



## Information about advance care planning for General Practitioners

### What is advance care planning?

Advance care planning (ACP) involves a patient thinking about and communicating to others how they would like to be treated in the future if they have a condition where they can no longer speak for themselves. This may happen, for example, because of a stroke, progressive dementia, or becoming unconscious from some form of accident or illness.

ACP is relevant for everyone, but particularly for people with progressive, life-limiting conditions such as cancer or late stage chronic disease. Other triggers to undertake ACP include diagnosis of early cognitive impairment and admission to a residential aged care facility.

An advance care directive (ACD) is a document that describes a person's acceptance or refusal of certain treatments in anticipation of a time when the person is unable to express those preferences because of illness or injury. Completion of an ACD is one component of the broader advance care planning process. Sometimes the terms advance care plan and advance care directive are used interchangeably.

### Why is it important?

Undertaking ACP means that future decisions about a person's care are more likely to reflect their wishes. It helps them raise sensitive issues about the future with those close to them that they might otherwise avoid. It will mean that other people will not have to make decisions on the person's behalf without knowing what that person's real feelings and wishes would be. It reduces the chance of confusion and conflict when others are making decisions about a person's care. It means that the patient and the people close to them can feel comfortable and reassured that there will be a common and calm approach to their care toward the end-of-life.

### The policy context of ACP

The main Policy Directive from NSW Health relevant to ACP is to do with patient consent – Consent to Medical Treatment – Patient Information (PD2005\_406).

Other guidelines published by NSW Health that are directly relevant to ACP include:

- Using Advance Care Directives – New South Wales (2004)
- Guidelines for end-of-life care and decision-making (2005)
- Decisions relating to No Cardiopulmonary Resuscitation (CPR) Orders (2008)

### The legal basis of ACP/ACD

Advance care planning has its legal basis within the common law right to determine one's own medical treatment. Clear messages about the legal basis of ACP/ACDs are provided in the above documents:

*"Health practitioners should not provide treatment or perform a procedure where there is an unequivocal written direction, such as an Advance Care Directive, by the patient that such treatment is not to be provided in the circumstances which now apply to the patient"*  
(Consent to Medical Treatment – Patient Information Policy Directive PD2005\_46, Page 8)



*“An advance care directive that complies with the requirements set out in this document is legally binding in NSW, and functions as an extension of the common law right to determine one’s own medical treatment. A failure to comply with such an advance care directive refusing a particular treatment may result in the health professional incurring criminal or civil liability for providing that treatment.” (Using Advance Care Directives – NSW, Page 5)*

The requirements referred to in the last quote are document standards that should be met before an ACD is considered to have sufficient authority to act on are outlined below.

- **Specificity:** the ACD should be clear and specific enough to guide clinical care in the circumstances under consideration
- **Currency:** while an ACD prepared some time ago may not reflect the current intentions of the patient, it should still be accepted as valid. People should be encouraged to update their ACD periodically
- **Competence:** the person must have been competent to make their own health care decisions when the ACD was made
- **Witnessing:** while this is not essential, it is encouraged to allow follow-up if necessary and to allay fears of forgery or the ACD being written under pressure from another person.

## What does ACP involve for GPs?

The following information is taken from the publication *Medical care of older persons in residential aged care facilities (2006)* Published by the RACGP.

**While the information is written specifically in the context of the residential aged care setting, it is suggested that the same principles can apply to patients seen in the GP surgery.**

The role of GPs in advance care planning may include:

- discussing the idea of advance care planning with residents
- providing residents with information regarding their current health status, prognosis and future treatment options
- witnessing or completing instructional directives where appropriate
- applying residents’ wishes to medical management.

A summary of GP steps to advance care planning is given below.

### Step 1. Incorporate advance care planning as part of routine care of residents

- Provide information and offer advance care planning when doing a comprehensive medical assessment
- Suggest that the representative or family be involved in future consultations about the resident’s wishes

### Step 2. Assess capacity of resident to appoint a representative and complete an advance care plan

- Where residents have the capacity, check and witness that the representative/s is/are appropriate and agree, and that the appropriate form has been completed correctly
- Where residents do not have capacity, refer to state legislation for who can be the representative

### Step 3. Support discussion and documentation of advance care plan

- Discuss the resident’s wishes with resident, representative, relatives/carers, and RACF staff
- Provide information on medical conditions, benefits and burdens of treatment
- Review advance care plan
- Complete relevant forms, e.g. refusal of treatment and/or not for resuscitation if appropriate



## Step 4. Apply the resident's wishes to medical care

- Advance care plans only come into use when residents are no longer able to communicate their wishes
- Consult advance care plans and resident/representative/relatives when major clinical decisions need to be made

**Step 5. Review plan regularly or when health status changes significantly** (can be revoked at any time as long as the resident is capable).

## Working with the residential care staff and systems

Many residential aged care facilities have developed policies and procedures to adopt a more systematic approach to advance care planning. Typically this will be done with input from some of the GPs visiting the facility. These procedures might include ACP discussions in the early family case conferences or as part of the annual resident review. GPs are encouraged to find out what systems are in place in the facilities they visit and work collaboratively with staff to ensure these systems can provide the best quality of care for the residents.

There are several Medicare items that GPs can use when undertaking ACP discussions with residents and/or their person responsible. These include Comprehensive Medical Assessment, Contribution of GP to Care Plan and Contribution to Case Conference.

## Using ACP documents in end-of-life decision-making

Medical officers and other staff involved in end-of-life medical decisions must:

- make every effort to ascertain if there are any ACP/ACD documents in existence by checking the medical records and asking the patient or their family
- make every effort to clarify the reversibility of the current problems and the patient's prognosis as accurately as possible
- carefully consider the currency, specificity and relevance of any ACP/ACD documents in terms of the current clinical situation
- refer to any ACP/ACD documents in discussions with substitute decision-makers about treatment decisions
- make medical decisions and recommendations that reflect the wishes of the patient as stated in an ACP/ACD that they consider to be current, specific and relevant to the current situation
- seek guidance from more senior staff if they are unclear about how to incorporate ACP into their end-of-life decision making
- document these considerations and the decision-making process fully in the patient's medical record, including reasons why an ACP/ACD may not have been followed.

## What if the patient already lacks capacity?

If the patient is already at a stage where they cannot nominate a substitute decision-maker and they cannot write an ACP/ACD (such as in moderate-severe dementia), there are still benefits from the 'person responsible' undertaking advance care planning on behalf of the patient. In this case, the 'person responsible' can consider and document the values and wishes they believe the person would have expressed themselves if they were able to. Having these considered and documented will make it easier to make important decisions about the person's care at the end-of-life.

## The Sydney South West My Wishes Advance Care Planning Program

While it is important that patients and their 'persons responsible' are free to choose any format of ACP, the My Wishes program has been developed by the Sydney South West Area Health Service as part of the medical records system and to be used across different care settings. The program consists of the



following processes and associated documents:

- *Statement of Values and Wishes*
- *Record of Advance Care Planning Discussions*

The forms that are part of the program can be completed by the patient themselves or by their 'person responsible' if the patient has already lost capacity. The program also includes a series of information sheets, practice guidelines for staff and educational resources, which can be found on the website listed below.

## FURTHER INFORMATION

### **The Sydney South West My Wishes Advance Care Planning Program**

Further information about this program and copies of the ACP forms can be obtained from [www.mywishes.org.au](http://www.mywishes.org.au) or by calling (02) 9612 0646.

### **Planning what I want**

An Australian primary health care website that has information for the general public as well as healthcare professionals. It includes general information on a range of ACP-related topics, examples of forms and several video clips from experienced practitioners. Available at: <http://www.planningwhatiwant.com.au>

### **Online ACP program from RACGP**

The College has a 2-hour online program about advance care planning that attracts CPD points. Available at: <http://www.gplearning.com.au>

### **Aged Services Learning and Research Centre**

This Centre at Southern Cross University has a range of information and forms associated with ACP as well as Powerpoint presentations by Prof Colleen Cartwright. Available at: <http://aslarc.scu.edu.au/downloads.html>

### **Medical care of older persons in residential aged care facilities (4th ed)**

A comprehensive resource providing information on a range of issues, including ACP. Available at: <http://www.racgp.org.au/guidelines/silverbook>

### **My Health, My Future, my Choice**

A 31 page booklet written specifically for NSW that also contains a directive form that can be filled out. Published by the Advance Care Directive Association, it can be ordered by ringing 0423 157 003 or through the web at: <http://www.advancecaredirectives.org.au>

### **Using Advance Care Directives NSW**

A 13 page booklet published by NSW Health to provide advice to health professionals on the best practice use of advance care directives within an advance care planning process. Available from the web at: [www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005\\_056.pdf](http://www.health.nsw.gov.au/policies/gl/2005/pdf/GL2005_056.pdf)

For further information go to:  
[www.mywishes.org.au](http://www.mywishes.org.au)