Advance HealthCare Planning in the clinic setting must be useable and consistent with ethical standards. This primer will include:

- Types of Advance Care Planning
- CPR Outcome data
- How to do serial ACP discussion

A Living Will is the oldest form or advance care directives. It was originally based on real estate law seeking to control property after one’s death. A typical example is “if I suffer an incurable, irreversible illness, disease or condition and my attending physician determines that my disease is terminal, I direct that life-sustaining measures that would serve only to prolong my dying be withheld or rescinded”. Or in other words I want to “die with dignity”. It is easy to see how beautiful this sounds but how ineffective it is operationally when it comes to the standard decisions we make in modern medicine. The second generation of advance care documents is the DPOA or durable-power-of-attorney for health care. This is the most important directive information as it is the most robust. However it only reflects the true preferences of the patient 68% of the time so it’s important that the patient know that they are entrusting decisions on someone who is acting on their best interest using their knowledge of the patient—even if they get it wrong. The third generation of directives is long, complex and not operationally useful in the field where decisions are made. The IPOST, Honoring Your Wishes, Five Wishes among other are examples that compliment but don’t replace actual discussions.

CPR outcome data suggests a range of surviving with a good quality of life at 10 to 15% after an in-hospital resuscitative event. This estimate is less secure for patients under 65 but that is not the intended audience for these discussions. For older patients with comorbidities or in a skilled nursing facility I recommend using the “3-3-3” rule. That is, 3% of inpatient CPR/ACLS events result in success, 3% are more impaired and 3% are in various durations of persistent vegetative state. If you’re like most physicians and are known to overestimate prognosis the go to https://www.gofarcalc.com/ and note that if your patient has four of these (dementia, trauma, hypotension, liver or renal insufficiency, acute stroke, metastatic cancer, sepsis, pneumonia, other medical non-cardiac disease or in a skilled nursing facility) then their ACLS outcome is only 1.7%.
This primer is for routine scheduled advance care discussions. You can compare the pros and cons of the four types of clinical environments where ACP is done:

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<tr>
<th>Environment</th>
<th>Advantages</th>
<th>Disadvantages</th>
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| **Routine prescribed advance directive discussion** | • Less urgency bias  
• More time  
• With PCP  
• Doesn’t need to be done at any one visit | • Not specific to any clinical situation  
• Needs updating if health status change |
| **Hospital admission**                           | • Codified into hospital policy and provider tradition  
• Reminds patient & family that choice exists | • “Medical Miranda”  
• Rushed discussion  
• Discordant discussion  
• Usually done poorly  
• Patient distracted or takes it the wrong way |
| **Major health status change (+/- acute admission)** | • Content of discussion is more clinically relevant  
• More time and more likely to be with PCP  
• Classic Goals of Care meeting | • Recency bias |
| **Critical deterioration**                       | • Relevant (has everyone’s attention)  
• Clinically specific | • Unlikely that patient is decisional (internal or external constraint on DMC)  
• Extreme time pressure |

ACP discussions in the clinic are effective because they are done over time. Find a way to have your continuity patients over 65 see you every 12 to 16 months for a Medicare Wellness evaluation. If you don’t want to do those just reserve a clinic visit to engage in preventive health issues and include an ACP discussion. The format I will present takes 10 minutes the first time you do it and 5 minutes in subsequent years for updating. If there has been a significant health changing event it may take 10 minutes again.

The common elements needed for an effective ACP discussion are:
- Critical and exact use of language
- Balance between overly specific and non-specific content
- Assume abandonment is always in the patient’s mind (especially if sick)
- Normative information helps when discussing confusing or threatening topics

Normative information is a statement you make that provides background information that helps the patient or their DPOA avoid assumptions. Examples include:
- “I would place a nasal feeding tube if you couldn’t eat with a temporary illness—but what I want to talk about is a permanent loss of eating ability”
- “Being in and ICU can be physically and emotionally uncomfortable for you and your loved ones”
- “It can be uncomfortable to talk about these things…”
- “Every day after two days in and ICU without clear improvement has diminishing returns”
- “90% of physicians state that if they had dementia or another chronic life-limiting illness would chose to be DNR/DNI”
- “If despite all you do your heart still stops you only have a 3% chance of recovery”
Here is a documentation example of my ACP discussion. It contains the 1. Date, participants and decision-making capacity of the patient, 2. DPOA, 3. Menu of Care Option with preference, 4. Code Status, 5. Artificial feeding status, and 6. May change at any time statement. Note the careful wording.

Jan 25, 2018. Patient was alone. Patient is decisional.
-- DPOA is her daughter Angela of Marshalltown. Second proxy would be her sister, Irene of Oelwein.
-- If the patient met criteria for critical care she would want to go there. If after 2 days she made no clear clinical improvement she would want a goals of care meeting on ICU Day 3 with consideration to transition to critical care.
-- She is DNR/DNI.
-- In the event she likely had both a loss of DMC and swallowing she declines artificial nutrition.
She is aware she can change this at any time.
R. Dobyns, MD

What if the patient does not appear to have decision making capacity—or is nowhere close to being able to do this? If so then it is best to just do the DPOA question, and then have your nurse contact that person to encourage them to attend a subsequent visit. At that visit proceed with the rest of the ACP list by allowing them to go back and forth between each other in answering the questions. The more impaired the patient the more the DPOA will take the lead. If it appears the DPOA and the patient are communicating well then the advance care planning preferences are legitimate.

Here is a script of each part of the discussion:

**DPOA**

“ I would like to talk about Advance Care Planning. In other words I want to record what kind of hospital care you would want for yourself if you got very sick. Is this okay with you?”

“First, if you were so physically sick or mentally unable to direct your own medical care who would you want to do it for you?” [one name only. If they struggle then assist with naming an adult child, sibling or close friend—in that order per Iowa Code. If more than two then get a rank order]

Remember that this person is supposed to make medical decisions **based on what they think you would want**—not what they want. Can they do this?” [this is important if the DPOA is present]

**Menu of Care Options** (can do this at another visit as it’s the longest part”

DNE—DO NOT go to the EMERGENCY Room. Manage over the phone or with a home visit (nurse or physician)

DNH—DO NOT HOSPITALIZE but if an ER visit possibly followed by a short palliative care stay would help guide treatment then that’s okay

DNC—DO NOT transfer me to the CRITICAL care unit. If I am in an acute medical bed and get critical then would prefer comfort cares

ICU—if critical transfer me to the critical care unit. But if I make no clear clinical improvement then I would like to have a goals of care meeting on Day 3, 5 or 7 to consider transfer to palliative/comfort care. If I’m improving then keep going.
Look at your patient and guesstimate which of the six options which two or three make sense. It’s okay for you to do this as an “ethical” ACP discussion recommends some level of determination of the patient’s best interests by the physician—especially in the context of a continuity relationship.

Note that for the 3 ICU options we’re only trying to establish what ICU day the intensivist team would want to schedule the “goals of care” meeting—not the “what day do we pull the plug meeting”. If you try to get more information than this you will get “lost in the weeds”, blow up your clinic schedule and exhaust everybody in the room including yourself. If you don’t get this information you will lose the opportunity to discuss what most physicians want to discuss with their patients—that is, how to negotiate our complex health care system toward the end of your life.

### DNR/DNI or FULL CODE

“Let’s discuss what you would want done if your heart would have trouble beating effectively. (signpost)
If you were in a hospital and your heart was having trouble beating effectively this could lead to your dying. We would be aggressive in giving you medicines and procedures to correct the problem. If DESPITE ALL THAT your heart still not beat effectively then we could use electricity to try to shock your heart back and place a tube down your throat to artificially breathe for you. This is called heart resuscitation. The chance that this would help you is small and it would be uncomfortable for you. The chance you would survive and ever leave the hospital is [3% or 10—15%]. If you prefer we not go that far and keep you comfortable instead we can do that. What would you want?”

Remember that DNR/DNI status only relates to hospitals. In the community it’s always a FULL CODE.
Artificial Nutrition

“If you were unable to eat or drink effectively for 5 days, say with the “flu”, I would artificially feed you with a feeding tube and IV until you got better. But that’s not what my question is about.”

[This statement clues the patient that you’re instead going to ask them about a more permanent situation which is a common misconception in artificial feeding discussions.]

“Imagine you had two things happen you —you have likely lost permanent ability to make your own decisions because of a brain problem—and you likely lost permanent ability to effectively eat. A likely reason for this would be a stroke.”

[If you ask a patient to not feed them if they still have their same quality of life then then this is not what you need to know. In that case an advance directive is not needed since the patient would be decisional. It is only when the patient is non-decisional that their preference in advance of the event is needed. The term phrase “…likely lost permanent ability…” is important to discriminate from something that is likely more temporary]

“If both things happen to you then the quality of your life compared to now would be diminished.”

[Again, you’re cueing the patient that their answer needs to reflect this different context]

“In this situation we could place a feeding tube into your stomach to feed you artificially. Would you want this?”

[Most patients say no. If they struggle than you may add that evidence has never shown that PEG/NG/NJ feedings in this context extend life. Feel free to acknowledge that one’s cultural or religious beliefs my suggest the need to feed. If after this studies show most decline artificial nutrition]

Close the discussion by saying that you’ll bring this up again next year or if their health changes and that they can change their directives at any time. Then document as shown above

PUTTING IT ALL TOGETHER

YOU DON’T NEED TO DO ALL OF THIS. EVERY TIME JUST MOVE THE DISCUSSION FORWARD. THE MOST IMPORTANT THING IS LETTING THE PATIENT KNOW THAT THEIR OPINION IS VALUED AND NEEDED.

IF THE PATIENT HAVE OTHER ADVANCE CARE PLANNING MATERIALS THEN ACCEPT THEM AND HAVE THEM SCANNED OR PLACED INTO THE MEDICAL RECORD. EXPLAIN THAT THIS DISCUSSION SUPPLEMENTS WHATEVER PLANNIGN THEY’VE DONE BEFORE BY COMMUNICATING THEIR MEDICAL PREFERENCES IN A WAY THAT FACILITATES HOW DOCTORS AND NURSES MAKE DECISIONS ON THEIR BEHALF