



# Recommendations for advance care planning in adults with congenital heart disease: a position paper from the ESC Working Group of Adult Congenital Heart Disease, the Association of Cardiovascular Nursing and Allied Professions (ACNAP), the European Association for Palliative Care (EAPC), and the International Society for Adult Congenital Heart Disease (ISACHD)

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Survival prospects in adults with congenital heart disease (CHD), although improved in recent decades, still remain below expectations for the general population. Patients and their loved ones benefit from preparation for both unexpected and predictable deaths, sometimes preceded by a prolonged period of declining health. Hence, advance care planning (ACP) is an integral part of comprehensive care for adults with CHD. This position paper summarizes evidence regarding benefits of and patients' preferences for ACP and provides practical advice regarding the implementation of ACP processes within clinical adult CHD practice. We suggest that ACP be delivered as a structured process across different stages, with content dependent upon the anticipated disease progression. We acknowledge potential

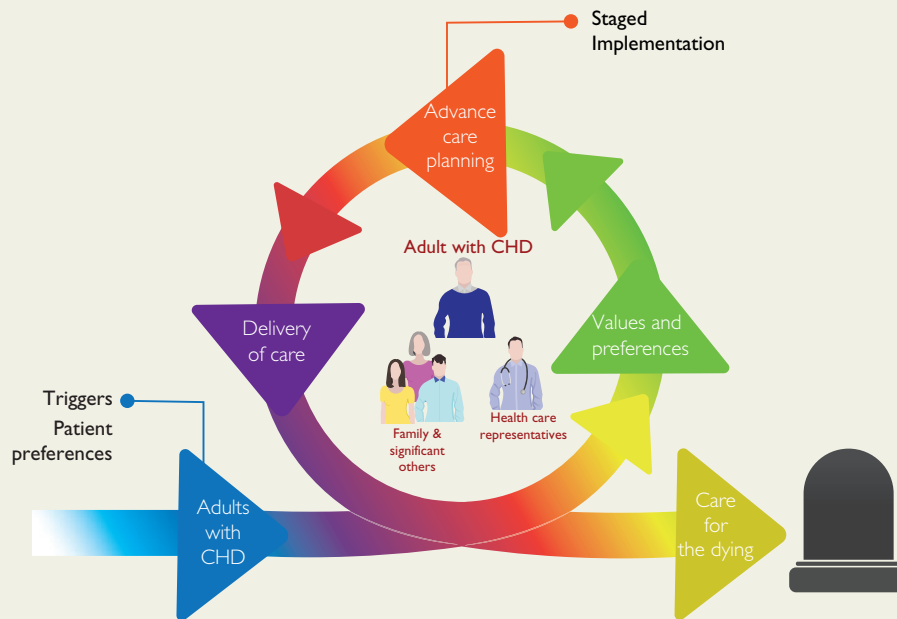
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barriers to initiate ACP discussions and emphasize the importance of a sensitive and situation-specific communication style. Conclusions presented in this article reflect agreed expert opinions and include both patient and provider perspectives.

## Graphical Abstract



## Keywords

Adult congenital heart disease • Advance care planning

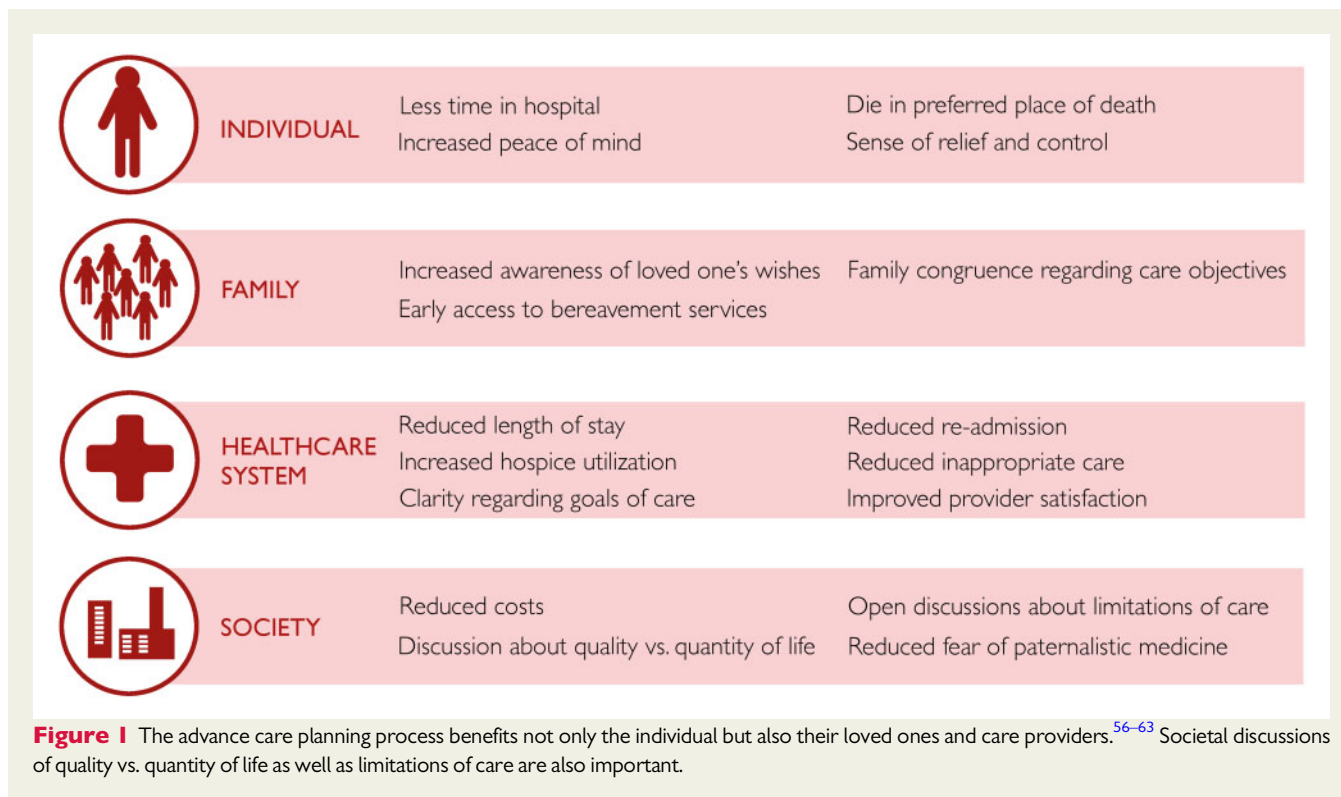
## Introduction

Advances in the diagnosis and treatment of congenital heart defects over the past few decades have led to unparalleled changes in the patient demographic profile, such that adults now outnumber children with congenital heart disease (CHD).<sup>1</sup> Improved survival has been driven largely by a reduction in infant mortality, particularly among individuals born with severe forms of CHD.<sup>2</sup> With decreasing mortality in the young, the CHD population is not only growing but also aging. The prevalence of adults with CHD older than 60 years increased 10-fold from 2000 to 2013 and is currently estimated at 5–10% of the entire CHD population.<sup>3,4</sup> Many now live long enough to acquire typical age-related comorbidities.<sup>5</sup> Over 50% of a contemporary adult CHD (ACHD) cohort receiving follow-up at a tertiary centre had at least one acquired comorbidity and almost a quarter had two or more comorbidities.<sup>6</sup> Although survival beyond the age of 18 years is now >90%,<sup>7</sup> survival prospects for adults with CHD still remain below expectations for the general population.<sup>8,9</sup> The most common cause of death among young people living with CHD is sudden cardiac death, while heart failure supersedes it in the aging CHD population.<sup>10</sup> Therefore, we should prepare adults with CHD and their families for both unexpected and predictable deaths, sometimes preceded by a prolonged period of declining health.

The aims of this position paper are to summarize current evidence regarding benefits of and patients' preferences for advance care planning (ACP) and to provide practical advice regarding the implementation of ACP processes within clinical ACHD practice. Adult congenital heart disease healthcare providers require skills facilitating the timely and sensitive initiation of ACP and the co-ordination of holistic care for adults with CHD at all stages of their life.<sup>11,12</sup> Conclusions presented in this paper are agreed expert recommendations of general rules extrapolated from the ACHD population<sup>12</sup> and also other adults with cardiovascular disease. This position paper includes both patient and provider perspectives and contributions. *Box 1* summarizes the patient perspective in the words of a representative living with CHD.

## Terminology and concepts related to advance care planning

A definition of ACP is provided in *Box 2*—glossary of terms. Advance care planning is based upon consideration of situations that might arise in the future in a person's life.<sup>13,14</sup> Advance care planning helpfully begins with identifying personal values and goals in an effort to align future medical treatment and care with these convictions.



Knowledge of a person's personality and her or his social supports may be helpful for tailoring discussions. The process can be presented to patients and families as 'preparing for the worst, while hoping for the best'.<sup>15</sup> During this reflective process a person may decide which treatments and care measures she or he would prefer in specific situations. Achieving the best possible quality of life within the context of advanced heart disease may entail timely involvement of palliative care (see *Box 2*—glossary of terms), of which key elements include symptom relief, psychosocial support, and spiritual care.<sup>16</sup> There are existing position papers and reviews related to the delivery of palliative care in heart disease patients.<sup>17,18</sup> The primary focus of this position paper is the extended process of ACP rather than palliative or end-of-life care.

## Benefits of advance care planning for people with advanced cardiovascular disease

The American Heart Association,<sup>19</sup> the European Society of Cardiology,<sup>20,21</sup> and the European Association for Palliative Care<sup>17</sup> recommend ACP for people with advanced cardiac disease, including those with heart failure. Advance care planning would ideally become a routine part of heart failure care, reviewed annually and more often as needed in accordance with disease progression. Benefits of timely initiation of an ACP process are summarized in *Figure 1*. Despite a limited quantitative and qualitative evidence base, ACP is considered as a marker of excellent care in advanced chronic heart failure.<sup>22</sup> Advance care planning is also indicated for ACHD patients with

advanced cardiac disease. However, the disease trajectory, patient characteristics, and social situation may differ substantially in ACHD compared to acquired heart failure. Specific recommendations for adults with CHD directed the preparation of this document.

## Advance care planning needs and preferences among adults with congenital heart disease

For adults with CHD, the following empirical findings regarding ACP experiences and preferences have been reported:<sup>23–27</sup>

- Discussions about ACP occur infrequently in routine ACHD outpatient visits.
- Most healthcare providers report that they reserve discussions about ACP for adults living with complex defects and/or at advanced stages of their condition.
- The majority of adults with CHD report interest in ACP independent of underlying defect severity and prefer that such discussions be initiated early in the disease course, before life-threatening complications occur. In one study, 18 years of age was identified as the most appropriate age to initiate an ACP dialogue.<sup>26</sup>
- Although most adults with CHD report interest in ACP and in receiving information about the general life expectancy of individuals with their type of CHD, some prefer not to have such conversations.
- Although the majority of adults with CHD favour having an advance directive (see *Box 2*—glossary of terms) available if they are

unable to speak for themselves, few have previously completed advance directives or appointed a healthcare representative.

- Most adults with CHD would prefer to have discussions about ACP care with their treating ACHD physician. The trusting relationship between a patient and their ACHD physician was identified as a facilitator for the initiation of such discussions.
- Factors associated with greater interest in ACP discussions include being married, perceiving a shorter lifespan compared to peers, and having more pronounced anxiety symptoms.

## Implementation of advance care planning within clinical adult congenital heart disease practice

### Initiation of advance care planning process

The process of ACP may be initiated at any moment in life, independent of a person's health status, and ACP should thus be addressed with all adults with CHD at some time in their lives.<sup>11</sup> Although tools like the 'surprise question' posed to healthcare providers (i.e. 'Would you be surprised if this person died in the next year?') are not validated as prognostic markers in adults with CHD, they can help identify individuals who may benefit from deliberate and thoughtful reflection regarding future health expectations.<sup>28</sup> Furthermore, the circumstances below might prompt the initiation of ACP discussions and review of previously expressed ACP preferences and documents as appropriate (see also [Supplementary material online, Table S1](#)).<sup>14,29,30</sup>

Disease progression and worsening prognosis are milestones in the disease course that may initiate the process of ACP in a way that seems most natural.<sup>31</sup> Population-based prognoses can be estimated using generic<sup>32,33</sup> or CHD-specific tools. Although estimating prognoses in individuals with CHD remains challenging due to less predictable disease trajectories, certain CHD diagnoses have been associated with markedly reduced life expectancy, such as Fontan circulation, a systemic right ventricle, and cyanotic heart disease. For example, the estimated 5-year mortality of a 40-year-old person with Fontan physiology is comparable to that of a 75-year-old person from the general population.<sup>34</sup> Many individuals with complex CHD are unaware of their prognosis and overestimate their life expectancy, which may result in requests or expectations that are at odds with experienced clinical judgement.<sup>15</sup> Exploration of these inconsistencies may naturally trigger ACP.

A second opportunity to initiate ACP occurs at the time of consideration of interventions including cardiac surgery, complex catheter-based therapeutic interventions, implantable cardioverter defibrillator (ICD) implantation, ventricular assist device implantation, or heart transplantation. A 'what if?' dialogue can be incorporated into the discussion of potential complications threatening survival, independent functioning or decision-making capacity.<sup>30</sup> During such dialogue, the option of declining the proposed treatment or intervention if incompatible with personal goals and alternative management options should be presented. The discussion can be expanded to include longer-term health expectations in addition to potential immediate complications of the intervention. The occurrence of an acute

event (e.g. acute heart failure, ventricular arrhythmia requiring cardioversion) or any other unplanned hospital admission can also trigger the reflective process of ACP. If not relevant or possible early in the course of a hospitalization, ACP can be initiated before discharge by exploring patient's wishes should another acute event occur.<sup>30</sup>

Changes in a person's social system, such as death of a close family member, death of an ACHD peer, and family planning, may trigger ACP due to acute awareness of mortality.<sup>35,36</sup> As part of the pre-pregnancy counselling process,<sup>37</sup> the impact of pregnancy on long-term functioning and future health can lead directly to a comprehensive discussion of ACP.<sup>38</sup>

Advance care planning discussions should not be restricted to adults of a certain age group and can also be appropriate for adolescents and young adults with CHD.<sup>39,40</sup> Discussion of the impact of CHD on later life and anticipated long-term outcomes can be an integral part of the transition process from paediatric to adult care,<sup>41</sup> particularly for patients with complex defects. As with patients of all ages, the potential emotional impact for patients and their families must be acknowledged.

### Overcoming barriers to the advance care planning process

*Table 1* presents known barriers that may hamper the initiation of the ACP process as well as proposed solutions. Advance care planning has become a frequent theme in ACHD peer groups and patient organizations, highlighting that people with CHD are increasingly identifying this as an important topic of discussion. As such, ACHD programmes are encouraged to partner with national or international patient organizations (e.g. [www.echdo.eu](http://www.echdo.eu), [www.global-arch.org](http://www.global-arch.org), [www.achaheart.org](http://www.achaheart.org)) to provide educational ACP activities, such as webinars. Some patients may appreciate an introduction to ACP concepts in this more general forum prior to having personal discussions in the clinical setting.

### Staged implementation of advance care planning

Advance care planning is a gradual process that is initiated by exploring a person's understanding of the aims and potential benefits of ACP and discussing their personal readiness for decision-making. Information about a person's health-related experiences, values, psychosocial resources, concerns, and expectations should be sought. Given the diversity in cultural and religious approaches to death and dying both between and within countries, a culturally sensitive approach is essential.<sup>42</sup> Assumptions should be avoided and provider is encouraged to approach discussions with a respectful curiosity. It should be noted, however, that core principles of ACP, such as the expression of respect and compassion, and alleviation of unnecessary distress, are largely similar across ethnic and cultural groups.<sup>43,44</sup> Open and sensitive communication concordant with personal needs and values should include an explanation of how the CHD diagnosis impacts longer-term health expectations and anticipated disease progression, prognosis, and the advantages and disadvantages of potential treatment options.<sup>29</sup> This allows providers to individualize ACP to the expected timing of health deterioration. As such, we suggest a staged implementation of the ACP process as outlined in *Table 2*.

**Table 1** Barriers to advance care planning communication and proposed clinical strategies

Barrier	Strategies for healthcare providers
<b>At patient level</b>	
No/minimal knowledge about ACP	Provide education about the rationale for ACP
Reluctance to begin this discussion	Introduce and normalize this topic in broader terms during a routine clinic visit and offer the opportunity to discuss in more detail at a follow-up visit Encourage patients to have loved ones present for these conversations Introduce ACP during situations when it seems to occur more naturally (e.g. death of a close family member or an ACHD peer, family planning, prior to cardiac intervention)
Avoidance of discussion of health deterioration (which might be amplified during acute cardiac events)	Initiate ACP during stable (rather than acute) phase of the disease to allow for a less-pressured patient experience
Desire to protect family and loved ones	Educate about the advantages of ACP communication and advance directives for family members should they be faced making treatment or care decisions for the patient in the future
<b>At healthcare provider level</b>	
Fear of causing patients to experience unnecessary emotional distress	Acknowledge that emotional reactions to disappointing information are understandable Acknowledge and label emotional reactions as they occur Strive for a balance between preparation for undesired outcomes and maintaining hope; emphasize that these are not mutually exclusive Emphasize that ACP is intended to be an empowering process for patients and their loved ones
Uncertainty about prognosis	Acknowledge challenges associated with an unpredictable disease trajectory Use standardized prognostic indexes (e.g. NYHA class) or results from functional testing (e.g. cardiopulmonary exercise testing) to guide predictions Offer broader time ranges for life expectancy (i.e. decades vs. years vs. months vs. weeks)
Lack of confidence and skills in ACP	Practice discussions with colleagues to develop comfort with this language Consider a standardized approach (e.g. ask-tell-ask) to initiate discussions Use a checklist to guide discussions (see <a href="#">Supplementary material online</a> ) Seek continuing education opportunities Liaise with a palliative care team to enhance skills
Low familiarity with specific patient factors that warrant unique attention (e.g. culture, religion, background)	Communicate in a respectful and sensitive manner Inquire about religious, cultural and background factors that may impact patients' decision-making Maintain a respectful curiosity regarding patients' beliefs and practices Avoid assumptions based on patients' culture, religion, or background
Personal discomfort with ACP discussions and end-of-life care	Acknowledge that emotional reactions are understandable Be aware that responding to emotions may enhance rather than diminish the patient-provider relationship Remain cognizant of situations in one's own life that may impact comfort level (e.g. death of a loved one, one's personal health challenges) and seek counselling as appropriate Seek peer/professional consultation to develop strategies to manage emotional distress
<b>At ACHD programme/institutional level</b>	
Ambiguity regarding who is responsible for initiating and maintaining the ACP dialogue	Acknowledge that adults with CHD prefer to discuss ACP with clinicians whom they trust Develop a standardized process for identifying the team member who is responsible for overseeing ACP
Lack of time	Advocate for a clinical scheduling practice that allows sufficient time to discuss ACP within a routine outpatient visit Schedule ACP-specific clinical visits Recognize that time might be more flexible within the inpatient setting

ACHD, adult CHD; ACP, advance care planning; CHD, congenital heart disease; NYHA, New York Heart Association.

Within every stage of ACP, patients should be given the opportunity to involve family members or loved ones and also to reflect and clarify previously documented wishes; as such, ACP is an iterative process (*Take home figure*).

When speaking with an adult with CHD with minimal anticipated major health problems in the upcoming years, it may be sufficient for the ACP discussion to include predicted long-term health outcomes and to explore a person's values, goals, and concerns for the future.

**Table 2** Staged implementation of advance care planning<sup>a</sup>

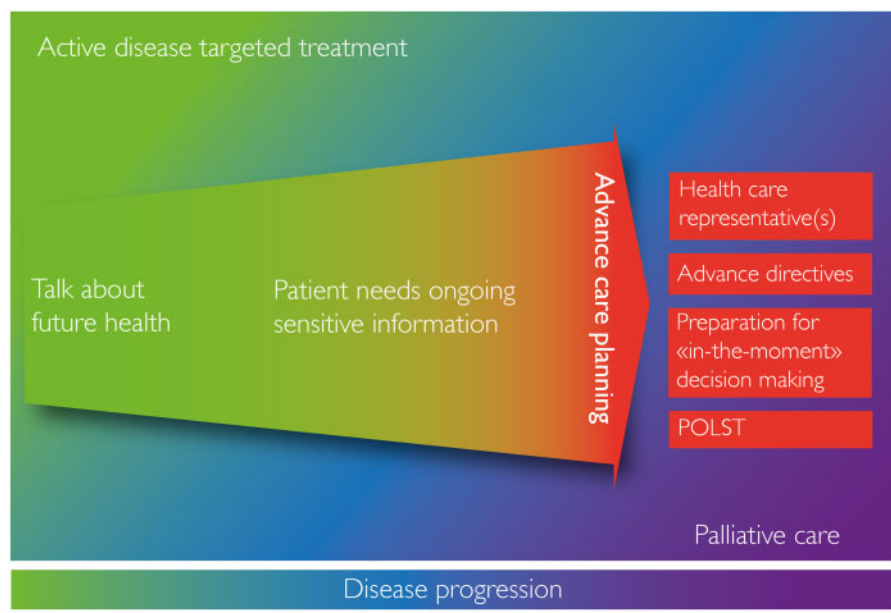
	Who	Action	Steps
Stage 1	<p><b>Anticipated life expectancy: decade(s)</b></p> <p>Adult with CHD with any of the following</p> <ul style="list-style-type: none"> <li>• expressing interest in future health discussion (e.g. during transition to adulthood)</li> <li>• having unrealistic health expectations, particularly when confronted with important life planning decisions (e.g. family planning)</li> <li>• reduced life expectancy, such as               <ul style="list-style-type: none"> <li>- adults with Fontan procedure</li> <li>- adults with cyanotic heart disease</li> <li>- adults with a systemic right ventricle approaching 40 years of age</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Invite discussions about future health expectations and preferences</li> <li>• Explain the rationale and advantages of ACP</li> <li>• Discuss future health expectations, while acknowledging challenges with longer-term prognostication</li> <li>• Inquire about personal preferences, goals and personal values</li> <li>• Offer to include relatives or loved ones in the conversation</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule dedicated outpatient visit(s) for the purpose, as appropriate</li> <li>• Provide written documentation in medical records of elements discussed</li> <li>• Share information with general practitioner and other healthcare professionals</li> </ul>
Stage 2	<p><b>Anticipated life expectancy: years</b></p> <p>Adult with CHD with any of the following</p> <ul style="list-style-type: none"> <li>• expressing interest in ACP discussion</li> <li>• before CRT or ICD implantation</li> <li>• at the time of diagnosis with advanced heart failure, particularly before heart transplant assessment<sup>22</sup></li> <li>• requiring cardiac surgery, complex catheter-based therapeutic interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Revisit the elements discussed at stage 1 and</li> <li>• Offer more comprehensive ACP discussion</li> <li>• Prepare or review advance directives including the nomination of a healthcare representative</li> <li>• Inform and discuss about POLST</li> </ul>	<ul style="list-style-type: none"> <li>• Schedule dedicated outpatient visit or facilitate ACP discussion during an inpatient stay</li> <li>• Provide an update of written documentation of ACP, if applicable</li> <li>• Document advance directives (including healthcare representative) and/or POLST and share this information with all stakeholders</li> </ul>
Stage 3	<p><b>Anticipated life expectancy: weeks to months</b></p> <p>Adult with CHD with any of the following</p> <ul style="list-style-type: none"> <li>• their provider would not be surprised if the patient died within the next year</li> <li>• refractory end-stage heart failure<sup>21,22</sup> (e.g. a failing Fontan circulation; repeated re-admission for decompensated heart failure requiring inotropic support and/or ICU stay; if temporary or long-term mechanical circulatory support is considered or may arise in due management course)</li> </ul>	<ul style="list-style-type: none"> <li>• Revisit the elements discussed at stage 2 and</li> <li>• Discuss end-of-life preferences, including the location of death</li> <li>• Organize support for family members</li> <li>• Involve palliative care team as appropriate</li> <li>• As appropriate, discuss deactivation of implanted cardiac device functions</li> </ul>	<ul style="list-style-type: none"> <li>• Update written ACP documents as applicable</li> <li>• Consider organization of home care</li> <li>• Consider involvement of social work</li> <li>• Consider involvement of palliative care</li> <li>• Consider involvement of psychology and/or religious support providers</li> </ul>
Stage 4	<p><b>Anticipated life expectancy: days</b></p> <p>The dying adult with CHD</p>	<ul style="list-style-type: none"> <li>• Provide end-of-life care reflecting personal preferences and documented directives</li> <li>• Co-ordinate bereavement care for loved ones, as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Consider involvement of social work</li> <li>• Consider involvement of palliative care</li> <li>• Consider involvement of psychology and/or religious support providers</li> <li>• Provide support to care team as necessary</li> </ul>

ACP, advance care planning; CHD, congenital heart disease; CRT, cardiac resynchronization therapy; ICD, implantable cardioverter defibrillator; ICU, intensive care unit; POLST, Physician Orders for Life-Sustaining Treatment.

<sup>a</sup>Adapted table from 'Staged implementation of advance care planning, anticipatory care planning and integrated end-of-life care planning'.<sup>30</sup>

During these discussions, the provider might discover that patient's expectations are in fact more pessimistic than would be predicted from long-term follow-up studies. The results of one study indicated that adults with CHD of low complexity were more likely to want

information about the average life expectancy compared to those with CHD of moderate or great complexity.<sup>26</sup> In some of these cases, discussions of long-term health expectations might be interpreted with reassurance and relief.<sup>25</sup>



**Figure 2** In accordance with advanced disease progression, discussion may transition from general health expectations to more specific topics. It is helpful for patients, loved ones, and providers to prepare for in 'in-the-moment decision-making' in acute health situations in ways that reflect patients' known preferences and priorities. Over time, an individual's care needs may shift from active, disease-targeted therapies (green), through periods of increasing symptoms and disability requiring more palliative care measures (purple). Active and palliative care strategies are not mutually exclusive (shades of blue). POLST, Physician Orders for Life-Sustaining Treatment.

For adults with CHD facing health deterioration, discussions about preferences for interventions and life-sustaining treatments become more pertinent and would ideally result in advance directives, including the naming of a healthcare representative, and Physician Orders for Life-Sustaining Treatment (healthcare representative; see Box 2—glossary of terms) that should be made accessible to all healthcare providers involved in the care process.<sup>35</sup> Figure 2 illustrates how the content of ACP discussions can transition from general information about future health expectations to more specific topics in accordance with disease progression.

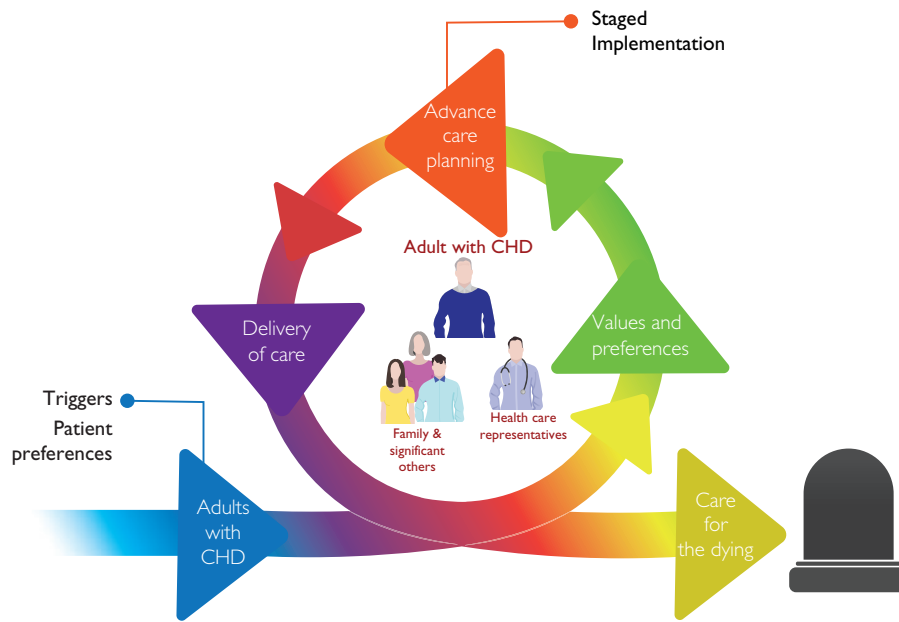
As a person's condition deteriorates further such that the possibility of death increases, discussions can be extended with specific questions related to end-of-life wishes, including issues related to the modification of cardiac devices (e.g. deactivation of shocking function of an ICD), specific treatments to consider and avoid, and palliative care measures.

Interprofessional collaboration (e.g. palliative care professionals, social workers, psychologists, spiritual advisors) may be particularly helpful in situations in which (i) patients and/or loved ones are struggling with the disease trajectory, (ii) disagreements exist between the patient, family, and care teams, or (iii) challenges arise in managing physical and/or psychological symptoms. It is important to emphasize to patients and loved ones that active disease-specific care can continue in parallel with palliative care if consistent with patients' preferences and goals.<sup>17,45,46</sup> The supporting role of palliative care for the family and loved ones goes beyond the person's death and includes bereavement counselling.<sup>47</sup>

## Structural requirements for implementing advance care planning in regular adult congenital heart disease practice

Effective ACP sometimes requires an interdisciplinary team approach.<sup>48</sup> In addition to the ACHD team (i.e. typically cardiologists and nurses), other members of the interdisciplinary team reflect needs of the person and his/her family (e.g. general practitioners, other subspecialists, social workers, spiritual care providers, psychologists, legal counsellors, palliative care specialists).<sup>49</sup> Within the team, it is important to identify the co-ordinating lead who may thus assign specific tasks to other team members. This is often the patient's identified primary ACHD cardiologist, who most patients consider the most appropriate person to initiate ACP discussions.<sup>23</sup> Advanced practice nurses (e.g. nurse practitioners) are also well suited for this oversight role, given their holistic approach and often long-term relationships with patients.<sup>50</sup>

In addition to staffing considerations, a set of programmatic processes is necessary to ensure regular review and accessible storage of advance directives.<sup>13</sup> Legal requirements, such as the binding effects of ACP documents, identification of one's healthcare representative, and matters related to assisted dying, depend upon laws of one's local jurisdiction.<sup>42</sup> At a minimum, ACP documents should be declared as 'statements of wishes to be given due respect'.<sup>51</sup> A formal document signed by patients and witnesses is ideal. This document should be



**Take home figure** Advance care planning is a staged and iterative process rather than a one-time event. Advance care planning supports and empowers individuals to consider and communicate preferences for future health care based on their personal values and beliefs, should they be unable to express their wishes at that time. Within every stage of advance care planning, patients should be given the opportunity to involve family members or loved ones and also to reflect and clarify previously-documented wishes. Most adults with congenital heart disease prefer to have discussions about advance care planning care with their treating adult congenital heart disease physician. A trusting relationship is a facilitator for the initiation of such discussions. The notion of disease progression and specific triggers should raise awareness of the adult congenital heart disease specialist to mention and initiate advance care planning, if wished by the patient. CHD, congenital heart disease.

### Box 1 The perspective of adults living with congenital heart disease

- In a society that mutes discussions on death and dying and that simplistically lauds improved adult congenital heart disease (ACHD) outcomes as success stories, healthcare providers tend to avoid and/or delay advance care planning (ACP) discussions with their patients.
- Patient organizations can help healthcare providers spread information about ACP. They are also irreplaceable for adults with congenital heart disease (CHD) to have conversations about ACP among peers.
- Documents for ACP available on the Internet through various organizations are usually tailored to elderly people and not to adults with CHD. Adults with CHD would benefit from assistance when using such documents.
- Discussions with healthcare providers about future health are typically welcome, even though this is often considered a stressful topic. Adults with CHD and ACHD healthcare professionals may be challenged by the art of finding the right words at the right moment.
- When an adult with CHD asks what can be done for them, the answer should be realistic and may include comfort measures rather than (or in addition to) strategies to extend life: 'all that can be done when nothing more can be done'.
- Many individuals have clear ideas about what they consider the worst possible way to die. It is helpful to discuss strategies for preventing such dreaded situations.
- Hope is not just about medical outcomes. Rather than lingering in discomfort, adults with CHD may hope for a sudden death, for effective comfort measures, and for emotional, spiritual, and interpersonal support during the last chapters of their biography.

easily identifiable and accessible within the electronic and/or paper medical record and not merely summarized in a clinical progress note. The aim is to ensure access by all inpatient and outpatient health providers.<sup>29</sup> It is also advised that patients provide family members and new healthcare providers with a copy of their advance directives to ensure at the time of admission, the patient or the

persons most involved with its medical support, have a hard copy or an electronic version at hand. Advance care planning preferences and decisions may change over time. It is important for ACHD providers to revisit this topic over time, and to adjust the corresponding documents accordingly. Providers may also require about the presence of externally prepared ACP documents (e.g. completed with a lawyer).



## Box 2 Advance care planning: glossary of terms

*Advance care planning* is a process that supports and empowers individuals, at any stage of their lives or the disease process, to consider, communicate, and document preferences for future health care to their loved ones and healthcare providers. During this process, individuals have the opportunity to make decisions in advance about treatment they would and would not want should they be unable to express their wishes at that time. This process benefits (i) patients (by increasing the likelihood that their wishes will be followed), (ii) loved ones (by helping them more confidently express patients' wishes if necessary), and (iii) healthcare providers (by providing information sufficient to align treatment plans with patient goals and preferences).

*Advance directives* are paper and/or electronic documents that specify a person's preferences and decisions (including the naming of a healthcare representative) for medical treatments or care in advance of a potential serious medical event/situation when they may be unable to communicate this information. Specific documentation requirements may vary depending upon where a patient lives.

A *healthcare representative* (also referred to as a substitute decision maker, surrogate decision maker, power of attorney for personal care or healthcare proxy) is a named individual that a person entrusts to express their wishes and make medical decisions on their behalf should the individual be unable to speak for themselves.

*Palliative care* has traditionally referred to care focused on alleviating symptoms and enhancing quality of life and quality of the dying experience rather than curing disease or extending life. The modern definition has been expanded to describe comprehensive care that addresses the physical, psychosocial, and spiritual needs of individuals with diseases unresponsive to curative treatments. Such care is ideally introduced early in the course of the illness and meets the needs of patients and their loved ones.

*Physician Orders for Life-Sustaining Treatment (POLST)* are medical orders to be honoured by healthcare workers during a critical event. Unlike advance directives, POLST document the patients' wishes in the form of binding orders (i.e. no referral to the intensive care unit) but do not include other more general preferences such as identifying a healthcare representative.

If available, the recommendation to include these in the medical record should be offered.

Provider training in ACP and end-of-life discussion is associated with increased ease and comfort to initiate ACP discussions.<sup>52</sup> Communication during the ACP process may be challenging for all stakeholders. Practical tools such as the Six Step Protocol for Delivering Bad News or the 'ask-tell-ask' algorithm can help healthcare professionals to communicate bad news in an effective but compassionate way.<sup>15,53</sup> Information on national courses is available through the European Association for Palliative Care ([www.eapcnet.eu](http://www.eapcnet.eu)). Given that ACP discussions can be emotionally burdensome,<sup>54,55</sup> it is advised that providers receive training in coping strategies and have support systems in place.

## Summary

Advance care planning has emerged as an integral part of comprehensive care for adults with CHD. It should be offered during routine clinical practice to all interested persons and particularly to those at risk for significant deterioration in the near future. We suggest that ACP be delivered as a structured process across different stages, with content dependent upon the anticipated disease progression. We acknowledge potential barriers to initiate ACP discussions and emphasize the importance of a sensitive, responsive, and adaptable communication style. Advance care planning benefits from a team approach, provider training, adequate staffing, and a systematic approach to documentation. Death is an inevitable outcome for all

Supporting patients to be well prepared for their final journey may be one of the most challenging and also rewarding experiences for ACHD providers.

## Supplementary material

Supplementary material is available at *European Heart Journal* online.

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