The documents in this package are adapted mainly from The Serious Illness Conversation Guide. This guide is a type of Advance Care Planning conversation within the context of serious illness.

The intention of the conversation:
Opportunity for patients to reflect on their values, goals and wishes, and concerns when thinking about the future and their health.
During this process an appropriate health care proxy might also be identified, leading to the completion of an Advance Directive.
It is not a process of decision-making nor of consent. It is not a legal document.

Benefits of having the conversation:
Gives the healthcare provider important information when having to make health care recommendations in the future.
Information assists the health care proxy in decision making when a patient becomes incapable.
It has been shown to decrease the level of stress experienced by the patient and family members.
Decreases the likelihood of being admitted to hospital or ICU if this is not the patient's wish.
Decreases frequency of tests, interventions and treatments if this is not the patient's wish.
Improves the patient and family member's experience of end-of-life care.

The guide, developed by Ariadne labs, was developed systematically and tested to determine acceptability of language and the format of the guide. Importantly key elements are addressed in the guide that might otherwise be forgotten or not deemed necessary.

Who should have the conversation?
The guide has been used in Cardiology, Pulmonology, Intensive Care, Nephrology, Oncology, Emergency Medicine, Geriatrics and Palliative Medicine.

When to have the conversation?
Have the conversation (or aspects thereof) early on in a patient's journey with serious illness at a time when things are relatively stable. This gives everyone time to reflect and concur. A pre visit letter given to the patient will help them prepare.

The "surprise question" was used as a trigger in the development of the guide:
"Would you be surprised if the patient died within a year (or two years)?"

It is important to return to the conversation from time to time as a patient's situation and ideas might change. Early on the conversation gives the opportunity to assess a patient's illness understanding and prognostic awareness. Later on specific treatments may enter the conversation.

What to do with the information?
Importantly the conversation needs to be documented (see Documenting the Conversation), dated and signed. A copy is to be given to the patient and ideally should be held in the patient's health records in a place where the rest of the team can find it.

Using the guide gives a well researched structure and language to the conversation. Practiced providers can have the conversation in less than 15 minutes. If possible attending a training workshop is advisable.