# *Looking Ahead, Acting Now:* Advance Care Planning

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Advance care planning (ACP) usually happens with the assistance of a physician who has an interest in end-of-life care. It is a process that develops over time, and is influenced by changes in life circumstances.

ACP may lead to the preparation of a document known as an Advance Directive (AD), which generally incorporates two elements:

- an instructional directive (Living Will), which provides specific instructions to be followed for various scenarios; and
- a proxy directive, which indicates the person(s) given the responsibility of instructing health-care providers about interventions to be provided for, or withheld from, the individual following loss of ability to communicate.

There are no national or international standards for the preparation and implementation of advance directives. The CMA, nonetheless, directs physicians to assist patients in formulating ADs on request, and to follow them, "unless there are reasonable grounds to suppose that it no longer represents the wishes of the patient or that the patient's understanding was incomplete at the time the directive was prepared."[1]

## Talking to Claire

Claire, 62, attends the office for her annual exam. She has well-controlled hypertension, and is otherwise healthy.

Her mother has advanced Alzheimer's disease and has lived in a long-term care institution for many years. You ask her if she is interested in discussing ACP. She expresses a strong interest, stating she fears loss of control if she becomes incapacitated, like her mother.

You offer her a brochure about ACP and invite her to return with her husband in two weeks to consider her situation.

## *What are the benefits of ACP?*

ACP has the potential to extend medical treatment preferences into the future. Table 1 outlines benefits of ACP.

A demonstration of ACP-derived benefits has been elusive in research done to date.[2] One study provides evidence that

## Speaking with George

You are providing care in the hospital for George, 51, who has metastatic malignant melanoma with a bowel obstruction.

The nurses are asking about a "DNR" order. You set aside 20 minutes and ask the patient what he knows about his condition. He knows he is dying and expresses a wish for no resuscitation in the event of cardiac arrest, but is willing to accept blood transfusions, intravenous fluids, TPN, and intravenous antibiotics in the event of a pneumonia.

You discover that he has four siblings, but is particularly close to one of them. He has not designated anyone as his attorney for personal care and in fact, has avoided discussing his illness with his family.

He gratefully accepts your offer to discuss his medical situation with his brother, who is also pleased to have more information about what is happening. Appropriate orders and a summary of the discussions are written in the chart.

***Although physicians are often reluctant to initiate ACP discussions, many patients expect them to.***

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advance directives completed with the assistance of family physicians influence end-of-life treatment decisions, and result in less aggressive treatment prior to death.[3] Another study documented a significant reduction in cost of care of inpatients who had documented advance directives.[4]

## *Can ACP do any harm?*

Physicians are generally reluctant to engage in ACP discussions, often out of concern that a discussion of this nature could harm the patient-physician relationship. This concern is understandable, considering the discomfort that most of us have with facing our own mortality. But, in reality, the opposite is true—most patients are interested in ACP and indicate the patient-physician relationship is enhanced through this dialogue.[5] Physician reluctance to initiate ACP discussion is the largest barrier.[6]

Clearly, patients cannot be coerced into ACP. However, most will welcome the opportunity to participate in a frank and open discussion of these issues with their physician.

One downside to ACP is it requires time to do well, and a sloppy AD could potentially increase confusion instead of providing clarity during crucial decision-making.

## *How can I incorporate ACP?*

The actual process of ACP is completely context-sensitive. The idea is occasionally introduced by a patient or, more frequently, by a physician during a routine visit.

The discussion may occur during:

- an "annual physical",
- a diagnosis of a serious illness,
- the death of a relative, or
- the time of hospitalization for acute illness or an elective procedure (possibly a more effective time).[7]

Ideally, the patient's proxy decision-maker would attend the meeting, so that communication can be as clear as possible for the individual who may be called upon to execute decisions. Vague, general statements (*i.e.*, "no aggressive treatment", "do everything") should be avoided. The more specific, the more useful the instruction.

If a patient has a pre-existing condition, it is helpful to anticipate potential outcomes (*i.e.*, intubation for COPD or dialysis for chronic renal failure).

Table 1

**Benefits of ACP**

- Promotes and protects the autonomy of individual patients.
- Potential to reduce conflict among family members when difficult health-care decisions regarding a loved one must be made.
- Reduction in health-care costs if unwanted medical intervention could be avoided based on an advance directive.

Although somewhat artificial, the concepts of "reversible" and "irreversible" illnesses can also be useful. Patients are generally more prepared to accept aggressive medical intervention for a condition that is considered curable.

It is prudent to be familiar with legislation pertaining to ADs, as it varies from province to province. It may also be useful to add a reminder in the cumulative patient profile for ACP and to keep track of these discussions.

## What about the AD?

While a written AD may be one of the outcomes of ACP, the primary goal is to encourage dialogue between the patient and their proxy.

It is important to emphasize to the proxy their role is to advocate on behalf of the patient in accordance with the patient's previously stated wishes, not on their own personal preferences in a given situation. It is also important to realize the proxy does not become the decision-maker until the patient has lost the capacity to make autonomous decisions.

***The proxy does not become the decision-maker until the patient can no longer communicate their own wishes.***

Practitioners must also note caregivers do not interpret the AD directly except under emergency situations. The document's purpose is primarily to assist the proxy to make health-care decisions for the patient.

Should an AD be generated as a result of ACP, distribute copies of the document to the proxy and relevant health-care providers, with appropriate explanation of contentious issues as needed.

Finally, as a patient's health status changes (for better or worse), it is important to review the AD, as previous preferences for care may no longer be appropriate or desired. CME

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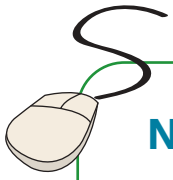
## Take-home message

- Advance care planning (ACP) is a process which may include an advance directive (AD), but the main goal is to establish/improve communication.
- You must identify the issue with the proxy and provide clear, specific instructions.
- While physicians are often reluctant to initiate ACP discussions, many patients expect their physician to do this.
- The AD only applies when the patient has lost the capacity to communicate their wishes.



## Net Readings

University of Toronto Joint Centre for Bioethics
www.utoronto.ca/jcb

A Guide to Advance Care Planning
www.gov.on.ca/mczcr/seniors

References

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