Advance Care Planning (ACP) Guide to ACP Conversations

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

ACP conversations:

- Prepare patients for future health care decisions by exploring their values, beliefs, goals, and preferences
- Help patients decide on a surrogate decision maker (SDM) and engage the SDM in the ACP process
- Are for everyone, not just the seriously ill
- Do **not** require decisions be made after just one discussion
- Are **not** just about resuscitation orders

Increasing urgency ↓

Triage ACP conversations according to life situation:	
Well patient	Full, focused ACP discussion triggered by life events (e.g., marriage, pregnancy, new job); emphasize choosing an SDM
Patient with chronic disease	Full ACP discussion at regular intervals and following medical events (e.g., new diagnosis, discharge from hospital)
Patient with acute ↓ in health	Revisit the ACP discussion with the patient or SDM emphasizing immediate or anticipated health care decisions

Remember:

- **Check** for and review previous ACP conversations
- **Follow up** over time to better understand patient's context and monitor changes in patient's health status and decisions

Compiled and prepared by the CFPC Section of Residents (2017)

Key references and resources:
http://www.cfpc.ca/sectionofresidents_training_guides/

The ID3 Framework for ACP Conversations: Introduce, Discuss, Decide, Document

1. Introduce:

- Seek permission: "Can we talk about where things are with your health and where things might be going?"*
- Explain ACP's rationale and that the patient's decisions can be revised as their health/life situation changes.

2. Discuss:

Understanding: "How much do you (and/or your family) know about your illness? What information would you like from me?"*

Goals: "What are the most important things you want to do in life?"
"What are some abilities in life you can't do without?"*

Fears: "What are your biggest fears and worries about your health? About life in general?"*

Trade-offs: "If you get sicker, what health care services are you willing to endure to gain more time?"*

3. Decide:

Decide on an SDM and on patient-centred principles of care. Reaching a decision may require multiple visits, depending on urgency.

4. Document:

Document the discussion and encourage your patient to record their wishes (i.e., SDM, values) in a formal document. Complete province-specific ACP documents.

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