Serious Illness Conversation Guide with Substitute Decision Maker

* Decide how you will refer to the patient or resident based on your relationship with the Substitute Decision Maker (SDM). Will you refer to them by their [name or as your loved one/relative/friend] and consider appropriate pronouns [she/he/they/...]
* Consider who should be involved in this conversation – additional family members, spouse, friends, ...

Conversation Flow	Suggested Language
1 Set up the conversation	"I'd like to talk about what is ahead with [...] health and what is important to [...] so that we can make sure we provide [...] with the care [...] would want – is this okay?"
2 Assess understanding	"What is your **understanding** now of [...] health?" "What changes have you observed in [...] over the past *(3 - 6 months)*?"
3 Share prognosis	"I want to share with you my understanding of where things are with [...] health." "[...] is *(give examples such as: staying in bed more, not participating in activities, eating less)*. It can be difficult to predict exactly what will happen and when; but generally, for someone with [...] condition(s), we can expect *(describe trajectory)* in the near future." **Select one – most appropriate sentiment.** *(Uncertain)* "I **hope** [...] will continue to be as well as [...] is /are now for a long time but I'm **worried** that [...] could decline quickly, and I think it is important to prepare for that possibility." *(Time)* "I **wish** we were not in this situation, but I **worry** that [...] may be nearing the end of [...] life in *(days/weeks/short months.)*" *(Functional)* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as [...] will feel, and things are likely to get more difficult."
4 Explore key topics	"Has [...] discussed with you [...] priorities and wishes in regards to [...] health?" "Does [...] have any previous advanced care planning documents?" "**If [...] could express [...] wishes** and make [...] own care decisions, what would [...] say was most important to [...]? (Attempt to understand the values and beliefs of both the client and the SDM) "What might [...] **biggest fears and worries** be? What are your **biggest fears and worries** for [...]?" "If [...] becomes sicker, **how much would [...] be willing to go through** for the possibility of gaining more time?" "Has [...] spent any **time in hospital**? How did [...] seem to feel about being there?" "How much do **other family members** know about [...] priorities and wishes?"
5 Close the conversation	"I've heard you say that ___ is really important to [...] and to you. Keeping that in mind, and what we know about [...] health, I **recommend** that we ___. This will help us make sure that the treatment plan reflects what's important to [...] and to you." "How does this plan seem to you?" "We will do everything we can to help [...] and you through this."
6 Document your conversation	
7 Communicate with key care team members: MRC (Most Repsonsible Clinician), Long Term Care Home, Home Health, ...	

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Conversation Flow

1 Set up the conversation

- Introduce purpose
- Prepare for future decisions
- Ask permission

2 Assess understanding

3 Share prognosis

- Explain changes and illness trajectory
- Frame as a "wish…worry", "hope...worry" statement
- Allow silence, explore emotion

4 Explore key topics

- Goals and critical abilities
- Fears and worries
- Tradeoffs
- Past care
- Family

5 Close the conversation

- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

6 Document your conversation

7 Communicate with key care team members

Vancouver Division of Family Practice
A GPSC initiative

Providence HEALTH CARE

Vancouver CoastalHealth