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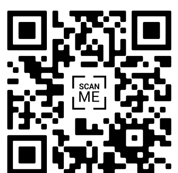
Advance care planning

Recommendation	Useful phrases (where applicable)
• Describe simply and clearly what advance care planning is. Give a rationale for why having these conversations can be helpful for families and the health care team. • Explain the mechanisms available for advance care planning within the patient's state or jurisdiction.	*"Have you thought about the type of medical care you would like to have if you ever became too sick to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even when communication may be impossible."*[1] *"Do you know who would make decisions about your medical treatment if you were unable to make them for yourself? Is this the right person?" "Have you spoken to the person who will make decisions for you? Would you like to include them in these discussions, so they know what is happening and what might happen in future?"* *"Some people have thought about what they want and document their wishes in what is called an advance care directive. Do you have an advance care directive? Would you like to complete one? I could get you some more information if you like, or refer you to someone who could explore this further with you."* *"It's often easier to talk through tough decisions when there isn't a crisis."* [2] *"Have you talked to anyone about your wishes, if you become too unwell to make decisions for yourself, about potentially life prolonging treatment? Have you talked to your family or general medical practitioner about what you want?"*
• Involve the potential proxy decision maker in the discussions and planning so that he or she understands the patient's wishes.	*"Sometimes people with your type of illness lose the ability to make decisions [or communicate their wishes] as the illness progresses. Who would make decisions for you if you were unable to do this for yourself?"* If the person can identify a substitute decision maker: *"Would you like to talk this through with them?" "Would you like me to assist you with this?"*

1. Emanuel LL, von Gunten CF, Ferris FD, editors. Advance care planning. In: The Education for Physicians on End-of-life Care (EPEC) curriculum. Chicago: The Robert Wood Johnson Foundation, 1999.
2. Roter DL, Larson S, Fischer GS, et al. Experts practice what they preach: a descriptive study of best and normative practices in end-of-life discussions. Arch Intern Med 2000; 160: 3477-3485.

Clayton JM, Hancock KM, Butow PN, et al. Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. Med J Aust 2007; 286(12): S79-S108. © Copyright 2007 The Medical Journal of Australia – reproduced with permission.



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Flinders University

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Recommendation	Useful phrases (where applicable)

• Develop an understanding of the patient's values and help him or her to work out goals and priorities related to his or her remaining life and treatment of the illness, and document the patient's preferences.
• Consider using clinical scenarios to structure the discussion.
• Document specific details such as timing or circumstances in which to cease blood tests, antibiotics, deactivation of implantable defibrillators, no attempt at cardiopulmonary resuscitation. Consider making reference to one of four potential levels of care, depending on the patient's condition at the time:
  o Comfort care only
  o Limited care (includes comfort care): use of antibiotics and intravenous medications where appropriate, but no surgery or other more invasive measures
  o Surgical care: surgery and palliative chemotherapy where appropriate, but no ventilation or resuscitation except during and after surgery
  o Surgical care: surgery and palliative chemotherapy where appropriate, but no ventilation or resuscitation except during and after surgery
  o Intensive care: includes all possible treatments, including invasive measures, to maintain life (it may not be appropriate to offer this level of care for this patient population).
	"Each person has personal goals and values that influence their decision when discussing advance care planning. I would like to find out your goals regarding your health and your health care and the things you most value in life. For some people, the goal may be to prolong life; for others, relief of suffering, optimizing quality of life; and for others, a comfortable and peaceful death.
	I suggest we go through examples of possible situations that may arise to help you decide your goals of care."

• Emphasise that advance care planning is an ongoing process that will need to be reviewed and updated periodically, as the patient's wishes may change over time, particularly with major health changes.	*"These are discussions we may need to revisit if there arechanges in the course of your illness."*
• Ensure that other health care professionals who are involved with the patient's care are aware of the patient's wishes. If an advance directive is completed, make sure its existence is known by all treating health care professionals and it is available when the patient's place of care is being changed (eg, from home or nursing home to hospital, during ambulance transfers).	

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