receive a **printout** of your Natural Dying Living Will judgments and treatments in two formats. One makes it **easy to compare** your past and future decisions (to check or prove consistency). A clinician can follow this sequence during your video-recorded interview.

The other format is a **logical set of instructions** that makes it easy for your future physician to honor your wishes by implementing the appropriate "**Future POLST**."

The full "**Strategic Advance Care Planning**" protocol goes beyond being clear and specific about "when," and requesting a "what" that is both effective and acceptable.

The full protocol adds a **Bilateral durable power of attorney for health care decisions** that facilitates your making certain decisions irrevocable to prevent others-- including your "future demented self," from sabotaging your

goals.

The full program also adds another document that recommends specific strategies for about a dozen common challenges. It is called the **Natural Dying Agreement**. Examples of these challenges are listed next.

Finally, your current physician/provider and you need to discuss and sign a series of "Future POLSTs" that can be implemented when your "**Patient Decision Committee**" agrees to authorize your proxy/agent to request your future physician/provider to ask for a "shared decision-making" conference with your future treating physician/provider, based on a new POLST having become clinically appropriate due to your meeting qualifying conditions.

Examples of challenges for which strategies are available:

1. You fear one or more relatives might try to influence your physician not to honor your end-of-life wishes based on their different (perhaps religious) beliefs.
2. Your “now-self” cannot talk, but can still grunt and point to the food and fluid placed nearby to indicate the wish for spoon-feeding to continue... But you have reached a condition that your “then-self” indicated you want spoon-feeding to stop. How do you want this conflict resolved?
3. A third party points out that you open your mouth without resistance, and argues: Continue spoon-feeding since your (apparent) willingness means you changed your mind.
4. A third party claims it is illegal or immoral to stop spoon-feeding since it is “basic care,” not “medical treatment.”
5. Your currently active proxy/agent does not effectively advocate for your end-of-life wishes. But going to court to replace him/her can take a long time and cost a lot of money.
6. You need medications to prevent you from hurting yourself or others, or to obtain relief from mental anguish. But your physician must wait until a competent person signs a consent form. You need a way to expedite receiving medications.
7. You want to live where you are, until you die. But facility administrators ask you to move out after they learn your living will requests oral feeding to stop.
8. Your doctor recently signed a POLST, but it conflicts with

your Natural Dying Living Will, whose previous instructions you still want.

9. You want relief from all types of unbearable pain and suffering. But your physician fears criticism for committing “slow euthanasia,” or for responding to existential suffering by Moderate Anesthesia.

10. A third party petitions you in court and asks the judge not to admit your living will and other forms into evidence.

11. A third party believes withdrawing spoon-feeding is elder abuse and requests an investigation, which could prolong your dying and suffering.

12. Your physician, or your facility refuses to honor your living will and states it is against medical advice for your proxy/agent or loved ones to take you home.

13. The legal department of the facility where you reside points out that your state’s laws, or the regulations of Medicare or another organization requires them to always offer you food and fluid.

14. A prominent national organization (such as the Society for Post-Acute and Long-Term Care Medicine) recommends disregarding patient's living wills as policy such as: Continue “Comfort Feeding Only” until the advanced dementia patient exhibits “refusal” or “distress”—even for patients whose living wills clearly refuse hand-feeding / hand-hydrating for their current condition.

Available upon request:

My Way Cards for Now Care Planning

so dying can be peaceful and timely for Advanced
Dementia and other terminally ill patients who
have lost capacity and lack effective Living Wills

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Psychiatrist and Bioethicist

Medical Director of Caring Advocates

Life Transitions Psychiatrist

Psychiatric Alternatives and Wellness Center



About the Patient Decision Aid, “My Way Cards”

About the author: Stanley A. Terman, Ph.D., M.D., is a board-certified psychiatrist and bioethicist; author of four books and several articles on end-of-life issues. Formerly on the U. C. Irvine faculty, he is currently medical director of Caring Advocates (non-profit) and Institute for Strategic Change/Effective Living Wills for Dementia, Etc. in San Francisco. He is also a life transition psychiatrist at Psychiatric Alternatives and Wellness Center, in San Francisco and Sausalito.

Development: Dr. Terman obtained and integrated valuable input from: clinicians (including Ladislav Volicer, Karl Steinberg, Guy Micco); bioethicists (including the late Ronald B. Miller, Ronald Koons); healthcare attorneys (including Thaddeus Mason Pope, Michael S. Evans); religious leaders/ethicists (including Ronald Hamel, Kevin McGovern, Moshe Levin); many patients (including Michael Ellenbogen); also geriatricians, estate planning attorneys, medical ethicists; William Young, illustrator.

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Conflict of Interest Statement: There is no right or wrong decision for any condition. The decisions that patients/principals or that their surrogate decision-makers make are not likely to have any influence on increasing sales of this patient decision aid.

Protection of Intellectual Property: The material herein is protected by copyrights, trademarks, and patent pending applications. Contact Dr. Terman for further information.

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This DEMO: MY-WAY-CARDS-DEMO