

Advance care planning in family medicine training

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On behalf of the Section of Residents

Advance care planning (ACP) is an increasingly important topic in primary care as more patients with multiple comorbidities and chronic diseases are living longer owing to advances in medical treatment. Family physicians are well positioned to guide ACP discussions given the longitudinal care they provide, yet many physicians, including resident physicians, feel uncomfortable directing these conversations. In this article we will describe ACP and its importance, as well as present a framework that we have developed to guide the ACP process.

What is ACP?

Advance care planning is a process that includes reflection and communication about a patient's values, beliefs, goals, and preferences to best prepare for his or her future medical care. The designation of a substitute decision maker (SDM) is a key element of ACP.¹

Why is ACP important?

Up to 76% of patients will be unable to participate in some or all of the decisions affecting their own health care at the end of life,² and 47% of Canadians have not had a discussion with a family member or friend about what they would want or not want if they were ill and unable to communicate.³ Without the direction provided by ACP, families often feel burdened by directing medical care in crisis situations and might feel ill-prepared to make decisions owing to a lack of understanding of the patient's values and preferences. When no previous direction has been documented, physicians often resort to using full resuscitative and medical care. This can mean aggressive treatments that the patient might not have wanted, and might result in unnecessary suffering for both the patient and family members.

Previous research has highlighted numerous benefits of ACP, including the following: improved quality of end-of-life care⁴; improved patient and family satisfaction with end-of-life care⁵; reduced stress and anxiety for families⁵; reduced hospital admissions and length of stay⁶; increased use of hospice care⁶; and shorter stays in the intensive care unit.⁷

Why is ACP important in family medicine?

Family physicians have long-standing relationships with their patients. They are the health care professionals who best know the health status, personal priorities, and social context of their patients. Furthermore, they have the advantage of being able to engage in the ACP

process over several visits. For these reasons, family physicians are best positioned to conduct these sensitive conversations with their patients.⁴

Despite the importance of ACP in family medicine, there is a lot of discomfort and uncertainty among resident physicians when engaging in ACP with patients. Based on the results of a survey, only 40% of family medicine residents at Canadian institutions think that they are prepared to guide patients in ACP discussions following their residency (K.D., D.J., R.T., Y.Y., unpublished data, December 2016). This discomfort appears to carry over into practice, as a national survey showed that 26% of practising primary care physicians are comfortable leading ACP discussions with their patients and 67% believe they need more resources in order to do this.⁸

Approach to ACP conversations

Most (80%) family medicine residents indicated that a clinical aid or how-to guide would be helpful for performing ACP (K.D., D.J., R.T., Y.Y., unpublished data, December 2016). To address this need, we conducted an extensive review of ACP literature and existing resources, as well as engaged in consultations with education and ACP experts, and then devised a simple framework for ACP: the Introduce, Discuss, Decide, and Document (ID3) framework (**Table 1**).⁹ The goal of this framework is to provide structure for ACP discussions and it is *not* meant to replace formal ACP instruction and education.

How to perform ACP

Consider the following when performing ACP with patients.

- Triage the discussion according to the patient's health status (**Table 2**).
- Check for and review previous ACP conversations.
- Plan for a serious discussion in an appropriate setting. (For patients who are well, this discussion might take only a couple of minutes; for patients with more serious conditions, this conversation will take some time.)
- Encourage the patient's SDM to be present for ACP discussions.
- Use the ID3 framework during ACP discussions (**Table 1**).⁹
- Revisit the ACP discussion over multiple visits or discussions as appropriate given the patient's health status.

The ID3 framework for ACP discussions

The ID3 framework provides an approach for clinicians to conduct ACP discussions. It might not be possible

Table 1. Introduce, Discuss, Decide, and Document framework: Use the following framework for ACP discussions.

FRAMEWORK ELEMENT	HOW TO APPLY
Introduce	<p>Begin ACP discussions by ...</p> <ul style="list-style-type: none"> • Introduce the topic: "Can we talk about where things are with your health, and where things might be going?" • Seek permission: "Is this okay?" • Inform: Explain what ACP is and why it is important. Describe the process. Tell the patient that his or her decisions can be revised as health status or life situations change • Follow up, if appropriate: After introducing the patient to the topic of ACP, consider having the patient return for a dedicated appointment to continue the rest of the process
Discuss	<p>Assess a patient's understanding</p> <ul style="list-style-type: none"> • "How much do you (or your family) know about your illness?" • "What information would you like from me?" <p>Determine a patient's goals</p> <ul style="list-style-type: none"> • "What are the most important things you want to do in life?" • "What are some abilities in life that you cannot do without?" <p>Ask a patient about his or her fears</p> <ul style="list-style-type: none"> • "What are your biggest fears and worries about your health? Or about life in general?" <p>Explore a patient's trade-offs</p> <ul style="list-style-type: none"> • "If you get sicker, what kinds of health care services are you willing to endure to gain more time?"
Decide	<p>Make decisions</p> <ul style="list-style-type: none"> • Patient should decide on who will be the SDM ("If you are unable to speak for yourself about medical decisions, who do you want to speak for you?") • You need to decide which patient-centred principles are based on, and comply with, the values that the patient has identified as being most important to his or her life • This component of the ACP discussion might require multiple discussions if there is no medical indication for an urgent decision
Document	<p>Include documentation of certain factors</p> <ul style="list-style-type: none"> • Document the designation of the SDM. The patient should ensure that the SDM is aware of his or her role and is informed of the patient's priorities and wishes • Document any principles-of-care decisions that have been made • Ensure that documentation complies with relevant provincial, territorial, or regional regulations regarding the documentation of designated SDMs and decisions specifying principles of care

ACP = advance care planning, SDM—substitute decision maker.
 Dialogue prompts adapted from Ariadne Labs.⁹

Table 2. When to have an ACP discussion with your patient

HEALTH STATUS	ACUITY	ACTIONS
Patient who is well	Nonurgent	<ul style="list-style-type: none"> • Have a full, focused ACP conversation during periodic health examinations and when important life events occur (eg, marriage, pregnancy, new job) • Emphasize choosing an SDM
Patient with chronic disease	Semiurgent	<ul style="list-style-type: none"> • Have a full ACP conversation during each periodic health examination and when triggered by medical events (eg, new diagnosis, discharge from hospital) • If the patient is living with chronic disease, discuss the disease course and potential health outcomes as the disease progresses and at decision points that might arise in the future • Revisit at regular intervals as appropriate
Patient with acute deterioration in health	Urgent; decision needed now	<ul style="list-style-type: none"> • Revisit the ACP conversation with the patient or SDM, or initiate the discussion if this has not already been done • Discuss code status or goals of care with the patient or SDM at this stage • Recommend best treatment based on the patient's goals, fears, values, and his or her specific illness context • Emphasize immediate or anticipated health care decisions

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or appropriate to complete the full ID3 process during a single discussion. Between appointments, encourage patients to review patient resources from the Speak Up campaign website (www.advancereplanning.ca) and to discuss their values and preferences with their family members and SDMs.

Conclusion

Advance care planning allows patients to assert their values and priorities for care throughout their disease course and throughout their lifespan, so that when unexpected situations arise and patients are unable to make treatment decisions, physicians and family members can direct care in a manner that is in keeping with the wishes of patients. In doing so, ACP not only improves the quality of patient care, but also might help direct constrained health care resources to areas of greater need, increasing the efficiency of the health care system. Engaging in ACP with patients might be challenging for some resident physicians. The ID3 framework provides structure to ACP discussions, and we encourage resident physicians to use this approach during ACP conversations with patients. ✨

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Competing interests

None declared

References

- Sudore RL, Lum HD, You JJ, Hanson LC, Meier DE, Pantilat SZ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary Delphi panel. *J Pain Symptom Manage* 2017;53(5):821-32.e1. Epub 2017 Jan 3.
- Sudore RL, Fried TR. Redefining the "planning" in advance care planning: preparing for end-of-life decision making. *Ann Intern Med* 2010;153(4):256-61.
- Teixeira AA, Hanvey L, Taylor C, Barwich D, Baxter S, Heyland DK. What do Canadians think of advanced care planning? Findings from an online opinion poll. *BMJ Support Palliat Care* 2015;5(1):40-7. Epub 2013 Oct 4.
- Bischoff KE, Sudore R, Miao Y, Boscardin WJ, Smith AK. Advance care planning and the quality of end-of-life care among older adults. *J Am Geriatr Soc* 2013;61(2):209-14. Epub 2013 Jan 25.
- Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ* 2010;340:c1345.
- Hunt RW, Jones L, Owen L, Seal M. Estimating the impact of advance care planning on hospital admissions, occupied bed days, and acute care savings. *BMJ Support Palliat Care* 2013;3(2):227.
- Khandelwal N, Kross EK, Engelberg RA, Coe NB, Long AC, Curtis JR. Estimating the effect of palliative care interventions and advance care planning on ICU utilization: a systematic review. *Crit Care Med* 2015;43(5):1102-11.
- Canadian Hospice Palliative Care Association. *What Canadians say: The Way Forward survey report*. Ottawa, ON: Canadian Hospice Palliative Care Association; 2013. Available from: www.hpcintegration.ca/media/51032/The%20Way%20Forward%20-%20What%20Canadians%20Say%20-%20Survey%20Report%20Final%20Dec%202013.pdf. Accessed 2017 Sep 13.
- Ariadne Labs [website]. *Serious illness conversation guide*. Boston, MA: Ariadne Labs; 2015. Available from: www.ariadnelabs.org/wp-content/uploads/sites/2/2017/05/SI-CG-2017-04-21_FINAL.pdf. Accessed 2018 Apr 6.

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