

# Advance Care Planning

This information pertains to the Guideline:  
*Frailty in Older Adults – Early Identification and Management*  
[www.BCGuidelines.ca](http://www.BCGuidelines.ca)

## **What is advance care planning?**

Advance care planning (ACP) is a process of communication between patients, their families, and health care providers regarding the care that will be appropriate when a patient is no longer able to make decisions themselves. It is based on patient preferences and wishes. In British Columbia, every capable adult (19 years-of-age and older) has the right to consent or withhold consent to health care. B.C. law supports adults in planning for a time when they are not able to make health care decisions by allowing them to legally appoint a health care representative. The person can also write down, or otherwise communicate instructions.

## **How could I incorporate ACP conversations into patient visits?**

The best way to start ACP in your office is to build it into your regular process of care. If you meet a healthy patient for the first time, or are seeing a patient for a yearly check up, you can remind them of the benefits of ACP. For example, you might say: *“I like to remind my patients that you cannot always predict what happens in the future. Have you ever thought about your wishes should you have an accident or become seriously ill? You can save your family a lot of distress by expressing your thoughts about being on life support, feeding tubes or being resuscitated.”*

All patients with chronic illness and those who are in the age range where they are more likely to have incapacitating illnesses (e.g. over 70 years) should be asked to visit to discuss ACP. ACP should be revisited both regularly (e.g. once yearly), and following major changes in health status as preferences

for care tend to evolve after people experience a significant change in overall health status<sup>1</sup>.

## **How might I initiate an ACP conversation with my patients?**

You can start with an open-ended question such as *“What do you understand about your illness at this time?”*, or, *“How are you feeling about your illness?”* Let the patient express concerns or ask questions about their illness then focus on important values/beliefs of the patient.

To follow-up and to share additional background information, you might say: *“I am now setting aside time to talk with all my patients with chronic illnesses about their choices for treatment so I would like to do this at our next visit. I want to respect your choices about health care treatment and should you become unable to make your own decisions, I need to know how you feel about things. Perhaps you already have a living will or have discussed this with your family? If so I would like to talk with you about it. Next visit, can you bring a family member or someone who would be making decisions for you?”*

## **What if my patient is from a culture where ACP decisions may be made as a family and/or it may be considered rude to be too forward in speaking of illness?**

In this case, you could ask: *“[Mr. Smith], if you ever had a serious illness, would you make your own decisions about your treatment or would it be a family decision?”* If the answer suggests that this person is not receptive to this you could say: *“If at any time you wish to ask me questions, I would be happy to answer them.”* Be careful not to stereotype any culture by presuming that because of a certain ethnicity, the patient would never want to discuss ACP.

## ***In general, what are some of the key points to remember when discussing ACP with my patients?***

Asking three questions of your patients could elicit most of the important issues in end-of-life decision-making:

- What present/future experiences are most important for you to live well at this time in your life?
- What fears or worries do you have about your illness or medical care?
- What sustains you when you face serious challenges in life?

Resuscitation should always be discussed. A way of raising this issue is to state: *“Everything will be done to help you live as well as possible for as long as possible, but when your disease becomes very serious and you die of the illness, we will not try to resuscitate you. Resuscitation – that is, trying to restart your heart pumping and lungs breathing – would have almost zero chance of success. The most you could gain is to return to the state you were in just before death.”* Focusing on what will be done for patients clears up the common misperception that “do not resuscitate” means “do not treat”. Patients should understand also that they could still choose to receive disease-modifying therapy but that they will not be resuscitated when they die of the illness.

Make a record of the visit by documenting the date and who attended. You may also wish to document patient comments from the three questions listed above.

Be mindful of the legal requirements in B.C. with regards to health care consent and decision-making.

1. Requirement to obtain informed consent from capable adults
2. Requirement to obtain informed consent from legally-appropriate substitute decision maker (Representative, Temporary Substitute Decision Maker, or Committee of Person).
  - \* The *Representation Agreement Act* allows a capable adult to legally name a health care decision-maker. If this is not in place and the individual loses decision-making capacity, then a *Committee of Person* should be undertaken.
  - \* The term *Committee of Person* refers to a representative who has been appointed to make decisions related to the patient’s physical well-being, including where the patient lives or whether medical treatment will be agreed to. A *Committee of Person* is granted by a Court Order, issued by the Supreme Court of B.C.
3. No requirement for health care provider to obtain informed consent in an emergency if none of the above is available
4. Requirement for all substitute decision makers (including health care providers) to make decisions based on the adult’s wishes when capable

## ***What tools are available to assist me with ACP discussion and documentation?***

- *No Cardiopulmonary Resuscitation Form* – HLTH 302.1  
<https://www.health.gov.bc.ca/exforms/mspprac/index.html#nocpr>  
No CPR MedicAlert® bracelet
- Fraser Health Authority – *My Voice*© A workbook for Advance Care Planning  
<http://www.fraserhealth.ca>
- Public Guardian and Trustee of British Columbia - Financial and Personal Care Management Services <http://www.trustee.bc.ca>

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<sup>1</sup> An exception to this is dementing illness. Decisions about end-of-life care must be made before patients become cognitively impaired to the point where they can no longer make personal decisions.