Advance care planning

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Many of us plan our lives incessantly – our day, our work, our recreation – but when it comes to planning for the end of life, few give it a thought beyond making a Will & Testament. When we call to mind the ageing population and the recent media frenzy surrounding Mr Christian Rossiter, the very important issue of advance care planning (ACP) should come sharply into focus.

The AMA defines ACP as: "A process that allows a competent individual to express their views in relation to future health care decisions when the capacity to express those views is lost".

Death is inevitable. When the time is appropriate, advance care planning enables medical practitioners to engage in a discussion with their patients to elicit informed choices on healthcare decisions in the form of an Advance Health Directive (AHD) or Living Will. Done well, this process can significantly assist in provision of the most appropriate care of the patient, in the environment of their choosing, and with the least anxiety for all involved.

The Department of Health and the Office of the Public Advocate have been working together to implement the *Acts Amendment (Consent to Medical Treatment) Act 2008*. When the Act is fully implemented, an AHD will be recognised as a legal document in WA. Furthermore, competent adults may appoint a legal guardian by using an Enduring Power of Guardianship. Until such time, the forms and guides at www.respectingpatientchoices.org.au can be used as discussion aids.

What to do:	
Recognise the need	Ask yourself: "Would I be surprised if Mr/Mrs X dies from their illness within the next 12 months?" If the answer is NO, proceed.
Assess patient's competence	Do they have capacity to weigh up the issues in general terms?
What to say	If you are unsure about how to broach the subject, see Table 11 in Communicating prognosis and end of life issues; MJA 2007; 186(12): S99. Example: Have you thought about the type of medical care you would like to have if you ever became too sick to speak for yourself? Have you talked to anyone about your wishes, if you become too unwell to make decisions for yourself about medical treatment?
Do your research	Download the forms and guides for WA from http://www.respectingpatientchoices.org.au
Begin the dialogue	All systematic reviews on ACP say the most effective intervention is face to face; patient-physician discussion over several sessions.
Discuss and document choices	You might have an understanding of your patient's values and priorities and be able to help them work out their goals – use example clinical scenarios to guide discussion. Common topics are: preferred place of care (home/nursing home/hospital/hospice); appoint caregiver; appoint Enduring Power of Attorney; update Will; attitude towards admission into hospital/ED; emergency procedures e.g. tracheostomy or CPR; artificial feeding – PEG insertion/feeding; artificial ventilation; comfort care; funeral plans.
Who is the proxy decision maker?	Who will make healthcare decisions on your patient's behalf should they become incompetent? This is also known as Enduring Guardian (new legislation). Invite this person to the next discussion.
Review AHD regularly	3 to 6 monthly – because attitudes will change as health deteriorates/improves.
Make ACP known to others	Make copies available to the proxy decision maker, all healthcare providers, and family members.

References:

- *http://www.ama.com.au/node/2428 (23/08/09)*
- *http://www.respectingpatientchoices.org.au*
- *Bravo G, Dubois MF, Wagneur B. Assessing the effectiveness of interventions to promote advance directives among older adults: a systematic review and multi-level analysis. Soc Sci Med. 2008 Oct;67(7):1122-32.*
- *Communicating prognosis and end of life issues; MJA 2007; 186(12): S76-S108.* ■