Policy Issue: Prioritize Advance Care Planning

Completion of advance care planning (ACP) documents, such as a living will,[1] is the best way a person can ensure that his or her treatment wishes are honored during a period when he or she is incapacitated and unable to communicate.

Recommendation

Texas policy should promote structured ACP as a routine standard for medical care at all stages of life. Texans should be educated on the benefits of ACP and the options it provides. With informed consent, structured ACP discussions can come from any provider that sees a patient on a regular basis, whether it be a primary care provider, therapist, or specialist. Proxy decision makers for the patient should be included in these conversations whenever possible. Information from ACP conversations should be entered into written and signed advance directives and recorded in the medical records of each patient seen at least annually, no matter the purpose of a visit.

Discussion

ACP is a process of regular discussion and documentation about patient goals and wishes for future medical care.[2] Advance directives are written, legal instructions produced by this process that record preferences for medical care and identify a proxy decision maker for a time when a person is unable to make decisions for him or herself. By planning ahead, a person can avoid unwanted or unnecessary suffering and relieve caregivers and loved ones of decision-making burdens during moments of crisis or grief. More information on advance directives, including templates for statutory ACP documents, is available on the Texas Palliative Care Information and Education website.[3]

[1] A living will is known in Texas as a "Directive to Physicians and Family or Surrogates."
[2] Emanuel LL, von Gunten CF, and Ferris FD. "Advance Care Planning." Archives of Family Medicine, 2000:9, https://micmrc.org/system/files/Advanced%20Care%20Planning_Archives%20of%20Family%20Medicine.pdf (accessed September 11, 2018).
[3] For more information see: https://hhs.texas.gov/services/health/palliative-care (accessed September 11, 2018).

A key concept for ACP is permission. As a general rule, palliative care and other professionals should avoid forcing a goals of care/advance directive discussion that a patient, family, or surrogate does not wish to have. No permission should mean no discussion.

With rare exceptions, goals of care and advance directive discussions should occur only when a patient is not ill or when his or her symptoms are under reasonable control. Professionals must not assume that goals of care discussions will necessarily lead to limitations on life sustaining treatments but instead may lead to aggressive treatments. Whether the patient's preference is for limited, intermediate, or the most intense treatments, the patient's preferences should be clearly documented.

Evidence indicates that structured ACP approaches are most successful at fully eliciting these preferences. A structured process involves the use of validated tools to facilitate dialogue over a range of potential healthcare scenarios and alternatives. While this Council does not recommend a single approach for structured ACP, it does recognize that many evidence-based and reliable options exist.[4]

If a patient agrees to a goals of care and advance directives discussion, this Council has previously recommended a focus on living wills first, to be followed by creation of a medical power of attorney, if desired by the patient. Living wills generally allow a more accurate expression of patient preferences if terminally or irreversibly ill and unable to communicate. This is especially true of modern digital advance directives, including video recordings that allow persons more flexibility and ease for changing treatment preferences. Such directives are usable under Texas law since the Legislature approved digital signatures on advance directives. The most recent study to test whether the living will and medical power of attorney reduce non-beneficial treatments for seriously ill patients found stronger statistical effects for the living will.[5]

[4] For a listing, see the Centers for Disease Control and Prevention (CDC) website: https://www.cdc.gov/aging/advancecareplanning/index.htm and CDC's Advance Care Planning -- Selected Resources for the Public: https://www.cdc.gov/aging/pdf/acp-resources-public.pdf (accessed September 18, 2018). ACP tools listed by the CDC include: Caring Conversations Workbook, Five Wishes, Consumer's Tool Kit for Health Care Advance Planning, and many others.

[5] Amol K, Wright AA, Nicholas LH. "Trends in Advance Care Planning in Patients with Cancer." JAMA Oncology, August 2015, https://jamanetwork.com/journals/jamaoncology/article-abstract/2383145 (accessed September 11, 2018).