Planning for the Future

In this issue of *CJGIM* Quinn et al discuss the merits of physicians taking the time to focus on the *overall goals of care* in patients with advanced dementia who present for the treatment of an acute problem. Rather than immediately managing the presenting new illness they suggest that the clinical management plan be put into the context of what are the specific overarching goals and expectations of the individual patient with an advanced dementia. The problem of course is that unless it is clearly spelled out in advance, it is a challenge to know what these consist of for a patient who is in an advanced state of cognitive decline. In this situation health care providers frequently have to rely on the patient's family for some direction, but the latter are not always fully informed.

In Ontario, a document issued by the Ontario Ministry of Health and Long-Term Care called a "Do Not Resuscitate Confirmation Form" gives clear direction regarding the use of CPR.[1] When completed for an individual in a long-term care facility, this information provides excellent guidance for first responders and health care providers regarding resuscitation. But these forms do not discuss the various degrees of medical care that can be provided beyond cardio-pulmonary resuscitation. Interventions such as IV fluids, antibiotics and feeding options, still need to be addressed. These are treatments that patients may or may not want. Clearly what is needed is a more comprehensive document that is widely proffered by provincial ministries of health, to be completed or updated annually by the patients in long-term care institutions (or by their power of attorneys).

When a patient deteriorates in a long-term care institution the nursing staff often feel uncomfortable making pivotal decisions and as a result patients are inevitably transferred to acute care facilities for assessment and possible treatment. But if the patients are accompanied by a clear and standardized detailed advanced directive this will assist the physicians to do what Quinn et al are suggesting in their article. As such, it should be apparent that the completion of an advanced directive is the vital step to ensuring that patient care is reflective of what patients want. Yet advance directives do not accompany all patient transfers from nursing homes to hospital emergency rooms despite that it is now more than one and a half decades since a clinical trial showed the benefits of employing advanced directives in nursing homes.[2] Perhaps what is needed is for the completion of a detailed advanced directive to become a designated Quality Indicator (QI) in the long-term care setting. In a health care environment that is linking budgets to QIs, nothing catches a health care administrator's attention faster than a QI with implications. The universal completion of a detailed health care advanced directive would provide sufficient guidance for all physicians treating patients with advanced dementia who they are meeting for the first time. As a consequence, making clinical decisions that reflect the patient's values will become the standard of care.

1. Government of Ontario. Do Not Resuscitate Confirmation Form. Ontario Publication Number 4519-45 (07/10).
2. Molloy DW, Guyatt GG, Ruso R, et al. Systematic implementation of an advance directive program in nursing homes. A randomized controlled trial JAMA 2000;283(11):1437–44. doi:10.1001/jama.283.11.1437

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