

ADVANCE CARE PLANNING PRACTICE PRINCIPLES

These principles were developed by a multidisciplinary group of experts convened in 2017 by the American Bar Association Commission on Law and Aging in collaboration with the American Academy of Hospice and Palliative Medicine, the University of California at San Francisco Medical Center and the UCSF/UC Hastings Consortium on Law, Science & Health Policy, with funding from **The John A. Hartford Foundation** and additional support from the Borchard Foundation Center on Law and Aging.

The principles provide a conceptual framework and guideline specifically for lawyers and health care professionals to align the practice of advance care planning in legal offices with the realities of implementation in health settings. These are informed by current evidence of what makes advance care planning effective in healthcare settings as summarized in the Institute of Medicine's report on *Dying in America* and a growing body of related literature.¹ Legal and health professional organizations are encouraged to endorse these principles.²

1. **Proxy Designation:** The most important *legal* component of advance care planning is careful selection and appointment of a health care agent/proxy in a valid power of attorney for health care document. Persons who cannot or do not want to identify a proxy should delineate their wishes in an advance directive.
2. **Ongoing Process:** Advance care planning takes place over a lifetime. It changes as one's goals and priorities in life change through different stages of life and health conditions. Reflection, discussion, and communication with one's proxy and clinical professionals, along with family, friends, and advisors is essential to having one's wishes understood and honored. These discussions should occur with patients/clients of all ages at all stages of life and health.
3. **Values, Goals, and Priorities:** Discussion should focus on one's values, goals, and priorities in the event of worsening health rather than on specific treatments or clinical interventions for distant hypothetical situations.
4. **Advance Care Planning Tools:** Advance care planning tools and guides can provide structure and guidance to the process of reflection and discussion and help individuals identify their values, goals, and priorities, and ensure more authentic and useful conversations and advance directives.
5. **Advance Directive:** Instructions and guidance documented in an advance directive should result from the process of information sharing, reflection, discussion, and communication and provide enough flexibility in application to allow surrogate decision-makers to respond to new circumstances and complexities.

6. **More serious illness:** If individuals are facing serious diagnoses, such as cancer, or have been told they have a limited prognosis, the focus may then move to specific treatment preferences. In these cases, the person’s primary/key health care provider should also meet with the client and/or their closest loved ones to create a care plan that aligns with the client’s goals, values and preferences. For advanced illness, medical providers should consider introducing palliative care options and the option of providing medical orders such as Physician’s Orders for Life Sustaining Treatment (POLST)³ to ensure the individuals wishes are translated by medical professionals into actionable medical orders.

7. **Sharing Documents:** Documentation of one’s values, goals, and wishes in the form of an advance directive or other record should be shared with one’s proxy, loved ones, significant others, and primary/key health care providers, and be included in the medical record, so that they are adequately informed before a crisis arises.

8. **Coordination:** Lawyers and health care professionals should aim for greater coordination of advance care planning efforts with the healthcare system/medical providers through congruent advice and practices in accordance with the principles above, greater willingness to reach out to one another with client/patient consent to obtain information when needed, and greater collaboration in joint continuing education. programming.

References

¹ IOM (Institute of Medicine). 2015. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press. Available at: <http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>.

² If willing to consider endorsement, contact project staff Charles Sabatino at charles.sabatino@americanbar.org, or David Godfrey at david.godfrey@americanbar.org.

³ For information about Physician Orders for Life-Sustaining Treatment, see www.polst.org.



ABA Commission on Law and Aging

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