Much has been said recently about advance medical directives, including living wills and health care proxies. Opponents of health care reform have used inflammatory rhetoric—death panels, care rationing, euthanasia—as a political maneuver to frighten people, particularly Medicare beneficiaries, by misrepresenting the facts. But in all the raucous town hall debates and incendiary statements circulated on the Internet, one critical fact is overlooked: Not getting enough time to talk with the doctor is the number-one concern of patients with advanced illness, and their families.

Research shows that people with serious illness want to talk to their doctors to ensure that their goals, values, and hopes will be primary considerations when difficult decisions must be made, when or if they are no longer able to speak for themselves. Research also shows that patients expect doctors to initiate these discussions, and as such, they are reluctant to raise these issues themselves, worrying that their doctor would not have time to respond—especially to their emotional needs.

Doctors indeed face immense time pressures, and operate in a system that does not reimburse or reward discussions with patients. Medicare and other insurers pay doctors well for procedures such as X-rays, chemotherapy, and surgery, but little or no compensation is provided for talking with patients.

Despite these obstacles, many medical professionals consider advance care planning to be as routine as annual flu shots and regular cholesterol checks. Doctors and patients dedicate time to share information and translate medical facts and patient wishes into a care plan that can, and does, change over time as doctors and their patients reconsider the options.

It is most important to document whom the patient would trust to help make medical decisions if the patient were no longer able to make his or her own decisions. It is also helpful to decide what kind of treatment a patient would want if he or she were facing a serious illness that could result in permanent communication loss.

In contemplating such situations, some patients say they would want care focused strictly on their comfort, but others want everything possible done to prolong life, no matter what its quality. Desires like these are recorded in the medical chart to guide designated family decision makers and doctors, if and when the need arises.

Discussions about advance care directives should be revisited periodically throughout a long-term illness because in truth, doctors generally cannot accurately predict prognosis until only a few weeks before death. Patients also change their minds, and new treatments become available. This is why regular conversations about hopes, worries, questions, and goals for medical care should be central to all doctor-patient relationships, no matter the patient’s age, medical condition, or prognosis. Such discussions are never mandatory, but the vast majority of patients welcome them and are relieved to have an opportunity to air concerns and goals with their doctor.

Conversations about treatment options and patients’ goals and wishes are a small but important step toward restoring power and control over medical decisions to their rightful owners: patients and their families.

Diane E. Meier, M.D., is Director of the Center to Advance Palliative Care at The Mount Sinai Medical Center. In 2008 she was named a MacArthur Fellow.