

Primer for Medical-Legal Symposium on Advance Care Planning

Covenant Health Palliative Institute
February 20, 2025



Land Acknowledgement

We acknowledge that we are located on Treaty 6, 7 and 8 territories. We respect the histories, languages, and cultures of First Nations, Métis, Inuit, and all First Peoples of Canada, whose presence continues to enrich our vibrant community.



Introductions

Moderators

Maureen Douglas JD

Trish Biondo PhD

Tyler Hamil MPA

ACP Alberta

Covenant Health Palliative Institute

Funding:  The views and opinions expressed do not necessarily reflect the official policy or position of the Alberta government.



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Chat



Using the Chat feature, please introduce yourself:

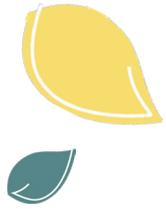
What does advance care planning have to do with your role?



Outline

1. Advance care planning: concepts & current state
2. How are personal directives used in health care settings?
3. Medical-legal collaboration on ACP in Alberta
 - a. Joint Practice Principles 2025
 - b. Recommendations for legal practice
4. Evaluation





Advance Care Planning Concepts



Advance Care Planning

The process of preparing patients (people) and alternate decision-makers for communication and medical decision-making.

ACP 5 Steps From: [Advance Care Planning Checklist](#) on [CompassionateAlberta.ca](#)



Benefits

Review > J Pain Symptom Manage. 2018 Sep;56(3):436-459.e25.
doi: 10.1016/j.jpainsymman.2018.05.016. Epub 2018 May 25.

Overview of Systematic Reviews of Advance Care Planning: Summary of Evidence and Global Lessons

Geronimo Jimenez¹, Woan Shin Tan², Amrit K Virk³, Chan Kee Low⁴, Josip Car⁵,
Andy Hau Yan Ho⁶

Review > J Am Geriatr Soc. 2021 Jan;69(1):234-244. doi: 10.1111/jgs.16801. Epub 2020 Sep 7.

Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review

Ryan D McMahan^{1,2}, Ismael Tellez^{1,2}, Rebecca L Sudore^{1,2}

Individual	<ul style="list-style-type: none">• Prepares for medical decision making<ul style="list-style-type: none">• in-the-moment <i>and</i> future• illness understanding, prognostic awareness, trade offs• Improves communication and documentation• Dying in preferred place• Satisfaction with care
Agent	<ul style="list-style-type: none">• Reduces decision-making burden• Decreases anxiety, depression, PTSD, complicated grief
Family/caregivers	<ul style="list-style-type: none">• Decreases caregiver burden
Health care providers	<ul style="list-style-type: none">• Decreases moral distress



A patient's ACP journey

“With multiple components, the interplay between personal, medical, and legal factors, and the reality of a complex health care system, how do all of the pieces of ACP fit together?”



Three general approaches to care

GCDs

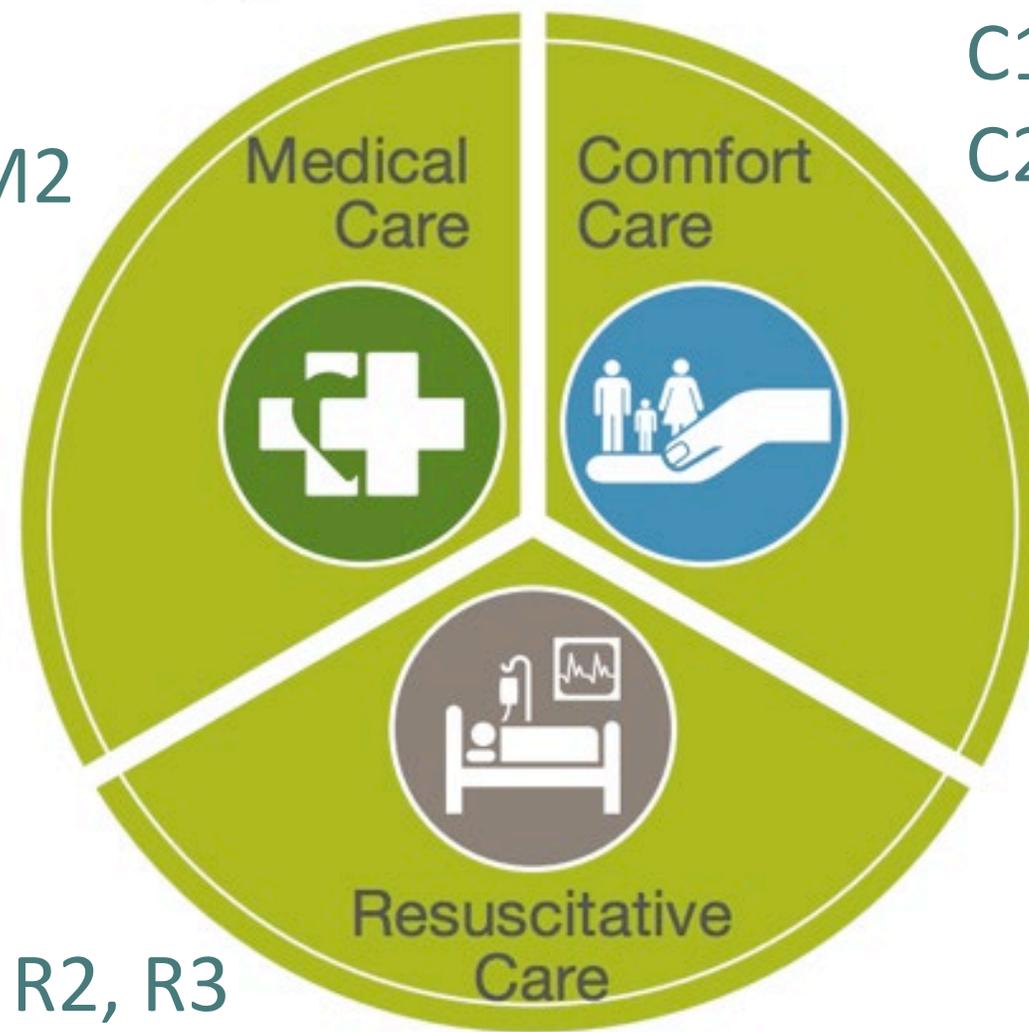
M1, M2

A Goals of Care Designation order (GCD)

provides direction on:

- general intent of care
- specific health interventions
- transfer decisions
- locations of care

C1,
C2



R1, R2, R3



GCD form



Date (yyyy-Mon-dd)	Time (hh:mm)	
Goals of Care Designation Order To order a Goals of Care Designation for this patient, check the appropriate Goals of Care Designation below and write your initials on the line below it. (See reverse side for detailed definitions)		
Check	<input type="checkbox"/> R1 <input type="checkbox"/> R2 <input type="checkbox"/> R3 <input type="checkbox"/> M1 <input type="checkbox"/> M2 <input type="checkbox"/> C1 <input type="checkbox"/> C2	
Initials	_____ _____ _____ _____ _____ _____ _____	
Check <input checked="" type="checkbox"/> here <input type="checkbox"/> if this GCD Order is an interim Order awaiting the outcome of a Dispute Resolution Process. Document further details on the ACP/GCD Tracking Record.		
Specify here if there are specific clarifications to this GCD Order. Document these clarifications on the ACP/GCD Tracking Record as well.		
_____ _____ _____		
Patient's location of care where this GCD Order was ordered (Home; or clinic or facility name)		
Indicate which of the following apply regarding involvement of the Patient or alternate decision-maker (ADM)		
<input type="checkbox"/> This GCD has been ordered after relevant conversation with the patient. <input type="checkbox"/> This GCD has been ordered after relevant conversation with the alternate decision-maker (ADM), or others. (Names of formally appointed or informal ADM's should be noted on the ACP/GCD Tracking Record) <input type="checkbox"/> This is an interim GCD Order prior to conversation with patient or ADM.		
History/Current Status of GCD Order Indicate one of the following		
<input type="checkbox"/> This is the first GCD Order I am aware of for this patient. <input type="checkbox"/> This GCD Order is a revision from the most recent prior GCD (See ACP/GCD Tracking Record for details of previous GCD Order). <input type="checkbox"/> This GCD Order is unchanged from the most recent prior GCD.		
Name of Physician/Designated Most Responsible Health Practitioner who has ordered this GCD		Discipline
Signature		Date (yyyy-Mon-dd)



GeorgeTwo-IPRN Doolin

Male, 60 y.o., 31/03/1964 🗓️

MRN: 2160000021

ULI: No Value Set

EDM UAH WMC 3E4-TRN IPCD
GeorgeTwo IPRN-TRN IPCD
GeorgeTwo IPRN

Cur Location: EDM UAH WMC
TRANSFUSION LAB

ACP/GCD: GCD-M1

Other Clinical Systems: None

Consent & eForms Navigator

Collection: Unit

🔍 Search (Ctrl+Space)

📍 Location: **Contact**

🚫 Communicable Disease
Screen Incomplete



Whitecoat, Walt, MD
Attending

Allergies

No Known Allergies

Client/Resident Safe Handling
Status: Independent

Alerts from Patient FYIs: None

ADMITTED: 31/03/2024 (2 D)

Patient Class: Inpatient

Expected Discharge: Today

Hypertension

Ht: 180.3 cm

Last Wt: 86.2 kg

3MI: 26.50 kg/m² !



Summary

Chart Re...

Results

Work List



MAR



Flowsheets

Avatar

Intake/O...

Consents

ALTERNATE DECISION
MAKERS AND PATIENT
CAPACITY

Documents

Capacity Worksh...

Capacity Interview

Over 18 Legal Inf...

Instructions

Patient Capacity

Decision Makers

CONSENT

Consent Forms

Consent Notes

Reference Links

MENTAL HEALTH ACT

MHA Forms

Reference Links

LETTER FORMS

Letter Forms

Documents

Consent Documents

Document Type	Status
Advance Directives and Living Will	Not Received
Power of Attorney	Not Received

[Jump to Document List to update filed documents](#)

Capacity Worksheet

+ New Reading

No data found.

Capacity Interview

+ New Reading

No data found.

Over 18 Legal Information

[Over 18 Legal information Flowsheet](#)

Capacity Status Instructions

Capacity Status

You have not been granted the necessary security to edit Patient Capacity.

Full capacity

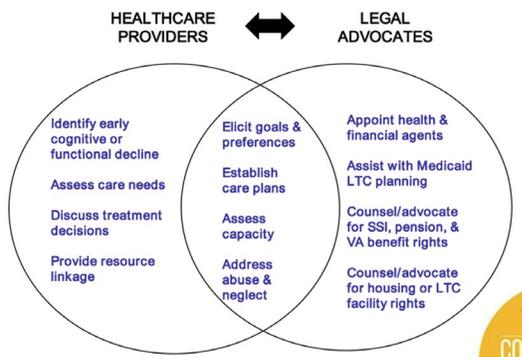
Incapacitated

Needs review



Roles in ACP

(under construction)



Health Care

- Assess care needs
- Discuss health & treatment decisions, implement
- Capture values, wishes and goals in GCD¹ & tracking record
- Locate & enact personal directives
- Prepare agent & family for decision making
- Obtain consent for treatment

Legal

- Provide advice on, document health care & financial agents
- Promote agent/decision-maker preparation
- Capture values & wishes in valid personal directive
- Provide advice on storage, & sharing of personal directive
- Anticipate family conflict



- Enacting personal directives
- Navigate conflict, anomalies (e.g. multiple personal directives)

- Address influence, abuse & neglect
- Advocate for individuals in health care settings

Court applications

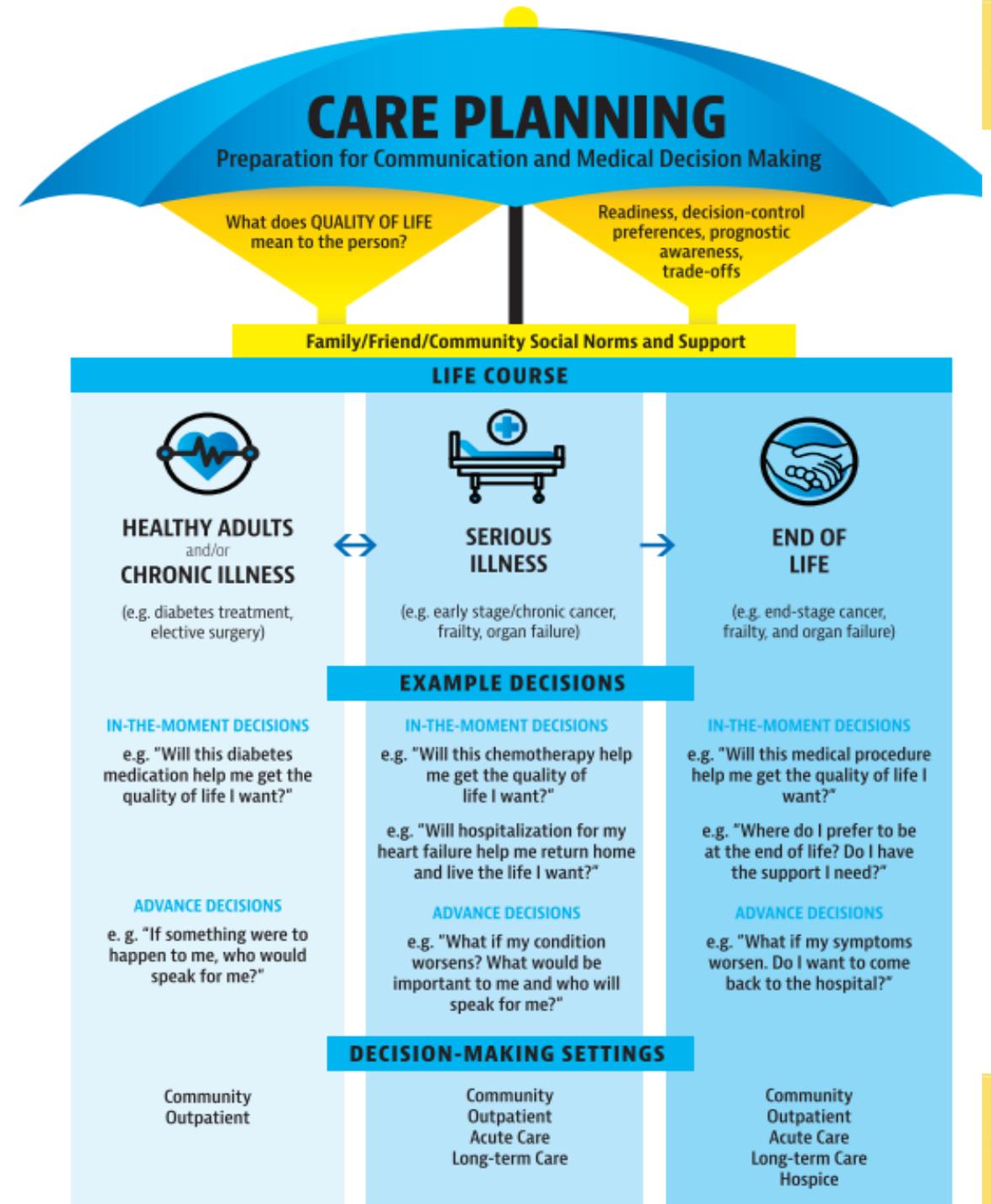
Government

- Draft, enact and review legislation relating to advance care planning
- Act as decision-maker as designated or appointed
- Maintain registry of personal directives
- Investigate complaints

¹Goals of Care Designation order

Complexity

“This process involves a complex array of patient, surrogate, and clinician behaviours, health systems workflows, interventions, communities, and policy”



Received: 4 November 2022 | Revised: 17 January 2023 | Accepted: 28 January 2023
DOI: 10.1111/jgs.18287

COMMENTARY

Journal of the
American Geriatrics Society

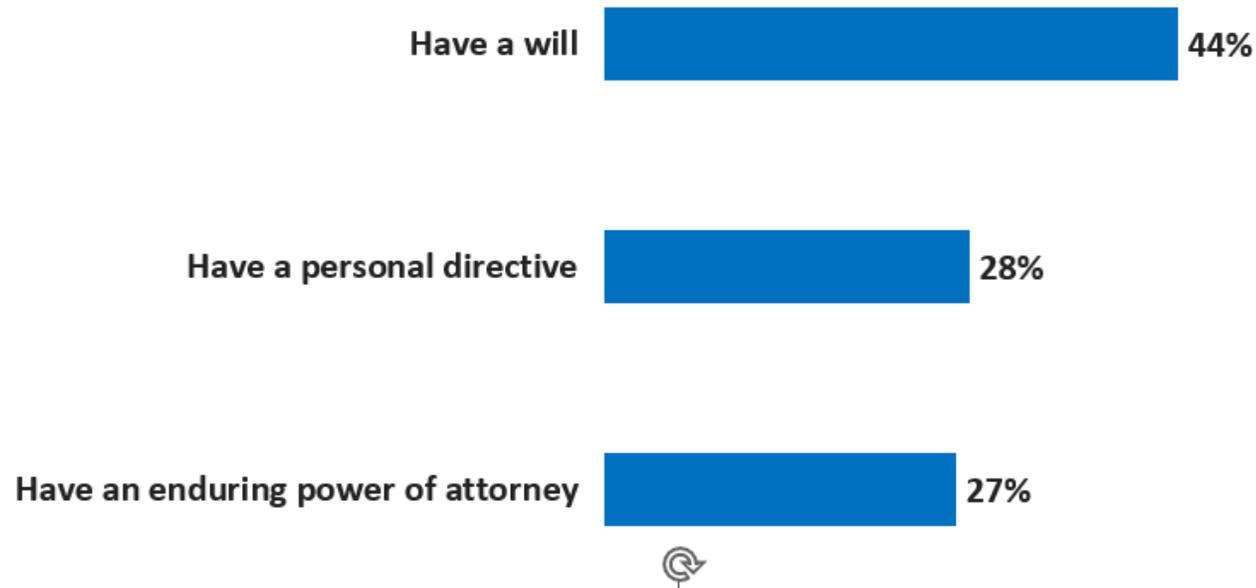
The care planning umbrella: The evolution of advance care planning

Susan E. Hickman PhD^{1,2} | Hillary D. Lum MD, PhD³ | Anne M. Walling MD⁴ | April Savoy PhD^{2,5,6,7} | Rebecca L. Sudore MD⁸

March 2024 IPSOS survey

Advance Care Planning Actions

Most Albertans do not have a will (44% have one), a personal directive (28% have one) or an enduring power of attorney (27% have one).



Definition provided: A will is a document that outlines how you would like your property and possessions distributed after your death. It also allows you to name a guardian for any children who are minors at the time of your death.

Definition provided: A personal directive is the legal document in Alberta that records who you want to make personal and healthcare decisions for you if you are unable.)

Definition provided: An enduring power of attorney is a legal document that gives another person the authority to make financial decisions on your behalf.)





How are personal directives used in health care settings?



Legislation and policy



Personal Directives Act

- a. Purpose and intent
- b. Coming into effect
- c. Authority



Province of Alberta

PERSONAL DIRECTIVES ACT



Health care policy & procedure

- a. Coming into effect
- b. Roles & processes



TITLE
ADVANCE CARE PLANNING AND GOALS OF CARE DESIGNATION

SCOPE
Provincial

DOCUMENT #
HCS-38



TITLE
ADVANCE CARE PLANNING AND GOALS OF CARE DESIGNATION

ACP & GCD Procedure



- Where a PD is **known to exist**, reasonable effort shall be made to obtain it for the health record
- A PD does not replace a GCD
- Where patient lacks capacity, but has previously expressed wishes (either directly or in a PD (that is in effect)) to **initiate, continue or limit an intervention that could be clinically indicated**:
 - the Most Responsible Health Practitioner (MRHP) has a responsibility to comply, after discussing with alternate decision-maker (ADM)
 - **Exception**: where MRHP believes patient did not contemplate current clinically indicated interventions, MRHP to discuss with health care team and ADM, and invoke dispute resolution process if necessary

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include: a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act*, an agent in accordance with a personal directive, a co-decision-maker, a specific decision-maker or a person designated in accordance with the *Human Tissue and Organ Donation Act*.



Personal Directives: *in reality*

*“Ideally, preferences are documented in an advance care directive (ACD) and used by doctors to guide medical decision-making should the patient subsequently lose their decision-making capacity. **However, studies demonstrate that ACDs are not always adhered to by doctors in clinical practice.**”*

BMJ Open Doctors’ perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study

Nadia Moore ^{1,2} Karen M Detering ^{1,2} Tessa Low,^{1,2} Linda Nolte,² Scott Fraser,^{1,3} Marcus Sellars^{2,4}



Difficulty locating

- Not provided
- No search (e.g. emergency, forget)
- Charts
 - Paper (e.g. supportive and long-term care sites)
 - ConnectCare



Painting a picture: ICU





“it makes no sense to scoop people out of the river when we could go upstream and prevent them from falling in in the first place. The ICU is not the place for these conversations to begin, and yet that is where they are often happening...”

Jessica Zitter, *Extreme Measures: Finding a Better Path to the End of Life*

“ Mostly, we are trained to resuscitate. I think we struggle to let people die. But reading this scenario . . . It’s different when you’re physically there, with all the stressors, and it’s all noisy and everything . . . It’s hard . . . We probably would resus in ICU. Probably, because we have the support – and I know it’s not necessarily the right thing to do by the patient, but I actually think that would happen.”

(Cardiology resident)

BMJ Open Doctors’ perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study

Nadia Moore ,^{1,2} Karen M Detering ,^{1,2} Tessa Low,^{1,2} Linda Nolte,² Scott Fraser,^{1,3} Marcus Sellars^{2,4}

Factors supporting adherence

- Desire to align care with patient's preferences
- Avoid unwanted care
- Prioritise autonomy
- Anticipate family opposition
- Patient's wishes confirmed by "human being" (decision maker, family)
- Health care professionals were involved in rigorous advance care planning



Supporting adherence

“I guess I don’t really know the circumstances in which he said that. . . It doesn’t really make sense to me if you’re 65, you’re young, you’re playing golf, everything’s fine, to say ‘I don’t want to have resuscitation.’ So, if someone really, really means it, then his family or spouse or whatever will know all about it and they’ll be able to confirm it.”

(Palliative care consultant)

“If I was confident about the advance care plan, if my team was involved in it, then I’d respect it, regardless. But, if there was a question then I’d have to try and revisit, have a family meeting, try and work out exactly what the situation is.”

(Infectious disease and general medicine consultant)



Factors undermining adherence

1. Physician's knowledge/confidence in enacting PDs
2. Length
3. Outdated preferences
4. Doubting rigour of ACP
5. Patient's understanding of decisions
6. Translating written preferences into practice
 - a. Contextualizing patient preferences
 - b. Subjective terminology
 - c. Emergency medical treatment
7. Advocating best interests
 - a. Futile care
 - b. Clinical judgment
 - c. Unreasonable decision



Decisional conflict *“Context is everything”*

It’s also useful to say, “I don’t want to be intubated’, but . . . [I]f they haven’t had much medical experience or medical training, you’d want to know, well, what is it about intubation you don’t like? Or, what have you heard? Their understanding of intubation might be very different to my understanding of intubation.”

Infectious disease and general medicine consultant

“The difficulty with the specific statement is, with a patient with multiple problems, but is stable at the time of your seeing them. You don’t know what specific scenario you’re thinking about. Like, you know, what if you had a stroke? What if you had an AMI? What if you had an arrhythmia? What if you aspirated? What if you fell over and broke your hip? What if you were in a car accident? What if you had anaphylaxis? Do you want an antibiotic? You know, very different scenarios in some situations.”

Nephrology consultant

BMJ Open Doctors’ perspectives on adhering to advance care directives when making medical decisions for patients: an Australian interview study

“Can you just replace all Mom’s organs?”



CPR

Variable success rates

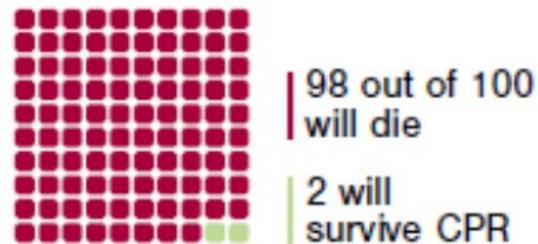
OVERALL POPULATION



PEOPLE WITH SERIOUS ILLNESSES like cancer, heart or kidney disease



PEOPLE WHO HAVE CRITICAL ILLNESS and are in the intensive care unit



OVERALL POPULATION over age 75



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Fall 2021



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Examples of health care's best practices on ACP



Serious Illness Conversation Guide

Serious Illness Conversation Guide

- Essential steps and sequence

- Critical topics
- Proven language

... in a **Process** that includes cuing and documenting

CONVERSATION FLOW

PATIENT-TESTED LANGUAGE

1. *Set up the conversation*

- Introduce purpose
- Prepare for future decisions
- Ask permission

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?"

2. *Assess understanding and preferences*

"What is your understanding now of where you are with your illness?"

"How much information about what is likely to be ahead with your illness would you like from me?"

3. *Share prognosis*

- Share prognosis
- Frame as a "wish...worry", "hope...worry" statement
- Allow silence, explore emotion

"I want to share with you my understanding of where things are with your illness..."

Uncertain: "It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I'm worried that you could get sick quickly, and I think it is important to prepare for that possibility."
OR

Time: "I wish we were not in this situation, but I am worried that time may be as short as ____ (express as a range, e.g. days to weeks, weeks to months, months to a year)."

OR

Function: "I hope that this is not the case, but I'm worried that this may be as strong as you will feel, and things are likely to get more difficult."

4. *Explore key topics*

- Goals
- Fears and worries
- Sources of strength
- Critical abilities
- Tradeoffs
- Family

"What are your most important goals if your health situation worsens?"

"What are your biggest fears and worries about the future with your health?"

"What gives you strength as you think about the future with your illness?"

"What abilities are so critical to your life that you can't imagine living without them?"

"If you become sicker, how much are you willing to go through for the possibility of gaining more time?"

"How much does your family know about your priorities and wishes?"

5. *Close the conversation*

- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

"I've heard you say that ____ is really important to you. Keeping that in mind, and what we know about your illness, I recommend that we _____. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

6. *Document your conversation*

7. *Communicate with key clinicians*



Summary of Discussion:

I conducted a Serious Illness Conversation with [REDACTED] on Nov 8, 2023

Also present was her husband

I received permission from the patient to proceed with our conversation.

The patient understands: prognosis of ALS - median survival 3-5 years from diagnosis

They wanted to know: they had a good understanding of what the future may look like

I shared: we would expect weakness to progress as well as further changes in respiratory function

Goals: to maintain current quality of life for as long as possible

Fears: losing ability to communicate, being on a ventilator, [REDACTED] does not want to suffer or to be kept alive 'on a machine' when she is 'at the end' with her ALS

Strengths: the support of her family.

Critical functions: being able to communicate, being as independent as possible

Trade-offs: Currently [REDACTED] is willing to consider admission to hospital as well as most medical interventions short of ICU care/CPR/intubation. She was clear that she expects that this will change in the future and would want to be able to focus on comfort as her ALS progresses.

Family understands: ALS is progressive.

[REDACTED]

Next steps: she would like to revisit GOC at intervals with me and I have said that if her wishes change between clinic visits I am happy to discuss by phone.

Evolving

- “ . . . a quagmire of variable terminology”
- creates uncertainty among clinicians as to the overall purpose, tasks and specific outcomes of conversations
- move forward serious illness education and research as well as process improvement efforts

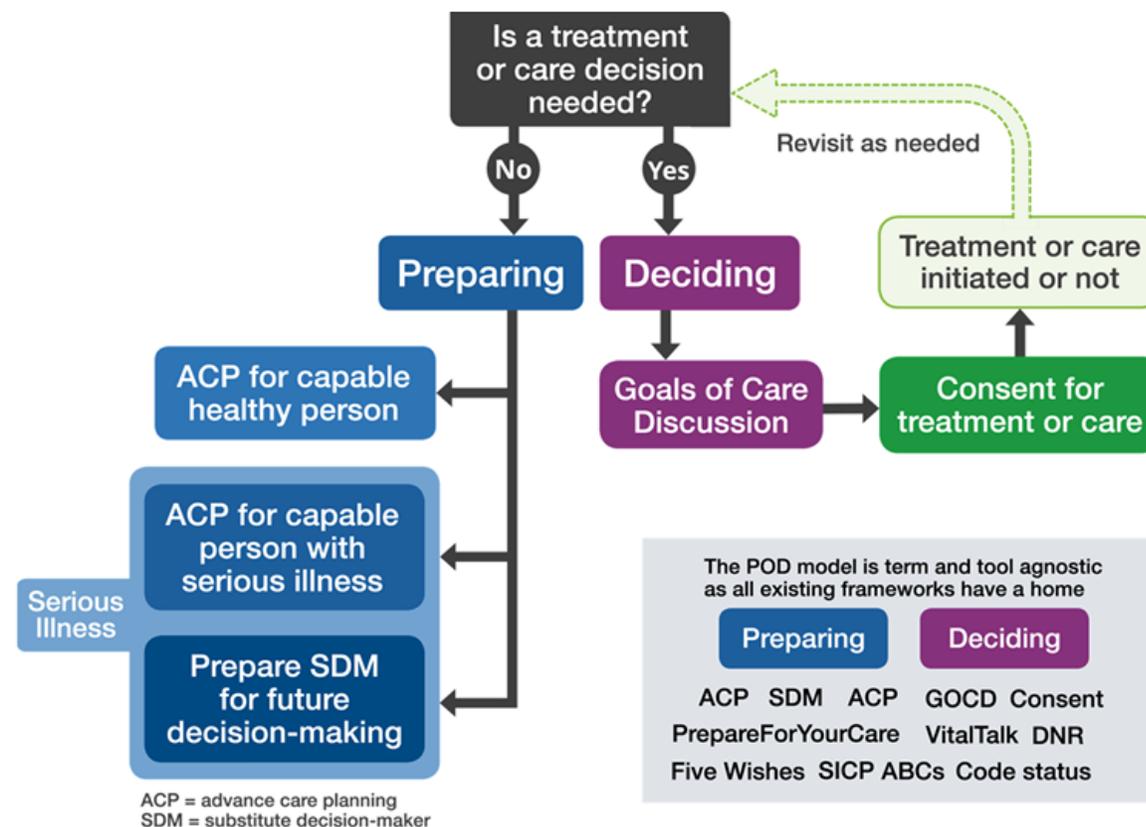


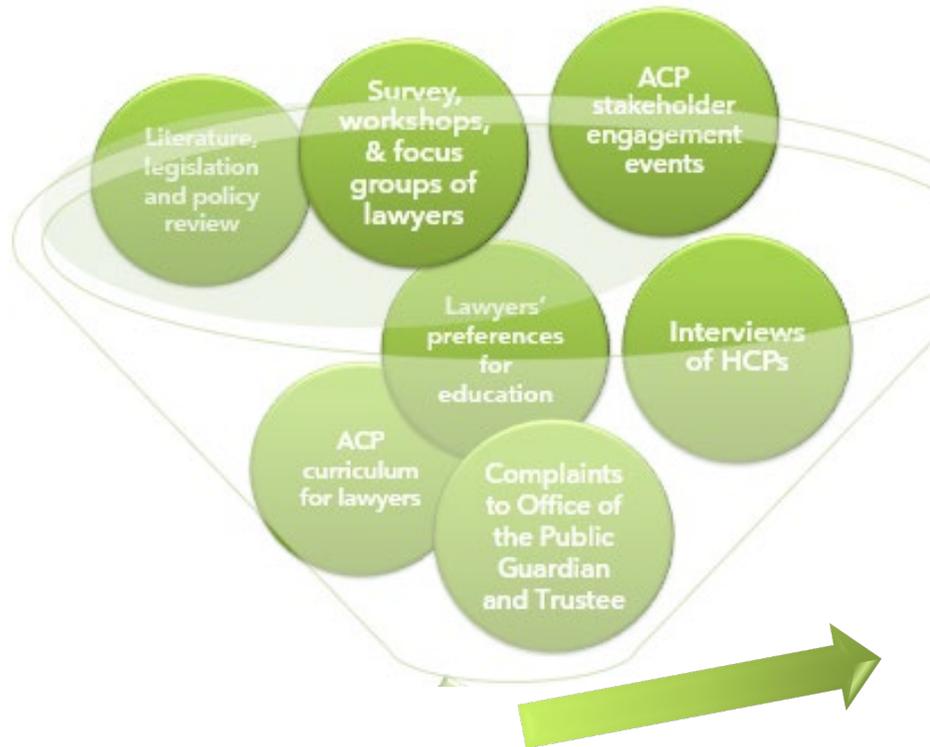
Figure 2. Expanded *Preparing or Deciding* model.



Medical-Legal Collaboration on Advance Care Planning



Medical-Legal Collaboration on ACP in Alberta

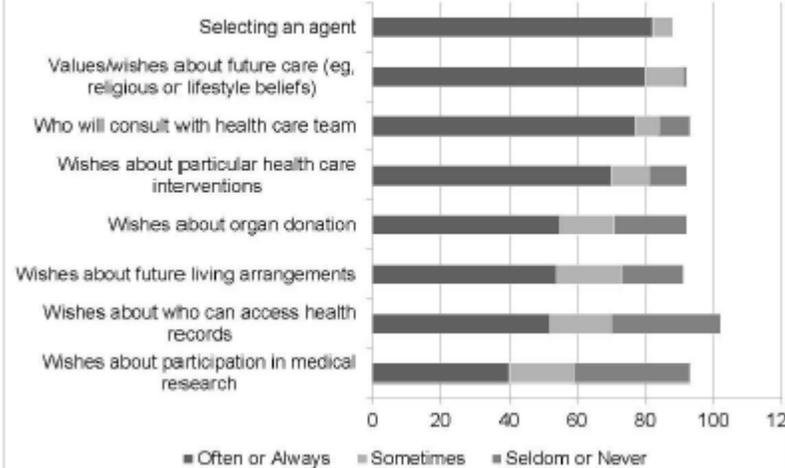


- Began 2014
- Multi-sector, multi-disciplinary

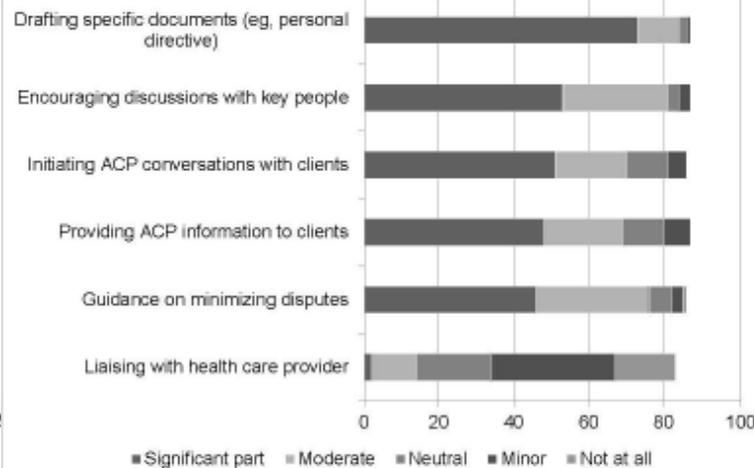


Survey of Alberta Lawyers

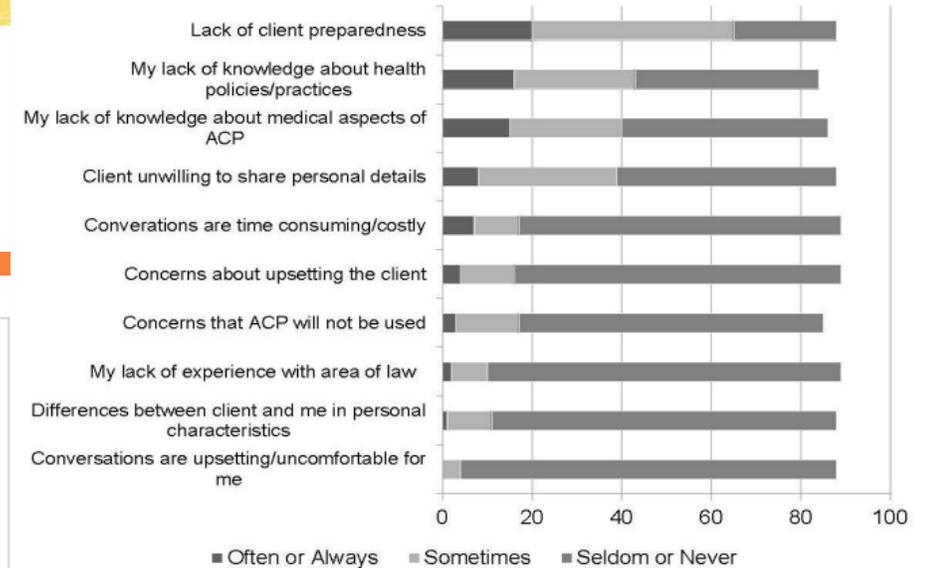
When you assist clients with planning for future health care, how often do you discuss or provide guidance about



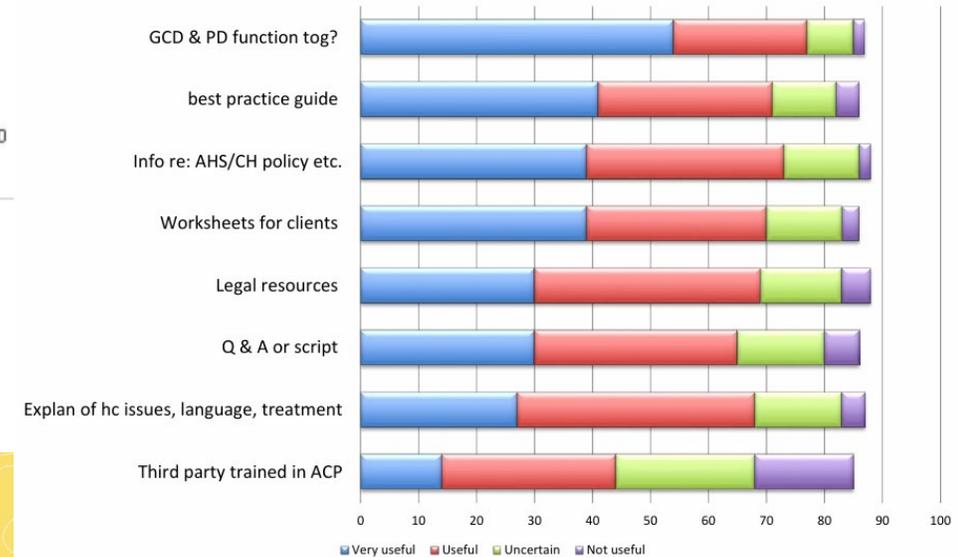
To what extent do you think the following activities are part of your professional role:



How much do the following factors hinder you in assisting your clients with ACP?



What resources would you find useful in your practice?



HOW DO LAWYERS ASSIST THEIR CLIENTS WITH ADVANCE CARE PLANNING? FINDINGS FROM A CROSS-SECTIONAL SURVEY OF LAWYERS IN ALBERTA

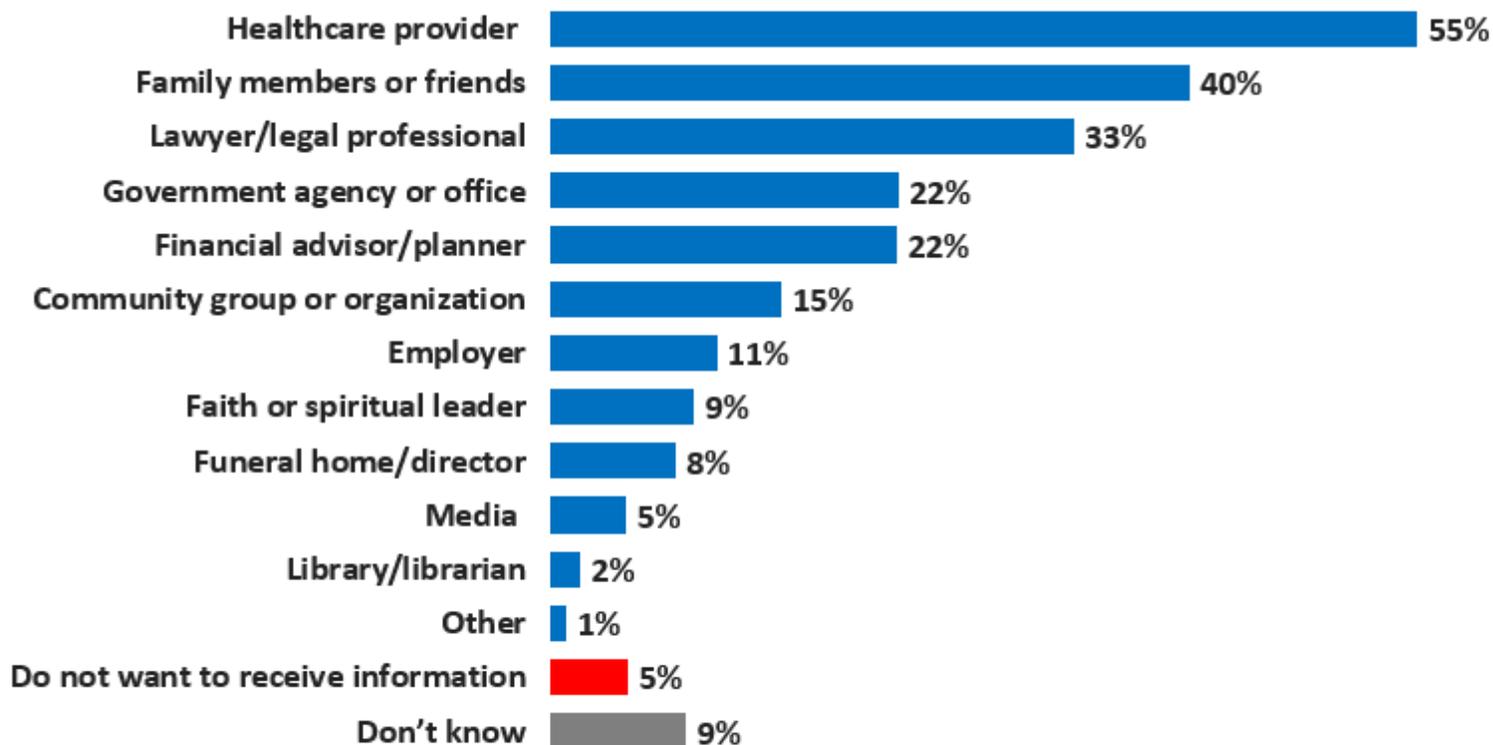
ALBERTA LAW REVIEW

(2018) 55:3



Opportunity

Albertans would most like to receive information about advance care planning from their healthcare provider (55%). Other top mentioned sources include family/friends (40%) and lawyers/legal profession (33%).



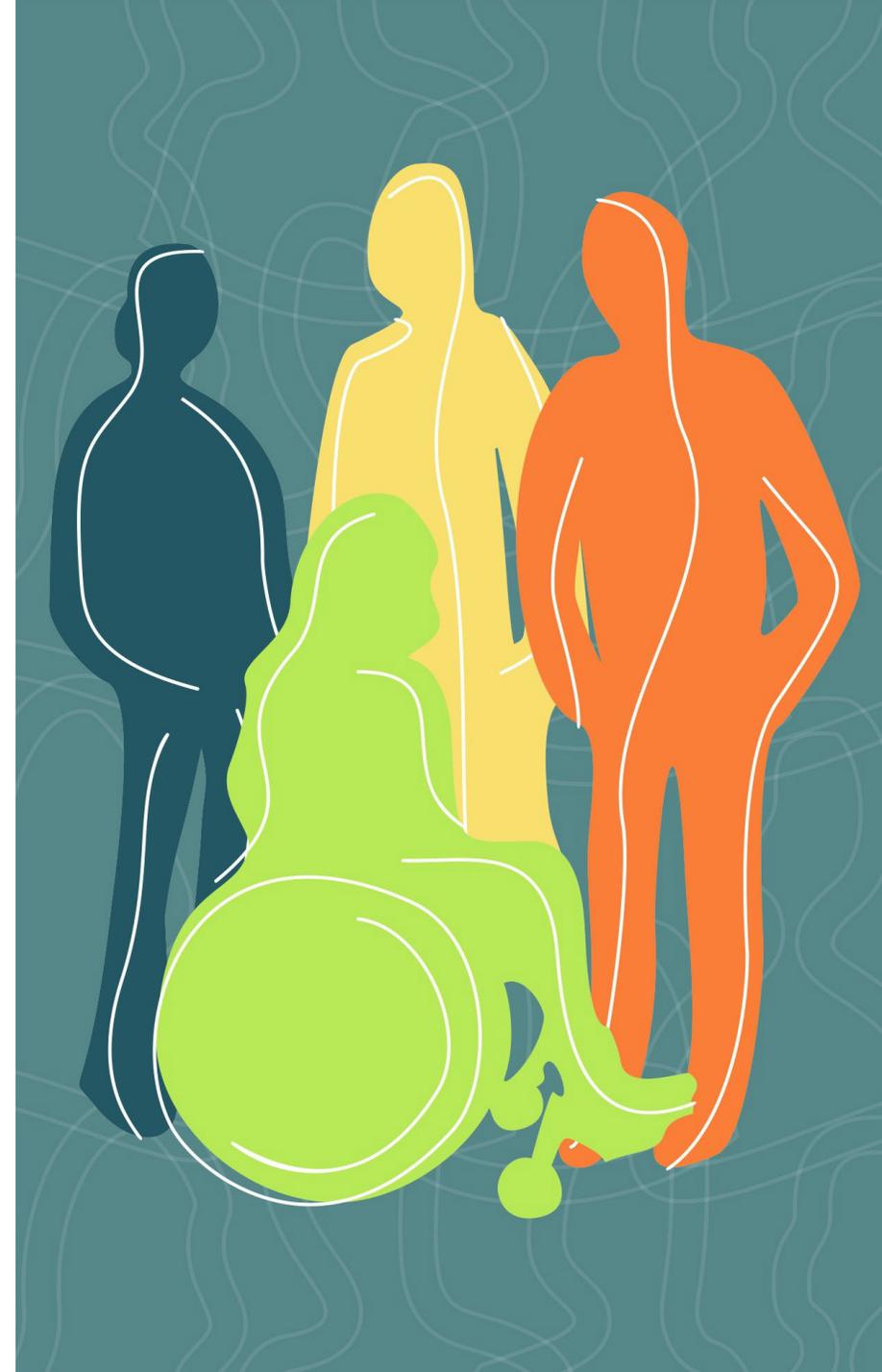
ALBERTANS' VIEWS ON ADVANCE CARE PLANNING & PALLIATIVE CARE

Public Poll Report

May 6, 2024



How might I better ensure that my client's wishes for health care are honoured?



Aligning practices

Alberta Joint Practice Principles on ACP & Recommendations for Legal Practice

Proxy Designation	ACP Tools
ACP as Ongoing Process	Role of Personal Directive
Focus on Beliefs, Values, Wishes & Goals	Sharing Documents
ACP in Serious Illness Care	Health-Legal Collaboration
Role of Goals of Care Designation Order	



#1. Proxy designation

- most important legal component of advance care planning
- careful selection
- appointment in a valid personal directive
- confirm agent is willing to act
- prepare 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



Equipping agent(s)

“You may assume your loved ones know what you would want, but that’s not always true. In one study, people guessed nearly one out of three end-of-life decisions for their loved one incorrectly.”¹ National Institute on Aging

1. Confirm will act
2. Help to understand the role (e.g. CPLEA guide)
3. Copy of personal directive
 1. Who does/does not get notice of enacting, decisions
4. Consider advising all others
5. Have conversations about values, wishes, condition, prognosis
 1. Early
 2. Ongoing
 3. Invite to appointments with health care provider? Lawyer?

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#2 Ongoing process

When to do advance care planning



#3. Focus on Beliefs, Values, Wishes & 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 treatment or clinical interventions for hypothetical situations



#4. ACP in Serious Illness Care

- Focus of advance care planning may then move to specific treatment preferences
- 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, (as acceptable to them)
- The health care provider should be informative and willing to educate the agent/alternate decision maker of their responsibilities.

Limitations of hypotheticals

Clause in 2015 Personal Directive	Current Situation
“No life support by artificial means under any circumstances”	Patient has diagnosis of ALS. She will very likely lose ability to swallow in the near future and ability to breathe on own

Consider:

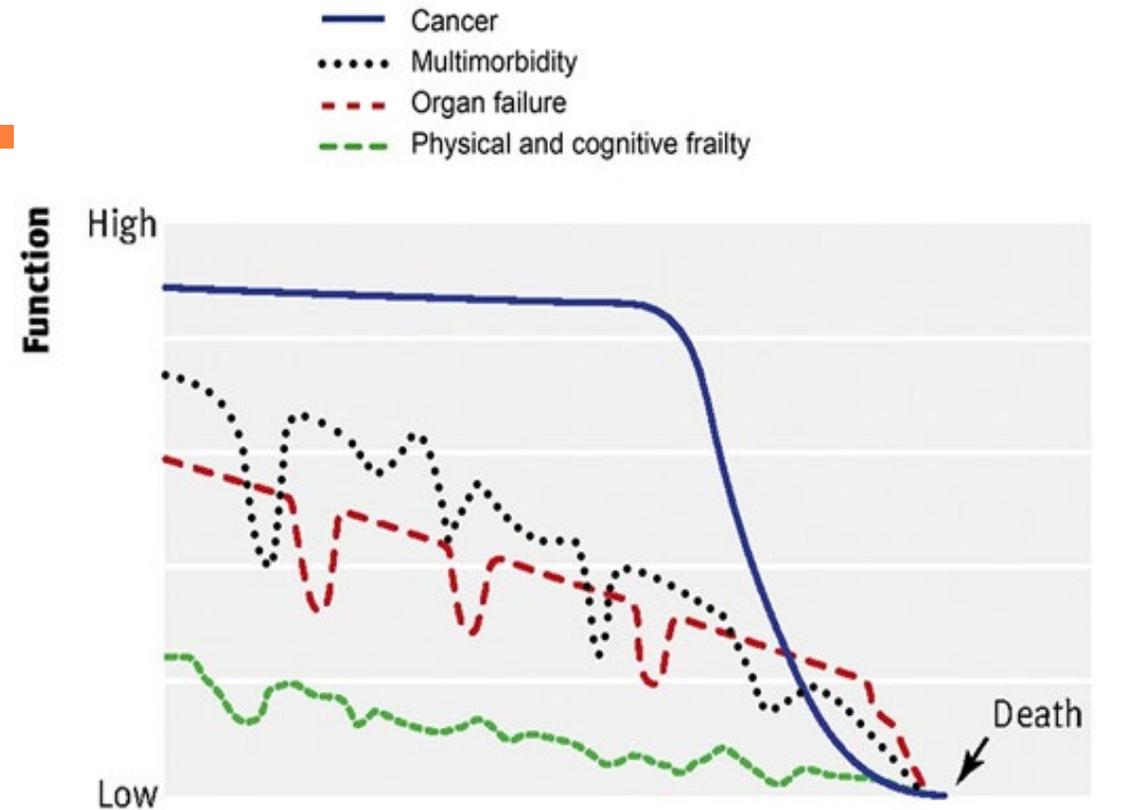
1. For clients with serious illness diagnosis (where trajectory is reasonably foreseeable), draft to specific circumstances, informed by health care provider(s).
2. For (majority) of “healthy” clients, draft “values directive”.



Subjective terminology

- *No drastic measures*
- *Near death, death imminent*
- *Recover or recovery*
- *Maintain my independence*
- *Don't want to become a burden to my family*
- *Irreversible*
- *No invasive treatments if . . . hopeless*

Trajectories of decline at the end of life



Adapted from Murray, S.A et al. BMJ 2008;336:958-959

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Time
BMJ



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An example of a values directive

“If I’m faced with an incurable progressive disease, my main goals as my health deteriorates would be to be able to speak and think as clearly as possible and be with my family.

I want to be able to listen to music and watch movies.

I fear loss of cognitive capacity.

I’m not afraid of loss of independence, but value my intellect, highly critical functions to preserve, if possible, would be my hearing and cognitive functioning.

I am an introvert and enjoy time alone and time with my partner and immediate family, and close friends.

I love music and the arts.

I love a great movie.

I love to think about big ideas and come up with innovative solutions for the world's ills, especially for healthcare and medical education.

If, due to illness or injury, I am left with profound cognitive deficits and am no longer able to engage in complex thinking and debate, or I’m permanently not able to make medical decisions anymore, I would not want life-prolonging treatments in that condition.

I would prefer palliative care and allowing the natural progression of disease and dying.”





My Wishes Alberta workbook

Thinking about your wishes for care

If you were to get sick, what would matter most to you?

If you were to get very sick, what would you be most worried about?

What would you want your care providers to know about you as a person so that they could give you the best possible care?

Thinking about your wishes for care

Next, think about your wishes for your care and what you value the most. How would you like your physical, emotional, social, and spiritual needs met?

If you were to get very sick, what would matter the most to you?

(For example: being able to spend time with your family and friends, being in your own home, having people around you who speak your language, being pain-free, being treated with dignity)

If you were to get very sick, what would you be most worried about?

(For example: being in pain, being alone, needing to leave your home or community to receive care, that the people you care for are looked after, finances)



What would you want your care providers to know about you as a person so that they could give you the best possible care?

I follow a traditional lifestyle and that would be part of my expectations in my care – that it would be incorporated into Western medical interventions. That might mean plant medicines, teas, or even ceremonies in a medical context. I would want my health care providers to support this.



My Wishes Alberta: Planning for My Care

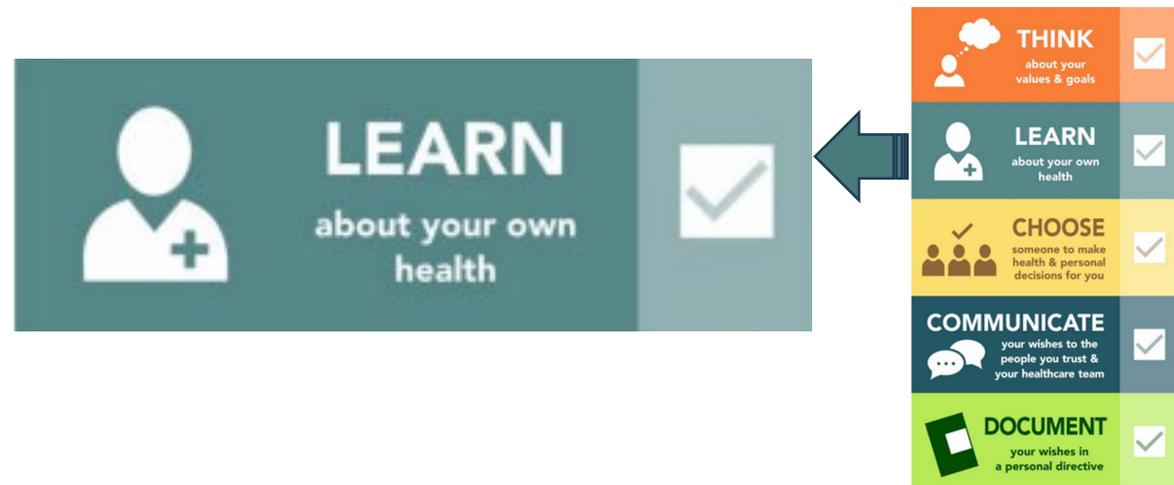
A workbook to help you explore and share your health care wishes



Compassionate Alberta

Learn about health

- “Learn”
 - Health
 - Trajectory
 - Prognosis
 - Uncertainties
 - Interventions



Letter to physician

ADVANCE DIRECTIVES: COUNSELING GUIDE FOR LAWYERS

Commission on Law and Aging
American Bar Association



SAMPLE LETTER TO PHYSICIAN

Dear Dr. Welby:

I am enclosing a document executed under [\[your State's Advance Directive for Health Care Act with citation\]](#). This was signed by my client and your patient, [\[name of principal\]](#).

Although we started advance care planning in my office, your role in explaining [\[name of principal's\]](#) conditions and care and treatment options is an important element for this ongoing shared, decision-making process. At the next office visit, please consider discussing and documenting your patient's wishes as well as including your patients' Directive in the medical record.

Of note, [\[name\]](#) state law defines terms such as [\[include relevant statutory terms, e.g., terminal condition, life-sustaining treatment, permanent unconsciousness, and end-stage condition\]](#). See [\[include hyperlink to relevant state law\]](#). However, you are in a better position than legislative drafters to help your patient understand these terms as they become relevant to decision-making.

If upon further discussion you believe that the patient's wishes do not match the declaration on the Directive, please notify the patient and our office. If you complete an updated Directive with your patient, please consider forwarding a copy to our office.

I would be pleased to provide any further information that may be helpful.

Very truly yours,



Covenant Health
Palliative Institute

#6: Role of Personal Directives

- legal document appoints agent
- and/or records the maker's beliefs, values, wishes and goals for personal matters, including health care
- should result from a process of information reflection and communication
- values-based statements & flexibility for agent to respond to new circumstances
- For serious illness, provide personal and clinical context





Who might be making/influencing decisions?

Other situations	Who might decide/influence
Agent is unfamiliar with wishes/values, health situation, uncomfortable making decisions	Family, friends (who are not agents) Health care provider
No agent (“solo ager”), agent unable/unwilling to act	Substitute decision maker Public Guardian
Agent is Public Guardian	Public Guardian
Family/friends oppose personal directive instructions (or selection/judgment of agent)	Family, friends (who are not agents) Public Guardian
Emergency	Emergency responders, Health care providers (unfamiliar with individual)
Transitions in care, change in health condition, . . .	Nursing home staff, Health care providers (unfamiliar)

Guidance on drafting

Query: How to address physician hesitancy over stale-dated PDs?

- Clear and concise
- Label “Personal Directive”, include summary of Personal Directive Act
- Provide context of wishes, especially if unusual, futile or vs. clinical judgment
- Demonstrate tailored to health condition
- Demonstrate rigorous advance care planning:
“Based on ongoing and formal discussion with my physicians about my health, which I understand, and about my goals of care, . . .”



Guidance on drafting

- Flexibility
- Anticipate opposition by family
- Anticipate interpretation based on clinical judgment or “best interests”

“When making decisions concerning life-sustaining treatment, I wish the following factors to be taken into account: the relief of suffering, the potential to restore functioning, the quality of my life, and the realistic extension of my life.”

“I recognize that I cannot foresee everything that might happen or all options that may be available My preferences stated in this [Section reference] are meant to guide my agent and my health care providers in making decisions on my behalf. It is my intent that my agent and my health care providers follow my stated preferences if my agent and my health care providers believe that doing so is in my best interest, but my agent shall have the discretion to make the decisions that my agent believes to be in my best interest at the relevant time regardless of what is otherwise stated in this [Section reference].



#7 Sharing, storage

- Maker share personal directive with agent and health care team
 - Maker ensure the personal directive is part of health record, so adequately informed before a crisis arises.
 - Makers should also be encouraged to consider sharing the personal directive with their family, trusted friends and advisors, as appropriate.
-
- Green Sleeve
 - Upload PD to MyAHSConnect

You can get a MyAHS Connect account if you

- Have visited an AHS or partner site that is using Connect Care
- Are over the age of 14
- Have an Alberta.ca Account

<https://myhealth.alberta.ca/myhealthrecords#>



#9 Role of Goals of Care Designation Orders

- a medical order
- 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
- can only be written by a physician or nurse practitioner
- does not require patient consent.
- 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





Discussion & Questions

March 3: Symposium objectives and exercises

What do **lawyers** need to understand about health care?

How can they increase the likelihood that clients' wishes are honoured?

How do they create **useful personal directives**?

What is their role *beyond* drafting?

What do **health care professionals** need to understand about the lawyer's role?

What interests are lawyers protecting?

What are **clients' expectations**?

What are the **risks** of not enacting personal directives?

**To strengthen understanding, collaboration and aligned practices,
join us to exchange stories and map out concrete approaches.**



Workshopping language

“Prolonging my life would be unacceptable to me if . . .

A. . . . I am not able to communicate with my family and friends.”

B. . . . I no longer have control of bodily functions.”

C. . . . I am kept alive with machines but with no chance of survival if I am taken off the machines.”

D. . . . I am declared brain dead and my primary organs may or may not be substantially affected”

“I’d be willing to continue life prolonging treatments even if I can no longer provide myself with personal care, as long as my cognitive ability remains intact so that I can converse, process emotions and reflect.”



Resources

[Aligning Practice to Reality: Understanding Advance Care Planning \(LESA on-demand course, April 2024\)](#)

[Recommendations for Legal Practice \(presented at LESA's Aligning Practice to Reality webinar, April 18, 2024.\)](#)

[My Wishes workbook](#)

[AHS website](#)

[American Bar Association: Advance Directives: Counselling Guide for Lawyers](#)

[American Bar Association Advance Care Planning Practice Principles](#)

[National Framework for Advance Care Planning Documents \(AUS\)](#)

[Canadian Hospice and Palliative Care Association Living Well Planning Well: An Advance Care Planning Resource for Lawyers](#)

DRAFTING TIPS:

- ▶ Avoid overly long advance directive documents. **Clinical experience suggests that the longer it is, the less likely it will be consulted.**
- ▶ Use plain language. Your audience is nonlawyers (family members, healthcare providers), who must be able to easily and quickly understand the document. If your state statute requires mandatory language, consider translating it into simple terms in the document or as a cover sheet.
- ▶ How specific should health care instructions be? For a healthy client, general. The closer to an end stage condition, the more specific one may be because more details are known.





To provide feedback or precedents for discussion:

1. Evaluation survey: <https://redcap.link/mlprimer>
2. Email: maureen.douglas@covenanthealth.ca