Title: Comment on Moody: '"Advance" Care Planning Re-envisioned'

Running head: Comment on Moody: ACP Re-envisioned

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Introduction

The COVID-19 pandemic has brought into sharp focus the challenges, fragility, and uncertainties of Advance Care Planning (ACP) discussions with people living with life-limiting illnesses. ACP programmes have been adapted to accommodate the pandemic (e.g., 'Serious Illness Conversation guide' and 'Vital Talk'*) and underscore the importance of timely ACP for COVID-19 patient management. If conducted well, ACP discussions facilitate a holistic, collaborative, and person/family-centric approach to addressing wishes and preferences before the onset of rapid illness deterioration. In the context of COVID-19, however, there has been concern that focus on process goals (e.g., completion rates of ACP), a conflation of ACP with Do Not Attempt Cardiopulmonary Resuscitation decisions, [1] and the general uncertainty that surrounds these discussions, [2] have led to the anticipated benefits of ACP being questioned.

In her recent editorial '"Advance" Care Planning Re-envisioned', [3] Moody expressed similar concerns and makes the case for 'reconsider[ing] whether current approaches to ACP are realistic for most individuals' and their family because 'in life, it is rare for people to make decisions far in advance of an event, yet in medicine, we ask patients to do just that.' The re-envisioning Moody proposes calls for the adoption of 'adaptive care planning'; a responsive and flexible approach that takes into consideration the dynamism of illness and clinical practice in which what 'ultimately matters most are decisions made in the moment(s) in response to unfolding clinical events'.

We provide further reflections on what 'adaptive care planning' may look like by (i) outlining a hybrid approach to ACP; and (ii) proposing a theoretical framework to accompany the implementation of this approach.

A hybrid approach: Realistic decision-making in the moment *and* preparing for the "near" future

We support Moody's sentiment on the importance of being able to make adaptive, in-the-moment decisions. Indeed, the value of this is supported by recent evidence in frail older people [4] and individuals with multiple sclerosis [5] in which the difficulties, instability, and (sometimes) perceived irrelevance of making future decisions based on incomplete information or hypothetical decisions have been highlighted.

A hybrid approach, however, embraces ACP as a multi-component process and resists the false dichotomy of seeing ACP as either decisions made in the moment, or decisions made for the future. Rather, we contend that the virtues of Moody's approach may be combined with approaches to ACP whereby opportunities are given to plan for the near future. One benefit of allowing the opportunity to plan for the near future is that it allows health professionals to maintain the trust of patients and their families by engaging in, and regularly reviewing, parallel care plans in which two sets of ACP are made; one for stability or improvement, and another for deterioration. [6]

The coalescence of these types of ACP may mutually enrich one another, enhancing person/family-centric communication in ways that prepare all involved for making difficult decisions in the near future, whilst maintaining the flexibility for adaptive and responsive decisions to be made 'in the moment'.

A socioecological approach to implementation

Effectively implementing high-quality ACP, however, requires an understanding of how ACP conversations can be brought to occur in a systematic, skilled, and consistent manner by (and across) services. This requires serious consideration of the multiple 'wrap-around' preconditions that underpin implementing holistic, multi-component, and person/family-centric ACP. We believe that the best way of understanding these is through a socioecological 'lens' in which a 'whole systems strategic approach' is adopted.[7]

This approach appreciates that there exist multiple, interconnected elements that reside at different societal and organisational levels of influence (e.g., individual, interpersonal, organisations, systems, and cultural) that are necessary to consider before, during, and after implementing/having ACP discussions. [7] Drawing on evidence from contemporary reviews and research studies that have been conducted in multiple contexts (e.g., nursing homes, multiple sclerosis patients, general practice, and palliative care), Table 1 provides a summary (yet not exhaustive) list of the multi-level considerations that are necessary when implementing the hybrid approach to ACP that we propose in any clinical context.

Conclusion

Adaptive care planning that allows patients and their families the autonomy to make 'in the moment' decisions about their care is important. However, this approach should be integrated with preparing people to plan for the near future through the adoption of a hybrid approach to ACP. When implementing high-quality ACP, a socioecological lens that appreciates multi-level factors impacting implementation should be considered.

Note:

***** More information about these programmes can be found here: https://covid19.ariadnelabs.org/serious-illness-care-program-covid-19-response-toolkit/ and here: https://www.vitaltalk.org/guides/covid-19-communication-skills/

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Conflicts of interest

None of the authors have any conflicts of interest to declare

Author contributions

All authors made substantial contributions to conception and design of this letter and approved the final version to be published. Andy Bradshaw led the writing process, and all authors were involved in the drafting of the article and revising it critically for important intellectual content.

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Table 1: Multi-level pre-conditions underpinning the successful implementation of high-quality ACP

Level of practice	**Factors to consider**
Individual	● Healthcare professionals, patients, and families are knowledgeable about illness trajectory/prognosis and how this may affect future decisions [5,8] ● Understanding demographics and previous care experiences of a patient and their family [9,10] ● Healthcare professionals understanding the value of, and having the skills and confidence to effectively engage in, ACP [5,7,9] ● Considering an individual's readiness/willingness to participate in ACP conversations [5,8,9]
Interpersonal	● Developing a strong, trusting relationship with patients and their family [8,9] ● Seeing ACP as a process; revisiting/repeating conversations where necessary [7]
Organisational	● Communication skills training and education provided to the workforce [5,8,9] ● Embed ways to evaluate the relative effectiveness of ACP [7]
System	● The 'normalisation' and standardisation of ACP into everyday practice within and between services/care settings [7-9] ● Efficient I.T./administration systems for storage, retrieval, and prompts for ACP [7-9]
Cultural	● Be aware of, and adequately adapt to, a person's socio-cultural beliefs and backgrounds [7,10] ● Understanding structural and legal constraints related to ACP [7]