Who and when should we discuss advance care planning?

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With advances in general sanitation, preventive care, and medical knowledge and technology, life expectancy has been prolonged. Hong Kong is proud to be the champion in life expectancy, but this is at the expense of increasing disability.¹ There is wide variation in personal willingness for a trade-off between quality of life, disability, and prolongation of life.² Patient autonomy should be respected in this regard. Advance care planning (ACP) is a process to facilitate in-depth understanding between healthcare professionals and patient / close family members on the patient’s values and beliefs about life as well as personal preferences for medical care. After ACP, some form of documentation (eg, an advance directive or AD) is preferred though not necessarily, as it provides a reference for multiple healthcare teams across various illness episodes. For patients with a disabling chronic illness, an ACP discussion should start when medical management fails to stabilise the condition despite optimal treatment, and when the patient requires frequent hospital readmissions for the same condition. Nonetheless, ACP is seldom carried out at public hospitals. One common belief is that death is considered taboo by elders in Hong Kong, and withholding life-sustaining treatment should preferably be discussed with the elders’ children. However, studies of Hong Kong nursing home residents revealed that elders preferred to voice their wishes.³,⁴ In general, nursing home residents are more disable and frail, and at a late stage of their life.

In this issue, Tsang et al.⁵ studied AD decisions of community-living elders who attended geriatric day hospitals or medical and geriatric out-patient clinics. The elders had multiple chronic diseases and were typical public hospital service recipients. They were willing to discuss ACP and their AD preferences. Contrary to the taboo belief and consistent with the studies of nursing home residents,³,⁴ about 80% of elders preferred to have a say in decision making. In contrast, only 15.1% of family members felt comfortable to make a decision themselves without involving the elder. There was marked discordance (around 50%) between elders and their paired close family members in preferences on life-sustaining treatment and non-natural feeding.

What are the implications of this study for our practice? Tsang et al.⁵ re-confirmed that elders are willing to discuss ACP and AD preferences before the very late-stage of disease when they cannot express themselves, and that they should be involved in making decisions about their own care. Family members should take part in such discussions. Clinicians should explain about medical conditions and treatment processes/options and act as facilitators to express treatment preferences of the elder to their family members. When AD decisions can only be made by family members (eg, when the elder is in a coma or cognitively unfit), family members should act as a surrogate for the elder and give ‘the best guess on the preference of the elder’, rather than ‘their personal preference as next of kin’. It is hope that with appropriate timing of ACP and facilitation on reflection on individual life value and beliefs, a balance between ‘add life to year’ and ‘add year to life’ can be made with patient’s autonomy respected.

REFERENCES