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Appendix 2

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to:Scott IA, Mitchell GK, Reymond EJ, Daly MP. Difficult but necessary conversations — the case for advance care planning. *Med J Aust* 2013; 199: 662-666. doi: 10.5694/mja13.10158.

Appendix 2. Approach to conversations around advance care planning*

Issues	**Facilitative questions and comments****
Assess understanding of disease and its prognosis	"What do you understand about your condition?" "What have your clinicians told you about your condition?" "From what you know, do you think over the next 12 months your condition will get better, worse or stay the same?"
Assess receptivity to ACP and preferences for information-sharing and decision-making	"Have you given any thought to how you wish to be cared for should your condition get worse?" "Would you like to talk about how we should decide your future care if you were to become too sick to talk to us directly?" "How much information would you like me to share with you regarding your condition and how it may unfold and what care we can provide?" "How much do you want to take upon yourself in making decisions about your care?" "Do you feel anxious in making such decisions?"
Identify other decision makers	"Do you know of anyone else who understands your wishes regarding future care and whom you confide in?" "What do you think your family and friends would want for you?" "Is there anyone else you rely on to help you make important decisions?" "Who in the family should be present when we discuss your care options?"
Explain the rationale for ACP	"ACP helps people like me gain a clearer understanding of your wishes so that we do not burden you with care you do not want" "ACP allows you to work out your future wishes while you are still able to think straight and communicate, and before an emergency crisis occurs" "ACP affords you peace of mind, knowing that you will receive the kind

	of treatment you want" "ACP relieves your family and friends of the burden and possibly the guilt of having to make decisions without knowing your wishes" "ACP doesn't cause people to die sooner. It helps people die naturally, in their own time and on their terms."
Define the patient's goals of care	"What do you hope for or want most over the next 12 months?" "Is there anything that you're really concerned about?" "What do you hope or expect your care to achieve?" "What would you regard as an unacceptable level of inability to communicate or function physically or mentally?" "Are there certain forms of care that you think you would never want, and why?" "Where would like to spend your last weeks and months of life?"
Reframe goals where appropriate – hoping for the best but preparing for the worst	"I wish we could guarantee that we could keep you alive until your daughter's graduation in 2 years time but we may not be able to. Perhaps, as a contingency, you could consider a letter to read on that day or a special gift, so she will know you are there in spirit in case you cannot be there" "When thinking about how you would like us to care for you, do you have experience of the care provided to a loved one or good friend who had a chronic illness and passed away?"
Summarise and link goals with care needs	"So I think I understand your main goal is to be able to live and die at home with your family, and to avoid invasive treatments or aggressive resuscitation. To do this, we may need to consider additional domestic help around the house and nurses who can assist you and your family with medications and personal care."
Respond to issues elicited • Acknowledge response	"You seemed surprised to learn how sick you are"

• Legitimise reaction	"Many people are understandably upset when they confront the need to consider end of life care"
• Empathise	"I can imagine this is not easy for both of you; you care about each other so much"
• Explore concerns	"Tell me what's upsetting you the most?"
• Clarify	"Could you explain what you mean by 'not wanting any heroics' or 'not wanting extraordinary care'?"
• Calibrate surrogates	"If your father could sit with us here, right now, what do you think he would want us to do over the coming months?"
Reinforce commitment to care	"Let's think this over the next few weeks and talk again when we next meet. You know I will continue to care for you and respect your wishes whatever way you want to go."

*Adapted from Balaban RB. A physician's guide to talking about end-of-life care. J Gen Intern Med 2000; 15: 195-200.
**Assumes patient's cognitive capacity has been assessed and deemed sufficient to participate in such conversations.