Alberta Medical-Legal Joint Practice Principles on Advance Care Planning

June 2025

Covenant Health
Palliative Institute

Introduction

The Alberta Medical-Legal Joint Practice Principles on Advance Care Planning (the "Joint Practice Principles") were developed collaboratively by members of the legal and health care sectors who have roles in advance care planning.

They describe key concepts and roles (including the role of the client/patient) and provide useful information about the respective practice contexts in health care and law. Their intent is to establish shared terminology and understanding of best practices, provide resources, lead professionals to evaluate and optimize the effectiveness of their practices, and further encourage collaborative approaches to advance care planning. They are not intended to create liability.

Development

In 2023-24, Covenant Health Palliative Institute hosted four focus groups attended by a total of 26 unique participants. Invitations were circulated through professional associations and communities of practice,[1] and to others as they were identified by the Palliative Institute's Advance Care Planning Advisory Committee, professional associations and team members. The first focus group reviewed and made recommendations based on the Joint Practice Principles on Advance Care Planning (2018) developed by the American Bar Association.[2] Using an iterative model of development, each subsequent focus group reviewed the most recently revised version of the Joint Practice Principles. Together we reached consensus on key elements of advance care planning, roles and coordinated approaches.

Companion Resource for Legal Practice

The Joint Practice Principles are augmented by a guide for Alberta lawyers called Advance Care Planning and Personal Directives: Recommendations for Legal Practice in Alberta (the "Recommendations for Legal Practice"), originally created for the Legal Education Society of Alberta's course on advance care planning ("Aligning Practice to Reality: Understanding Advance Care Planning", April 2024). This guide contains six specific recommendations, additional rationale and examples from health care providers and the Office of the Public Guardian and Trustee, precedent language and a list of resources.

[1] Canadian Bar Association, Alberta sections of Elder Law, Health Law, and Wills, Estates and Trusts; Alberta Health Services Palliative Care Grand Rounds, Provincial Advance Care Planning and Goals of Care Designation Community of Practice and Provincial Palliative and End-of-Life Care team.
[2] Advance Directives: Counseling Guide for Lawyers, Commission on Law and Aging, American Bar Association, 2018.

Definitions

Advance care planning or ACP:
The process of preparing people and alternate decision-makers for communication and medical decision-making. The process is conceptualized as being five steps:

1. Think about your values and goals;
2. Learn about your health;
3. Choose someone to make health and personal decisions for you;
4. Communicate your wishes to the people you trust and your healthcare team; and
5. Document your wishes in a personal directive.

Agent:
A person designated in a personal directive to make personal decisions on behalf of the maker.

Alternate decision-maker:
A person who is authorized to make decisions on behalf of an individual.

Maker:
A person who makes a personal directive.

Public Guardian:
The Public Guardian of Alberta appointed under the Adult Guardianship and Trusteeship Act SA 2008, c A-4.2.

Serious illness:
A condition that carries a greater risk of mortality and negatively impacts a person's daily function or excessively stresses their caregivers.

Joint Practice Principles

Principle	Definition	Relevant provisions of companion resource: Recommendations for Legal Practice
1. Proxy Designation	The most important legal component of advance care planning is the careful selection and appointment of an agent and alternate agent(s) in a valid personal directive. It is important for the maker to confirm that their agent is willing to act and prepare their agent by sharing with them the maker's beliefs, values, wishes and goals for health and personal care. Individuals who cannot identify an agent may designate the Public Guardian as their agent by complying with the Personal Directives Act, as amended. For individuals who do not want to appoint an agent, it is especially important for them to record their beliefs, values, wishes and goals in a personal directive as a means of sharing these with alternate decision-makers.	See Recommendation #1: Strongly advise your client to appoint and equip their agent (page 11) Criteria to choose the best candidate(s) (page 11) Agent's authority and duty (page 11) Considerations regarding appointing multiple agents (pages 12-13) Naming the Public Guardian as agent (page 13)
2. Advance Care Planning as an 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. Ongoing reflection, discussion and communication with one's agent and health care team, along with family, friends and advisors, are essential to having one's beliefs, values, wishes and goals understood and honoured. These discussions should occur for all adults (over the age of 18), who have decision-making capacity, at all stages of life and health.	See: Revisiting advance care planning upon certain events (the "Six Ds") (page 16) Communication between individual and their health care provider (pages 15-16) Communication with agent and others (pages 11-12, 15)
3. Focus on Beliefs, Values, Wishes and Goals	In general, individuals should be encouraged to focus on their overarching personal beliefs, values, wishes and goals in the event of worsening health instead of specific treatments or clinical interventions for hypothetical situations.	See Recommendation #2: Encourage your client to identify and discuss their values with their agent(s), loved ones and health care providers, and thoughtfully and comprehensively document these in their personal directive (page 13) Questions and resources to elicit client's values (pages 13-14), sample clauses (pages 14-15) Reasonableness of predicting future wishes about specific limitations and treatments (page 16)

Principle	Definition	Relevant provisions of companion resource: Recommendations for Legal Practice
4. Advance Care Planning in Serious Illness Care	If individuals are facing serious illness, the focus of advance care planning may then move to specific treatment preferences. In these cases, the individual is encouraged to meet with their primary/key health care provider to create a care plan that aligns with their beliefs, values, wishes and goals. Ongoing discussion between the individual, their agent, family, friends and advisors about the individual's beliefs, values, wishes and goals, and as acceptable to them, continues to be important. The health care provider should be informative and willing to educate the agent/alternate decision-maker of their responsibilities.	See: Advise client to have a goals of care discussion with their health care provider (page 16) Communication between individual and their health care provider (pages 15-16)
5. Advance Care Planning Tools	Advance care planning tools and guides can provide structure and guidance to inform the process of reflection and discussion, and help individuals identify their beliefs, values, wishes and goals. Such tools and guides may help ensure more authentic, compassionate and effective conversations, personal directives, and Goals of Care Designation orders so they better align with an individual's beliefs, values, wishes and goals for health care now and in the future.	See: Recommended resources (page 23)
6. Role of Personal Directive	A personal directive is the legal document that appoints a maker's agent and/or records the maker's beliefs, values, wishes and goals for personal matters, including health care, to guide decision-making if the maker loses capacity. The personal directive should result from a process of information sharing, reflection, discussion, and communication. Inclusion of values-based statements can help ensure enough flexibility in the personal directive to allow alternate decision-makers to respond to new personal and/or medical circumstances. Although instructions about specific interventions are generally discouraged, they may be justified in special circumstances by the maker's clinical and personal context. In such cases, the personal directive should provide an explanation of the context to assist those who may be interpreting the personal directive.	See: Recommendation #4: Guidance on drafting personal directives (page 17) Addressing potential concerns and confusion about validity of personal directive (page 17) Providing context for "unusual" wishes (pages 17, 21) Health care's difficulty in interpreting subjective language and decontextualized instructions (pages 17-19) Drafting to foster agent's flexibility (page 20)

Principle	Definition	Relevant provisions of companion resource: Recommendations for Legal Practice
7. Sharing Documents	Makers should share documentation of their beliefs, values, goals, and wishes in the form of a personal directive with their agent and health care team, and ensure the personal directive is part of the health record, so that they are adequately informed before a crisis arises. Makers should also be encouraged to consider sharing their personal directive with their family, trusted friends and advisors, as appropriate.	See: Recommendation #5: Guidance on storing personal directives (page 21) Sharing and uploading personal directives (page 21)
8. Health-Legal Collaboration	Joint initiatives on advance care planning between the legal and health care sectors benefit clients and patients. These initiatives aim to increase awareness of respective professional and practice contexts, identify issues, and develop and implement new approaches, such as joint education, congruent policies and practices, best practice guides and precedent documents.	
9. Role of Goals of Care Designation Order	A Goals of Care Designation (GCD) order is a medical order that provides one set of short-hand instructions by which health care providers describe and communicate general care intentions, specifically indicated health interventions, transfer decisions and locations of care for a patient. A GCD order can only be written by a physician or nurse practitioner and does not require patient consent. A GCD order strives to harmonize a patient's values, wishes and goals for health care as it relates to their current health care status and clinically indicated care. Individuals should be directed to their health care team for more information about GCDs.	See: Information and resources from the Government of Alberta, Alberta Health Services and Covenant Health Palliative Institute (pages 16, 23)