

Virtual Mentor

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VIEWPOINT

What Is Advance Care Planning?

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Advance care planning is a process, not an event. It is the process of planning for future medical care in the event that the patient is unable to make his or her own decisions. During this process patients explore, discuss, articulate, and document their preferences. The process helps patients identify and clarify their personal values and goals about health and medical treatment. They identify the care they would like, or not like, to receive in various situations. Patients also determine whom they would like to make health care decisions on their behalf in the event they cannot make decisions for themselves.

Ideally, advanced care planning is a process of structured discussion and documentation woven into the regular process of care that is reviewed and updated on a regular basis. It is designed to ensure that a patient's wishes will be respected in the event that the patient is unable to participate in decision making.

The physician plays an important role in initiating and guiding advance care planning. He or she needs to be involved in some, but not all, stages of advance care planning in order to understand the patient and establish a trustworthy shared decision-making process.

The patient, proxy, and family can do most of the work without the physician if they are given a worksheet and background materials.

Some physicians choose to have other members of the health care team assist them with advance care planning (eg, a nurse, physician assistant, or social worker). Once the patient's ideas have been gathered, the physician can focus on the core discussions in direct meetings with the patient, proxy, and family. Preparatory work will permit these discussions to be to the point and effective. Once the core discussion has taken place, invite the patient to reflect on things and then return at a subsequent visit with decisions to review.

Terms used in advance care planning can be confusing.

- *Advance directives* are prior directives by the patient for his or her health care. Advance directives fall into two categories, those that have to do with instructions for medical care and those that have to do with designating a proxy for the patient.

- *Instructional directives* for care can be re-corded in a number of types of documents.
- *living will* is usually a simple statement asking for no heroic care in case of poor prognosis. A personal letter may also be used.
- *values history* is a statement of values regarding health care in life-threatening illness situations.
- *medical directive* is a set of instructions based on likely scenarios of illness, goals for care, and specific treatments, combined with a general values statement. It is also combined with a proxy designation section.
- A person who is empowered to make decisions in the place of the patient is sometimes termed *health care proxy* or *durable power of attorney for health care*.

Steps for Successful Advance Care Planning

Five steps are identified for successful advance care planning. These steps are explained in greater detail in the handbook for the project to Educate Physicians on End-of-life Care (EPEC).

Step 1: Introduce the topic

Step 2: Engage in structured discussions

Step 3: Document patient preferences

Step 4: Review and update the directive

Step 5: Apply directives to actual circumstances

Common Pitfalls of Advance Care Planning

Anticipating and avoiding the common pitfalls is essential to a successful advance care planning process. There are several.

Failure to plan: Do not avoid advance care planning. Too often, situations occur and decisions are made without the benefit of advance care planning. Be proactive. It is easy to forget the central role of the patient, and easy to forget the importance of the proxy. Involve both early and often.

Proxy not present for discussions: Do not leave the proxy decision maker(s) out of the initial discussions with the patient.

Unclear patient preferences: Vague statements can be dangerously misleading. Be sure to clarify patient preferences if they do not seem clear to you or to the proxy. For instance, patients who make statements such as "I never want to be kept alive on a machine." should be asked to clarify whether their wishes would change if their condition were readily reversible, or if their prognosis were unclear.

Discussion focused too narrowly: Avoid isolated do-not-resuscitate (DNR) discussions; they often create chaotic emotions and thoughts in patients who have to imagine imminent death to make the decision. A DNR discussion is usually an

indication that other palliative goals and measures should be considered in the context of a range of scenarios.

Communicative patients are ignored: Sometimes people assume that what a patient wants in the present is what he or she indicated for future possible scenarios. As long as the patient is competent, talk to him or her. An impaired patient may still be able to express wishes at some level. In such cases, both the advance directive and tangible evidence of the patient's current wishes should be taken into account.

Always read advance directives: Sometimes physicians assume that they know what is stated in an advance directive. This is a mistake. Advance directives can be for aggressive intervention, comfort care, or a wide range of specific views and must be read and understood.

Note: This information on advance care planning is excerpted from Module 1 of the Participant's Handbook for the project to Educate Physicians on End-of-life Care (EPEC). The [complete text](#) is available online.

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Advance Care Planning

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