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, ...

<table>
<thead>
<tr>
<th>Conversation Flow</th>
<th>Suggested Language</th>
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<tbody>
<tr>
<td>1 Set up the conversation</td>
<td>“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?”</td>
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| 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**

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