Advance Care Planning:
Resource Guide for Patients and Caregivers

What is Advance Care Planning?

Advance care planning is the process of thinking about and communicating your wishes and/or instructions for future health care treatment in the event you become incapable of deciding for yourself. Advance care planning gives you the opportunity to think about your future health care decisions and talk them over with family or friends and health care providers. All capable adults in B.C. – regardless of age and health status – are encouraged to do advance care planning and to document their wishes and instructions for future health care.

Your BC advance care plan should include:

- Conversations with family or friends and health care providers about your beliefs, values and wishes.
- A written record or video of your beliefs, values and wishes for future health care treatment.
- The names and contact information of your Temporary Substitute Decision Makers or Representatives – the people who qualify to make health care decisions for you in the event you become incapable.

Use the BC Government’s advance care planning guide My Voice (available in English, Punjabi and Chinese) to learn about advance care planning and to make your own advance care plan to serve as your voice in the future.

- [gov.bc.ca/advancecare](http://gov.bc.ca/advancecare): My Voice – Expressing My Wishes for Future Health Care Treatment

**STEP 1: Learn about how decisions are made for you in the event you become incapable of making health care decisions, including who may make decisions for you.**

In the event you are unable to express your wishes or make decisions (e.g. if you are unconscious), and if you have not named someone to make health care decisions for you (see **STEP 5**), your health care providers will choose a “Temporary Substitute Decision Maker” (TSDM) from the significant people in your life – see the box to the right.

Here are some useful resources on advance care planning:

- [gov.bc.ca/advancecare](http://gov.bc.ca/advancecare)
- [www.nidus.ca](http://www.nidus.ca)
- [www.speak-upinbc.ca](http://www.speak-upinbc.ca)

**STEP 2: Think about who you would want to make health care decisions for you if you were incapable.**

Gather the contact information of people who could act as your TSDM and write it down in your advance care plan.

If you don’t like the order of people to be asked on the TSDM list set out in BC law, then you can choose the person you want to decide for you by naming them as your Representative in a legally binding Representation Agreement, so your health care provider can ask them instead. Note that you cannot just write this person’s name down in your advance care plan – it must be set out in a formal Representation Agreement – see **STEP 5**.
STEP 3: Think about your beliefs, values and wishes for future health care and decide what health care treatments you will or will not accept, and write them down.

It’s important to think about when you might want to accept life-supporting interventions — things like breathing machines or feeding tubes. You should also think about when you might prefer not to have life support or life-prolonging interventions. Here are some resources to help you decide what kinds of treatment you may or may not want to receive.

- [HealthLinkBC.ca: Should I have artificial hydration and nutrition?](#)
- [HealthLinkBC.ca: Should I receive CPR and life support?](#)
- [HealthLinkBC.ca: Should I stop treatment that prolongs my life?](#)
- [Transplant.BC.ca: Do I want to be an organ and tissue donor?](#)

STEP 4: Write down your beliefs, values and wishes for future health care in an advance care plan and have conversations with family or friends and health care providers about them.

It may seem awkward at first, but it’s important to start the conversation with family and friends — the people who may act as your TSDM — about your beliefs, values and wishes for future health care. Your substitute decision maker (Representative or TSDM) may have to make life-changing decisions for you, and having conversations or recording your wishes for future health care can help them make these decisions more easily.

It is the legal duty of your substitute decision maker to respect the instructions or wishes that you shared with them in conversation and/or have written or recorded in an advance care plan.

STEP 5: Consider whether you want an Advance Directive and/or Representation Agreement.

You may want to decide to include the following legal documents in your advance care plan:

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<thead>
<tr>
<th>Document Type</th>
<th>Scope</th>
<th>Excludes</th>
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<tbody>
<tr>
<td>Standard Representation Agreement (Section 7)</td>
<td>Available to adults who need help today because their mental capability/competency may be in question. Allows an adult to name a representative to make their routine financial management decisions, personal care decisions, and some health care decisions.</td>
<td>Does not allow the representative to refuse life support or life-prolonging medical interventions.</td>
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<tr>
<td>Enhanced Representation Agreement (Section 9)</td>
<td>Allows capable adults to plan for the future by naming a representative to make personal care decisions and some health care decisions, including decisions to accept or refuse life support or life-prolonging treatment.</td>
<td>Does not allow the representative to make financial or legal decision on your behalf.</td>
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<tr>
<td>Advance Directive</td>
<td>Allows capable adults to plan for the future by stating their decisions about accepting or refusing health care treatments directly to a health care provider. The advance directive must be followed when it addresses the health care decision needed at the time.</td>
<td>No one will be asked to make a decision for you (see exceptions in My Voice guide)</td>
</tr>
<tr>
<td>Enduring Power of Attorney</td>
<td>Allows capable adults to appoint someone to make financial and legal decisions on their behalf if you become incapable.</td>
<td>Does not cover health or personal care decisions.</td>
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Step 6: Share your advance care plan and keep it somewhere accessible.

Put your documentation in a safe, accessible place (e.g. on your fridge) and give copies to your doctor, health care providers, substitute decision makers, caregivers and family and friends.

You can review, change, or cancel your advance care plan at any time as long as you are capable.