"Planning for future health care choices is a wise thing for all capable adults to do. Life threatening illness or injury can happen at any time and it's important that those who may have to make decisions for your care, if you are unable to do so, are clear about your wishes and know that they are supporting you in the choices you have made. **My Voice: Planning in Advance Regina Qu'Appelle Health Region, p. 3**.

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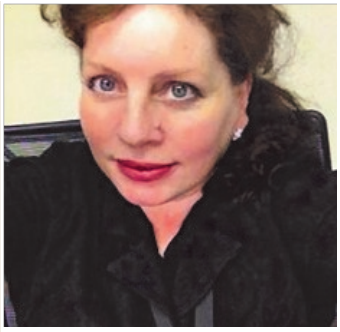
Catholic Health Association of Saskatchewan

St. Paul's Hospital

An ethics newsletter for Catholic health care organizations in Saskatchewan

SaskEthics

Clarifying legal and process aspects of advance care planning in Health Regions - Part 2



In Part 2, I want to look further at the advance care planning process for people with and without capacity.

1. Patient with capacity who has made an advance directive

Ask for a copy of the Advance Directive on admission or soon thereafter. Place in chart.

While advance care planning can be mentioned at the time of admission, it is better to wait until the patient/resident has settled into a long term care home, do not engage with advance care planning until the patient is settled. At least a week, maybe longer, depending on the patient. In acute settings, advance care planning exercises, such as resuscitation care plans and discussions may be more urgent. Explain the advance care planning process in your health region to patients. (For example, the 'My Voice' goals of care forms in Regina Qu'Appelle Health Region or the 'Serious Illness/ Sudden Collapse forms in the Saskatoon Health Region).

Explain the advantages of using these forms. "To ensure we respect and follow your wishes, respect your autonomy, so the staff can quickly see what to do if you become ill, so that your family knows what you want, etc."

Ask patient/resident if they would like to complete a form. If they do not wish to do so, explain what will happen, especially in the case of a cardiac arrest. For example: "we will follow your advance directive", or if resuscitation is not mentioned on the advance directive, "without your direction we will commence CPR and call 911".

If the patient chooses to complete health region paperwork, the existing advance directive can be used to inform the discussion. During discussion the patient may decide to rescind their existing advance directive or to change parts of it.

On this point it is important to realise that some people make advance directives in isolation and without the input of clinically trained people who are able to speak to diagnosis, prognosis and the impact of advanced life support measures in a patient's or resident's particular case. The advance care planning conversation provides a perfect opportunity for decision-making to take place in a more informed way.

The patient/resident may rescind an existing advance directive IF HE OR SHE CHOOSES TO DO SO and at this point may designate the health region form as their advance directive. The person should never be coerced to do so. He or she may choose to keep an existing advance directive.

If the patient or resident chooses to change his or her advance directive at this point, the change can be made by writing a new directive, or in the case of a minor change, making it on the form and initialling and dating each change.

At the end of the process any advance directive and the health region paperwork should show consistent choices. The documents should be attached to each other in the chart and travel with the patient if he or she is transported to another health care setting.

2. Patient with capacity who has not made an advance Directive

In this circumstance the patient is the person engaged in advance care planning. Again, wait until the person has settled into care in long term care settings. An explanation of the advantages of advance care planning can be given.

If the patient/resident does not wish to engage in an advance care planning process and does not have an existing advance directive, an explanation of what will happen if he or she becomes seriously ill or experiences a cardiac arrest should be given. This is not coercion, it is providing information about what will happen. The patient may, if he or she chooses, designate a health region form as his or her advance directive

but should not be coerced to do so.

A person may choose to complete both an advance directive form of their own choosing and the health region paperwork at this point or to do one or neither. At the end of the process the advance directive and the health region paperwork should be consistent. The documents should be attached to each other in the chart and travel with the patient if he or she is transported to another health care setting.

3. Patient without capacity enters care who has made an advance directive

Ask for a copy of the advance directive and place in chart. The advance directive will inform any advance care planning process in the health region. THE ADVANCE DIRECTIVE IS NOW IN OPERATION BECAUSE THE PERSON WHO MADE IT LACKS CAPACITY. Note also, that a proxy/proxies or substitute decision-maker cannot rescind or change the advance directive and act according to the known wishes of the patient and DO NOT OVERRIDE an advance directive made by the patient.

There may be items that have not been covered by the advance directive or are unclear. The proxy/proxies or substitute decision-maker can make decisions on these items according to the known wishes of the patient/resident, or where unknown, in the best interests of the patient/resident.

At the end of the process, the advance directive and any health region forms must be consistent. The documents should be attached to each other in the chart and travel with the patient if he or she is transported to another health care setting.

4. Patient without capacity enters care and has not made an advance directive

In this circumstance the proxy/proxies or substitute health care decision-maker will engage in advance care planning. Again, they may choose not to do so and in this circumstance should be informed what will happen e.g. "If we don't have guidance and a cardiac arrest occurs, a Code Blue will be called", or "CPR will be started and 911 will be called".

An explanation of the advantages of advance care planning can be given. If the proxy/proxies or substitute decision-maker is agreeable, proceed with the health region advance care planning process. An explanation that a proxy or substitute decision-maker acts according to the known wishes of the person they represent should be given and can act from a best interests position where wishes are unknown can be given. Those making decisions should be guided by discussions they or others may have had with the patient/resident while he or she had capacity where wishes were expressed. Where direct conversations have not taken place, the expressed values and beliefs of the patient/resident can be useful in guiding decision-making. 'Some people may have been involved in decision-making for others. During these times, how did the patient/resident tend to think?' may be a useful question to help proxy, proxies or substitute decision-maker put together a picture of how the individual they represent may have thought about health care decisions.

At the end of the process you do not have an advance health care directive of the patient. This is because only a person with capacity can make an advance directive while he or she has capacity. Rather, you have a directive of the proxy/proxies or health care decision-maker (in this case a written instruction about how to proceed in an emergency or serious situation given by a proxy or health care decision-maker).

Please email any questions to joy.mendel@saskatoonhealthregion.ca and I will address them in Part 3.

Joy Mendel
Ethicist, Catholic Health Association of Saskatchewan

Upcoming Telehealth Events

Advance Directives and Health Care Decision Making in Saskatchewan

August 25th 2:30pm-3:30pm

PLEASE NOTE: DATE HAS BEEN CHANGED

St. Paul's Hospital

ST. PAUL'S HOSPITAL FOUNDATION INC.

Saskatoon Health Region

William F. Mitchell Bioethics Seminar 2014
presents

The Ethics of Physician Assisted Suicide and Euthanasia
with Professor Margaret Somerville

Tuesday, November 4, 2014
Time: 10:30 am
St. Paul's Hospital Pylypchuk Hall

Annual seminar funding supported by

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TeleHealth will be available for this event.
Mainpro 2 credits possible.