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Commentary

# Advance care planning; we need to do it more, but it needs to be done differently

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Central to the patient-centered care movement, is that medical care provided to patients should be aligned with their values and treatment preferences. This requires that patient values and preferences are known and are authentic and informed as well as being accessible by the treating clinical team when decisions have to be made. Advance care planning (ACP) is one tool to enable patients (and/or their legal representative or next-of-kin) to pre- determine their values and preferences and document them in a way which facilitates patient-centered care. ACP has been shown over the years to improve concordance between patient preferences for use (or non-use) of life-sustaining treatment and actual care received [1].

In this article of *EClinicalMedicine*, Knight and colleagues [2] have provided a national snapshot on the accessibility of ACP at the point of medical decision-making for the UK. They audited a total of 123 hospitals in the UK and found, of all acute care admissions that approximately 5% had advance care plans available to the admitting medical team. This percentage was only slightly higher if the patients being treated were greater than 90 years old (12%) or were admitted from a long-term care facility (25%). These data are consistent with public polling data from Canada, where less than 20% of citizens had fully engaged in ACP [3]. The lack of a standardised definition of ACP and a standardised form to record the outcome of these planning conversations is a limitation of this work. But even in settings where such standardisations are in place, compliance rates are suboptimal [4].

Remarkably, in the above study, of hospital readmissions of patients aged 90 or more, only 15% had an advance care plan. This was such a lost opportunity for these older patients (or their surrogates), not being engaged in high quality planning discussions while in hospital or shortly after discharge. Consequently, most of these older patients are not likely getting 'patient-centered care' or the medical care that is right for them. In such a clinical context, we have shown that older patients are likely to get the medical care that's right for them only 1 in 3 times [5]. That's a high rate of medical error. Clearly, a higher rate of ACP is needed to be sure that patients are getting the medical care that is not only right for them but that they so desperately deserve.

One of the most puzzling findings, that may give clues as to what needs to be done differently moving forward, is that in only 60% of clinical encounters with patients aged 90 or more who are admitted to an acute medical service, did the attending physician state that having an advance care plan was appropriate. This number should be much higher. Which are the reasons why it isn't at 100%? Why wouldn't a clinician see a clinical encounter with a hospitalized 90+ year old with an acute problem as an appropriate time for engaging in a planning conversation, especially given the high rate of readmission or death in the ensuing 12 months? Despite being defined as planning for future medical care [6], could it be that some clinicians just see ACP as planning for 'terminal' or 'end of life' care and if they perceive the patient isn't going to die on this admission, it is possible that they mistakenly consider ACP as not appropriate? Unfortunately, eliciting preferences for future medical treatments is done today through the lens of when there is certainty around death or a poor health outcome. ACP done under conditions of certainty are rarely helpful to those working in acute care because clinical decisions are made about the use or non-use of life-sustaining treatments when the outcome is uncertain**.** Some acute care clinicians, might be dismissive of ACP because they question the validity and utility of certain instructional directives [7]. Moreover, we have shown that when we do standard ACP, we do not elicit values in a way that reliably informs medical decisions about the use or non-use of life sustaining treatments and that they are ill-informed about the risks, benefits and possible outcomes of such decisions [8,9]. This too may contribute to the attitudes of acute care physicians that ACP is not helpful or indicated. The way to advance and move forward involves more robust, reliable, and useful tools that help patients establish their authentic values and transparently connects those values to possible treatment options made in the context of uncertainty [10]. Unfortunately, in the study by Knight and colleagues the quality or utility of existing advance care plans is not commented or investigated. Suffice it to say, we need to increase both the quantity and quality of ACP. Patients deserve better.

## Declaration of Competing Interest

The author has nothing to declare.

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## References


[1] Houben CHM, Spruit MA, Groenen MTJ, Wouters EFM, Janssen DJA. Efficacy of advance care planning: a systematic review and meta-analysis. J Am Med Dir Assoc 15(7):477−89

[2] Knight T, Malyon A, Fritz Z, Sabbe C, Cooksley T, Holland M, Lasserson D. Advance care planning in patients referred to hospital for acute medical care: results of a national day of care survey. EClinicalMedicine 2019. doi: 10.1016/j.eclinm.2019.12.005.

[3] Teixeira AA, Hanvey L, Tayler C, Barwich D, Baxter S, Heyland DK. Canadian researchers at the end of life network (CARENET). what do Canadians think of advanced care planning? findings from an online opinion poll. BMJ Support Palliat Care 2015;5(1):40–7.

[4] Potenzi B, Lim AKH. Patient factors affecting the proper completion of a goals−of−care form in a general medicine hospital admission. Intern Med J 2019 (in press). doi: 10.1111/imj.14703.

[5] Heyland DK, Barwich D, Pichora D, Dodek P, Lamontagne F, You JJ, et al. Failure to engage hospitalized elderly patients and their families in advance care planning. JAMA Intern Med 2013;173:778–87 (PMID: 23545563).

[6] Rietjens JAC, Sudore RL, Connolly M, van Delden JJ, Drickamer MA, Droger M, et al. Definition and recommendations for advance care planning: an international consensus. Lancet Oncol 2017;18(9):e543–3551. doi: 10.1016/S1470-2045(17)30582-X.

[7] Moore N, Detering KM, Low T, Nolte L, Fraser S, Sellars M. Doctors' perspectives on adhering to advance care directives when making medical decisions for patients: an australian interview study. BMJ Open 2019;9:e032638. doi: 10.1136/bmjopen-2019-032638.

[8] Heyland DK, Heyland R, Dodek P, You JJ, Sinuff T, Hiebert T, et al. Discordance between patients' stated values and treatment preferences for end of life care: results of a multicenter survey. BMJ Support Palliat Care 2016;0:1–8.

[9] Heyland DK, Frank C, Groll D, Pichora D, Dodek P, Rocker G. Gafni a for the Canadian researchers at the end of life network (CARENET). understanding cardiopulmonary resuscitation decision making: perspectives of seriously ill hospitalized patients and family members. Chest 2006;130(2):419–28.

[10] Howard M, Slaven M, Bernard C, Borhan S, Elston D, Arora N, et al. Decision support intervention (Plan well guide) for patients and their substitute decision-makers to improve engagement in advance care planning: protocol for a randomised trial. BMJ Open 2019;9(9):e027897.