

How to implement Advance Care Planning for patients

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Palliative care. Credit: Lancaster University

Emeritus Professor Sheila Payne from the International Observatory on End of Life Care at Lancaster University helped conduct the study commissioned by the European Association for Palliative Care (EAPC)

and published in *The Lancet Oncology*.

The recommendations are based on the knowledge and experience of more than a hundred experts from fourteen countries in the field of Advance Care Planning.

Advance Care Planning (ACP) is a process in which patients discuss their goals and preferences for future medical treatment and care with their relatives and health-care providers. These preferences can be documented in an advance care directive, to be used if patients at some point are unable to express their preferences themselves.

ACP is important because people sometimes receive treatments they might not wish to receive such as resuscitation or admission to hospital in the last phase of life. Such decisions are often taken in circumstances in which [patients](#) are unable to express their preferences themselves, or when decisions have to be made urgently.

By timely consideration and discussions with relatives and health-care providers about what one would prefer in such circumstances, the chances are increased that people's goals and preferences for future medical treatment and care can be included in the medical decision-making. ACP also helps relatives to feel comfortable to make medical decisions with health-care providers, when the patient is no longer able to do so.

There is still a lot of uncertainty about what ACP is and how it should be conducted in practice. Is it applicable to everyone? What topics should be discussed? At what time? And whose responsibility is it to start ACP?

The study recommended, for instance, that ACP should be adapted to the individual's readiness to engage in the ACP process.

Professor Payne said: "We consider that ACP is a process rather than a one-off conversation or a tick box exercise. If the patient prefers, ACP can be initiated early on in the disease [process](#).

"We recommend that as values and preferences might change over time, ACP conversations and documents should be updated regularly. This can happen for instance if the individual's health condition worsens, their personal situation changes, or as they age."

More information: Judith A C Rietjens et al, Definition and recommendations for advance care planning: an international consensus supported by the European Association for Palliative Care, *The Lancet Oncology* (2017). [DOI: 10.1016/S1470-2045\(17\)30582-X](https://doi.org/10.1016/S1470-2045(17)30582-X)

Provided by Lancaster University

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