Tips for Advance Care planning (ACP) for GPs.

Take opportunities as they arise. Don't wait for perfection.
An ACP conversation (and documentation) can evolve over time.
Advance Care planning is *any planning* with a patient about their future care that becomes relevant if they lose the mental capacity for decision making. It is a conversation. It does not have to tick all the boxes of a great ACP. It certainly does not have to tick them all in one go and can evolve over time as part of the rolling dialogue we GPs have with our patients.

I've opened the box but I don't have the time/skills to deal with what's come out.
You can reschedule "Sounds like we should make time to talk about that properly" or reroute "I know/can find out who can help you with that."

Fear not a chat with a patient
Many GPs are not confident about initiating an End of Life conversation, but if they do 90% of patients will continue the conversation and most GPs report relief and satisfaction afterwards. See www.dyingmatters.org/gp and "*Go with the flow"* below

The key environment is inside our heads. Delaying an ACP discussion in order to *get the external circumstances and environment right* may mean the opportunity is lost.

Asking permission engages the patient.
When proposing an option to a patient, describe, jargon free, whatever it is you are asking permission for and then ask "Are you happy with that?"

Document and share.
What counts as documentation? Beyond the GP record, the *Out of Hours Handover* counts. This is traditionally a faxed form, but electronic local registers are on the increase. There are various ACP proformas. Though not essential, their use can add structure and depth to the ACP, and make good patient held records.

Go with the flow
Be respectful and conversational. Never insist on an ACP discussion. Look for and offer opportunities. Elisabeth Kubler-Ross in 1969 (yes 1969!) for her book "*On death and dying*" spent a couple of years interviewing terminally ill patients. She described how doctors were the main reason conversations around death and dying *didn't* happen. Most patients at some point would like to talk about death and dying, but they are not *always* ready. The easy conversations are those where the patient is ready. You won't know if you don't ask. If they are not ready, they will have learnt that you are not a doctor stuck in the 60's, and that you are comfortable with such a conversation.

In difficult terrain wear comfortable shoes.
Even if it is just opening the door to the conversation that is there to be had it's still a challenging door to open. You may find yourself fishing for the right choice of words. Don't fish. Use phrases that are at home in *your* everyday consultations. How would you normally focus in on a patient's agenda?
As examples, typical phrases might include

- What's the main thing on your mind?
- What's your greatest health concern?
- How do you see the future?
- What are your priorities?

Remember, a strength of general practice is time.
Much is said about adequate time being available, rightly so. A strength of general practice is that rapport builds up and conversations move forward in a series of interactions over time.

Dr. Patrick McDaid mcdaid@nhs.net
Macmillan Palliative Care GP Facilitator for Camden and Islington 21st Jun 2012

An Example in practice: ACP in 5 minutes.
This is based on a real consultation that took 5 minutes. Honest !! The more time and space the better, but you may be surprised at the number of opportunities to do something, or get the ball rolling within a limited time frame.

At the end of a Nursing home session I was asked "While you're here doc…" to see a 78 year old man with chronic renal failure who had recently been discharged from hospital. He attended dialysis three times a week and had been admitted from the dialysis unit. He was treated for pneumonia with intravenous antibiotics. Now three days post discharge his breathing was again deteriorating. The hospital discharge letter was brought to me along with the patient who was wheeled in on a wheel chair. He had signs of a chest infection and mentally had his full faculties. I thought I should prescribe oral antibiotics but also that they might not be sufficient to avoid a hospital admission. I had just been to a local End of Life Care event advocating the involvement of patients in decisions about their care. It would not be long before my afternoon surgery would start and I had not had lunch.

So the dilemma. Antibiotics and run, or open up a conversation with the patient and come to a joint decision. Did I have the time? My energy levels were dipping.

I went for the conversation which was surprisingly short.

- Dr: It looks like you have another chest infection.
  I can treat you here with the same Antibiotics you had i.v. in hospital. Would you be happy with that?
- A: Yes
- Dr: You should get better but you might not. If you weren't improving we would normally send you back to hospital. Would you be happy with that?
- A: No
- Dr: Is that the case even if your life was at risk?
  A: Yes

Touchingly he made a small salute, tapping his forehead as he was wheeled out backwards in his wheelchair. I managed to grab some lunch and the Out of Hours Handover form was completed after surgery. The brief conversation meant that I was confident a recommendation he was not for CPR would be in line with his wishes. He got over his chest infection but died peacefully one week later having declined further dialysis, repeatedly saying "Not today" when the ambulance came to pick him up. The nursing notes indicate he remained in good spirits.

This encounter was outside my comfort zone but my comfort zone increased as a result.
Go and increase yours.

Continuing Professional Development - Useful resources
Much can be done by acknowledging and using our existing skills and reflecting on our experiences. There are also a wealth of resources that do an excellent job of framing the issues, guiding us through relevant legislation, expanding our choice of words and illustrating with patient stories. These include

- A good overview of ACP on the End of Life Care for All e-learning website. www.e-lfh.org.uk/projects/e-elca/launch/acp.html . Allow 20-30 minutes
- The National End of Life Care Programme provides a useful one sided support sheet www.endoflifecareforadults.nhs.uk/assets/downloads/supportsheet3_1.pdf
- And a comprehensive page on Care planning and ACP. www.endoflifecareforadults.nhs.uk/publications/pubacpguide
- The GMC frames it all around our obligations as registered Doctors and provides ample learning materials. www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp
- The ever resourceful GSF www.goldstandardsframework.org.uk/AdvanceCarePlanning
- Two Comprehensive GP specific Web portals on End of Life Care exist www.dyingmatters.org/gp with their *Find your 1%* Campaign and http://www.rcgp.org.uk/end_of_life_care/end_of_life_care.aspx from the RCGP

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