ACP
And
Goals of Care

Practical Tips

Dr. Deb Harrold

Disclosure

I have no conflict of interest for information shared during this talk.

I have completed a conflict of interest declaration.

I have submitted my presentation to the organizers in advance.

Objectives

1. Review the practicalities and the differences between ACP, goals of care and treatment decision making.
2. Recommend how to have goals of care discussions in a timely way within the setting of a busy practice.
3. Highlight the commonly misunderstood fundamentals of ACP and Goals of Care and the pitfalls to avoid.

Now it is your turn…

WHO ARE YOU?

1)Primary Care MD or NP

2)Other practicing MD/NP

3)Nurse

4)Allied Health

5)Medical learner - resident/student

This is an example of me

1. Setting my advance care plan?
2. Setting my future goals of care?
3. Setting my future resuscitation status?
4. Setting my future medical treatment decisions?

This is an example of me

1. **Setting my advance care plan?**
2. Setting my future goals of care?
3. Setting my future resuscitation status?
4. Setting my future medical treatment decisions?

Advance care planning

It is as easy as

1) name your SDM by completing a POA for personal care document

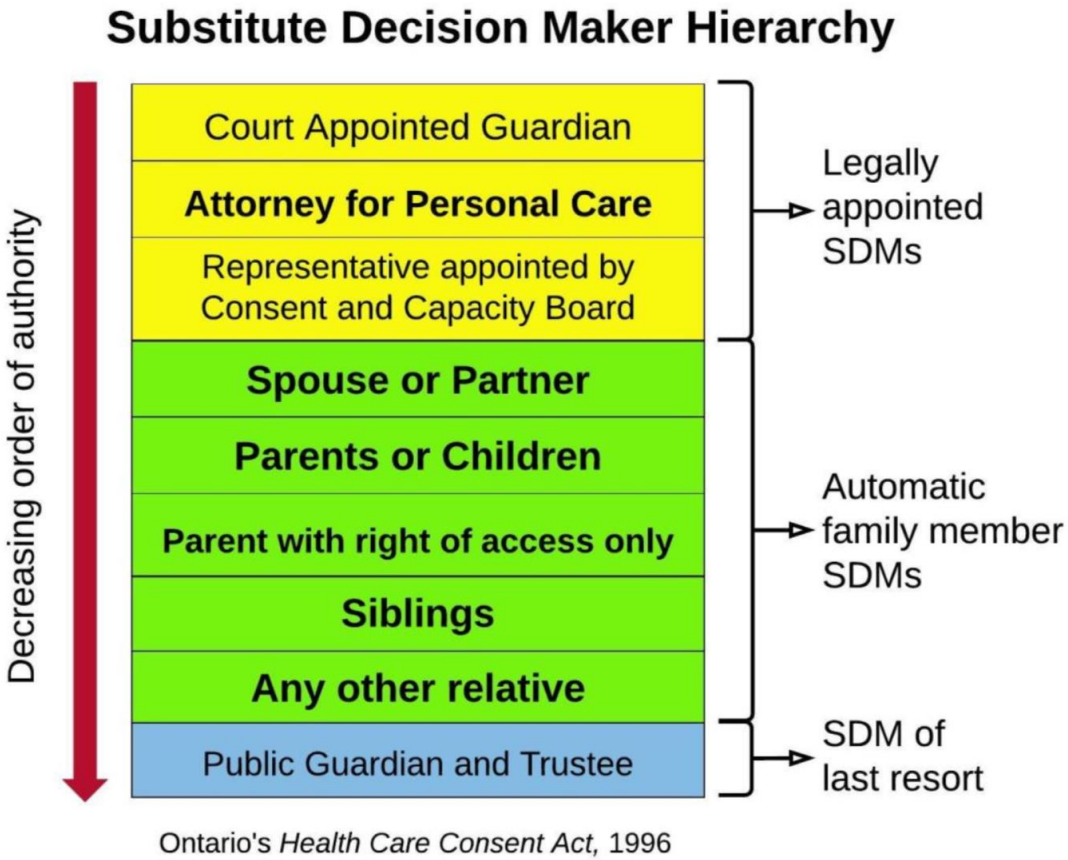
OR agree with the SDM who would be named based on hierarchy

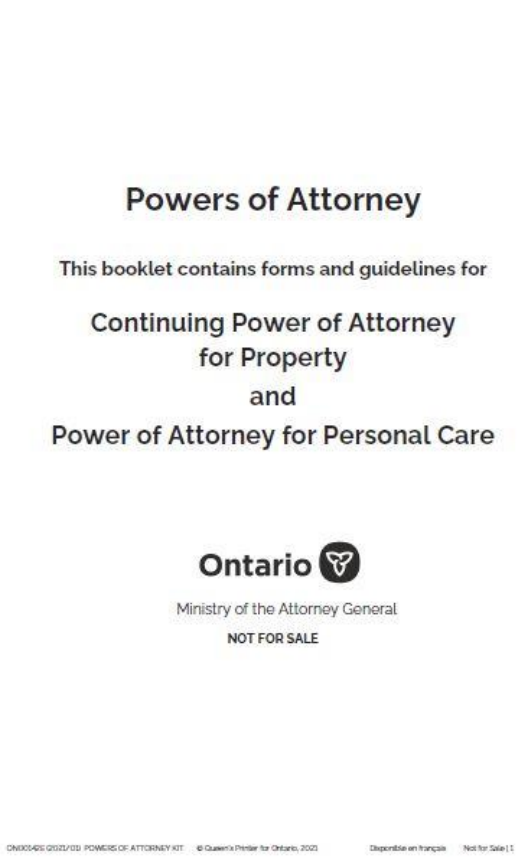
AND

1) TELL that person what your general values, wishes and beliefs are with respect to quality of life and health…and TELL them again….and TELL them again….

Who is your SDM?

1. Spouse (although living separate lives, sharing home for financial reasons, not legally separated)
2. Same-sex partner x10yrs
3. Eldest Child
4. Parents
5. All Children
6. Child who lives closest
7. Child at bedside
8. Child who is most vocal





https://www.ontario.ca/page/make-power-attorney

www.advancecareplanning.ca

ACP 5 steps

ACP Myths

ACP is a document that speaks for itself

ACP must be written

ACP takes a LONG time to incorporate into a busy practice

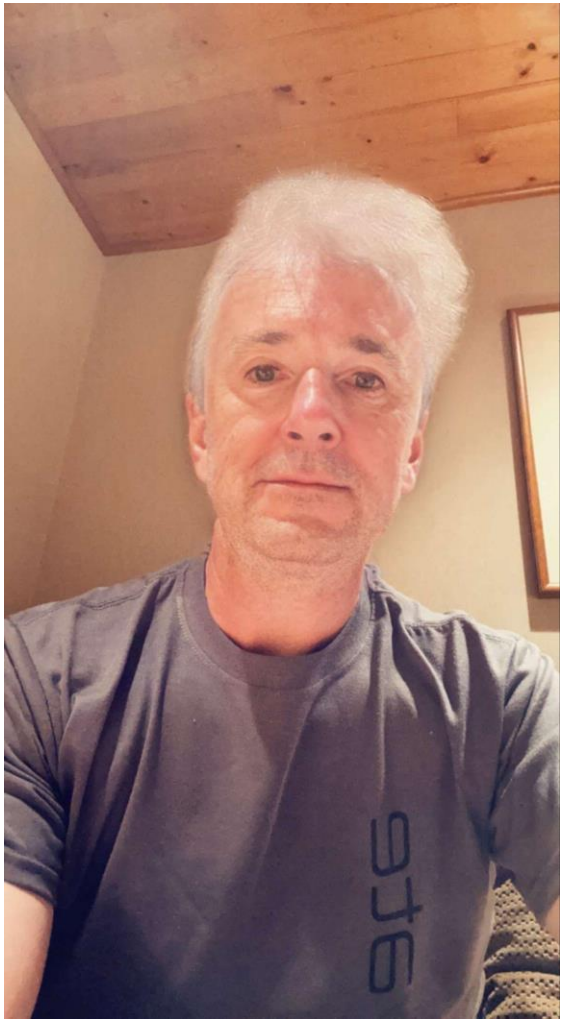
ACP should be discussed at a certain age/with a certain at risk population (ie. cancer patients)

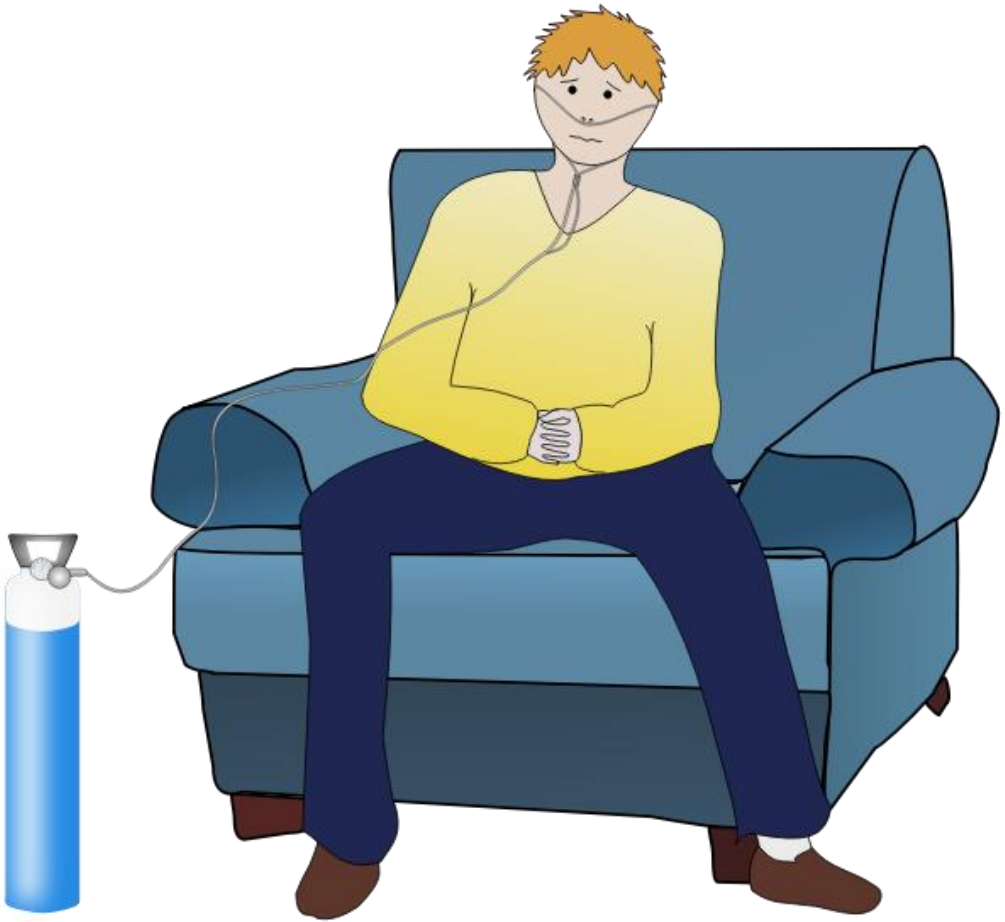
ACP can be done by an SDM on the patient's behalf

ACP discussion must be done by a doctor

An incapable person can name their POA/SDM to speak on their behalf

questions??





This is an example of...

1. Setting Robert's advance care plan?
2. Setting Robert's goals of care?
3. Setting Robert's resuscitation goals?
4. Setting Robert's medical care plan?

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1. Setting Robert's advance care plan?
2. **Setting Robert's goals of care?**
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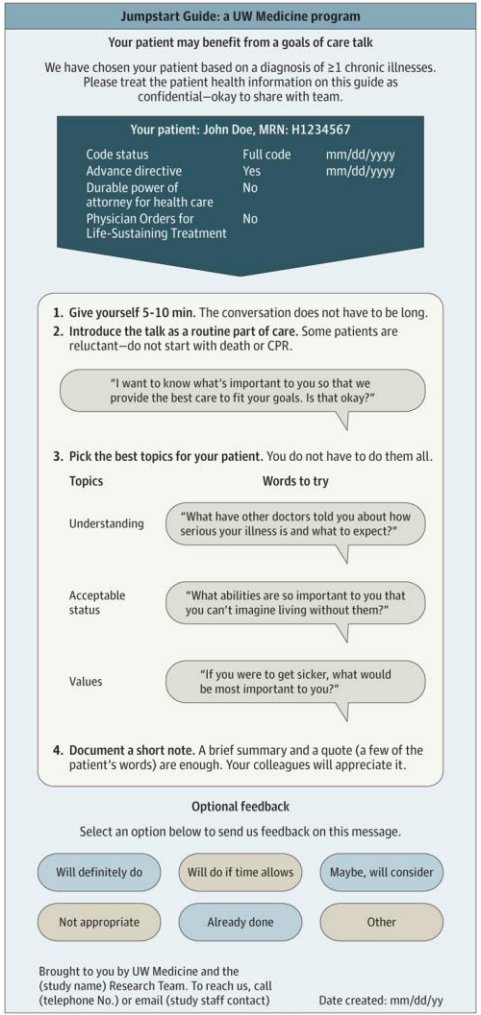
Goals of Care

Knowing what you know now about your health…..

…..what are your goals???

ILLNESS UNDERSTANDING
INFORMATION SHARING
GOALS/VALUES
DECISION/PLAN



Intervention to Promote Communication About Goals of Care for Hospitalized Patients With Serious Illness:

A Randomized Clinical Trial

J. Randall Curtis, MD, MPH[1,2]; Robert Y. Lee, MD, MS[1,2]; Lyndia C. Brumback, PhD[3]; et al

JAMA. 2023;329(23):2028-2037. doi:10.1001/jama.2023.8812

visual abstract

Goals of Care Myths

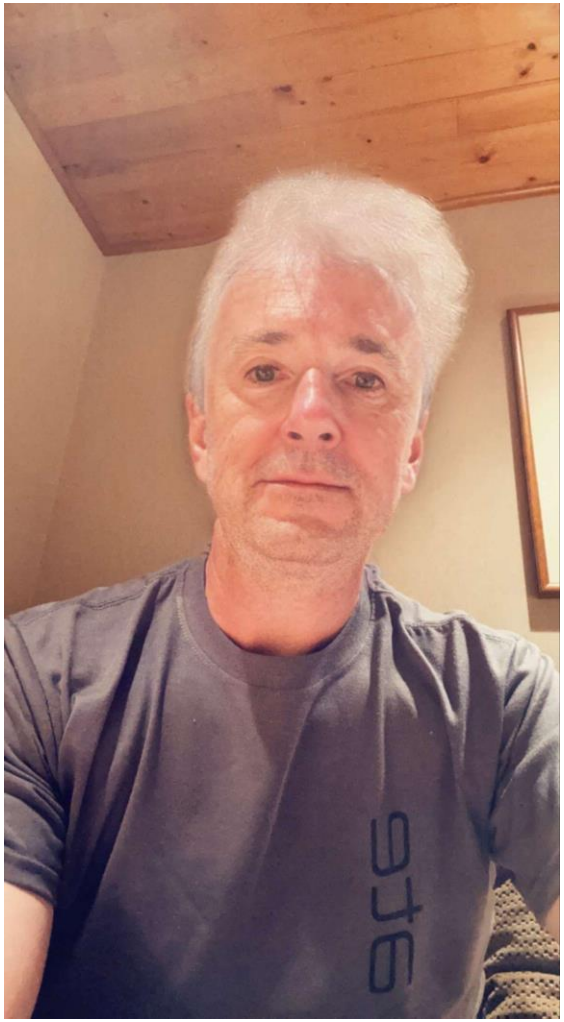
Goals of Care must be chosen from a drop down menu

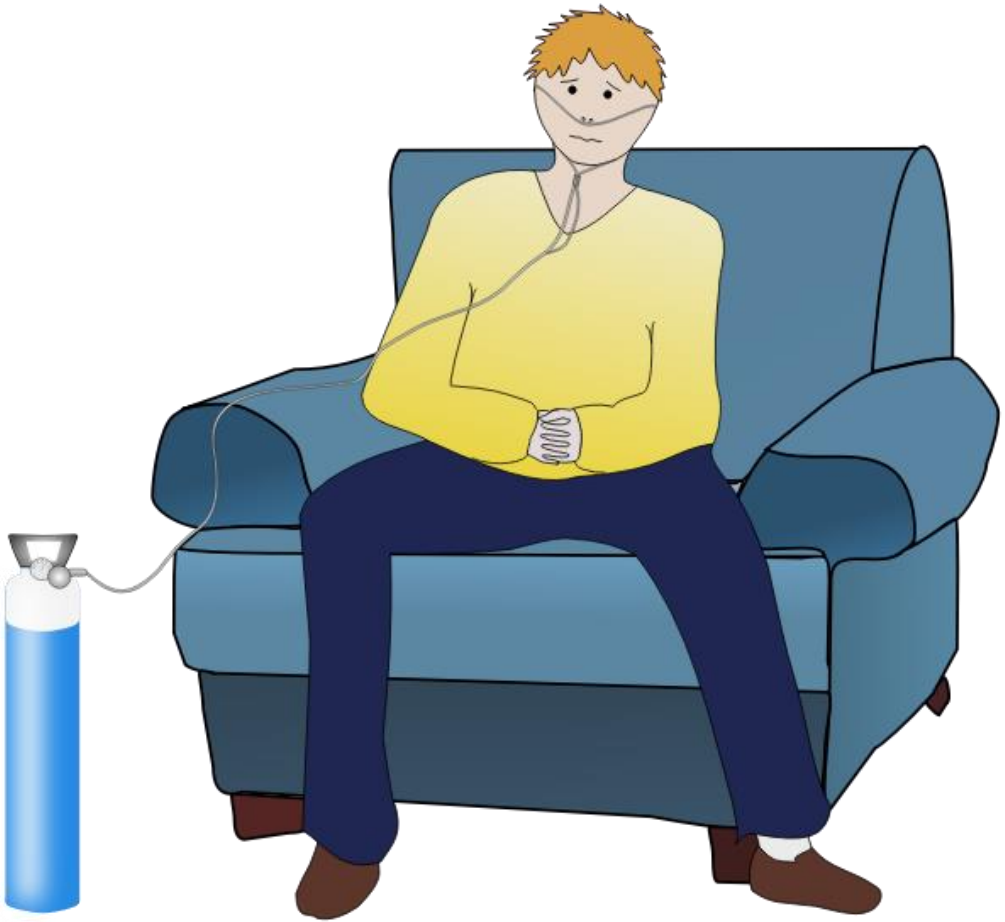
Goals of Care are directives set to be followed without further decision

Goals of Care = Resuscitation status

Goals of Care are only important for institutional medicine (hospital/LTC)

questions??





This is an example of...

1. Robert making decisions through shared decision making.
2. Robert making medical treatment decisions.
3. Robert setting his medical care plan.
4. All of the above.
5. None of the above.

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1. Robert making decisions through shared decision making.
2. Robert making medical treatment decisions.
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4. **All of the above.**
5. None of the above.

Capacity to make Medical Decisions

Being mentally capable means that you must have the ability to BOTH:

1. Understand the information you are given about the decision to be made:

- Why is the treatment being recommended?
- What are the benefits of saying Yes or No?
- Are there any other options?

AND

2. Understand what could happen if you say Yes or No to the treatment:

- How might it help or harm you?
- What will likely happen if you have it (or decide not to)?

Informed Consent

- Informed consent is the process where a capable patient or an incapable patient's SDM makes a decision about whether to agree to the decision to the treatment or plan of treatment proposed by health care practitioner.
- In Ontario, informed consent can only be obtained from a person. Health Care Practitioners cannot take direction (or accept as consent) from a document such as an advance directive or a level of care form.
- Informed consent is required before any treatment is started. The only exception this rule is certain emergency situations where the delay required to obtain consent would result in serious bodily harm. For example initiation of life saving treatment in an unconscious patient who arrives in the emergency department

Medical Treatment Decision Making

- Background information - review of health status
- Shared Decision Making
    - a) introducing choice,
    - b) describing options, often by integrating the use of patient decision support, and
    - c) helping patients explore preferences and make decisions.
- Review of Possible Outcomes of receiving or declining treatment. (ie. survivability etc)

Unlikely to benefit Sure to harm	Possible benefit Possible harm	Likely to benefit Limited harm

Having the resuscitation status conversation….

Tips

Know you levels of care in your institution (ie. shock only, cpr no intubation..).

Know the ins and outs of a DNR-c form in the community.

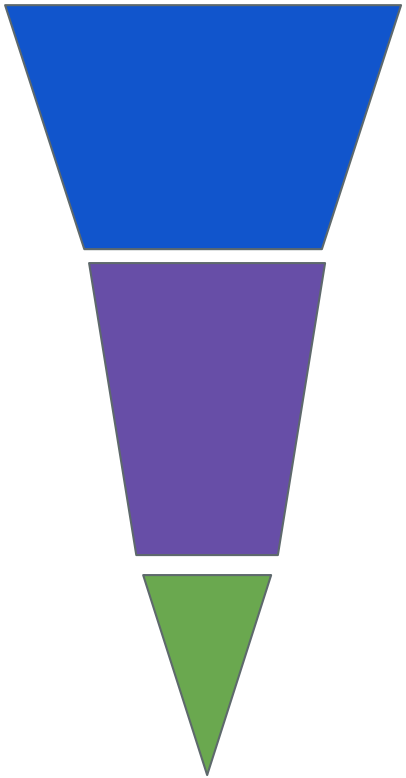
Resuscitation decision is made in the context of current illness.

An incapable person CAN NOT decide their own resuscitation status.

If you enter into the resuscitation conversation “knowing” what the right answer is…then don’t give the patient a choice…..

This is based in medical decision making concept of futility…

(ie. setting a “medical DNR”)



Advance Care Planning

- Conversations to confirm a person's substitute decision-maker (SDM) and prepare that SDM for future decision-making
- Focus on values and what's important to the person
- ACP is not consent for future care

Goals Of Care Discussion

- Discussions in the context of a current illness about
- a person's values & goals leading up to a treatment or care decision
- Aim is to align available treatment options with a person's goals

Consent For Treatment Or Care

- Conversation a healthcare provider must have with a person or their SDM prior to initiation of any treatment or personal care
- SDM only acts when the person lacks capacity for that decision

Questions?

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Me speaking to my husband (also a doctor)

"It was so sad today. I got a new consult for a man admitted with a stroke. He has a dense hemiplegia and can't speak. The TPA caused a secondary bleed. His wife and kids have never spoken to him about his wishes. They want IV hydration.

You know I would never want to live like that. I don't want to be in bed unable to communicate. Never extend my life if that happens to me."

Me to one of my home based palliative care patients with advanced CHF requiring home oxygen

“Robert, you seem to have a good understanding about your heart condition. You know that heart failure is not fixable and that you will continue to need medications and oxygen to help with your symptoms of shortness of breath etc. I am interested to find out from you – what is important to you right now? and what can I do to help you right now?”

“Robert, the fluid has collected in your lung again. Do you remember how Dr. Smith drained it a week ago, with the needle in your back?”

“You appear more short of breath and you are needing more oxygen; I think that draining the fluid will make you feel better. Last time you had it drained did it help you feel better? Was it hard on you to have the draining done? How long did feeling better last?”

“Robert, I can ask Dr. Smith to come and drain your lung again if you would like. There are two other options that you may want to consider….”

Me with Robert some more…..

“It sounds like being able to get from your room to the living room with your walker to watch your tv and talk with your friends who visit is important to you. Being independent in your mobility so that you can stay at home is fundamental to your quality of life. If you needed more assistance to get out of bed and couldn’t be home by yourself any more…where would you move to?

If your breathing got worse would you be willing to come to the hospital for tests or to stay? Would you want the doctors to use that special breathing machine with the tight mask that we had to use last time you were in hospital?”