Advance Care Planning

Advance Care Planning (ACP) is a process of discussion and shared planning for future care. All people with advanced life-limiting illness or condition should be given the opportunity to discuss their prognosis and end of life care. ACP may result in the patient choosing to write an advanced care plan and/or an advance directive and/or appointing an enduring power of attorney (EPA).

Advanced Directives (sometimes referred to as 'living wills') are written or oral directives in which a patient makes a choice about a future health care procedure, and this choice is intended to be effective only when the patient is not competent.

With ACP [22]:

- the focus is on the patient's wishes and preferences for a time when they lose capacity to make decisions
- discussion on end of life care is encouraged
- the discussion should be documented in the patients notes
- it is important that the health professional understands the legal framework e.g. the role of EPA

Tips for talking about end-of-life care, prognosis and advance care planning [20]:

- initiating discussions about end-of-life care:
    - frame this discussion as an important part of care for all patients with severe Chronic Obstructive Pulmonary Disease (COPD)
    - identify whether the patient or someone close to the patient has been seriously ill, whereby they were not able to make their own medical decisions, and use these situations to facilitate discussion
    - inquire as to whether a family member or other person should be present for the discussion
- discussing prognosis:
    - use 'ask-tell-ask' to ask if patients are willing to discuss prognosis, then deliver prognosis, and then confirm understanding
    - use numeric expressions of risk rather than qualitative statements
    - frame prognosis as referring to groups of people rather than individuals
    - explicitly discuss uncertainty in prognostication
- discussing advance care planning:
    - frame as being important to 'hope for the best and prepare for the worst'
    - if appropriate, clarify that discussing advance care planning with the physician will not diminish the physician's focus on maximising the patient's survival
    - discuss particular importance of advance directives if patients have strong opinions about use of CPR, mechanical ventilation or other treatments
    - discuss important of advance directives if patients have a preference for another person to make medical decisions for them if they are not able and, especially, if that preference does not match the default surrogate decision-maker according to local laws
    - identify whether there are specific health states that the patient would consider 'worse than death'
    - explicitly discuss a commitment to nonabandonment
    - offer patients the opportunity to raise issues about their spirituality or religion that they would like their physicians to be aware of

There is no standard format for advance directives in New Zealand. Information and sample forms are available on the Advance Care Planning website. The Advance Care Planning: A guide for the New Zealand health care workforce can also be of assistance.