can approach EOL discussions with the cultural sensitivity and understanding to improve the quality of living and dying.

**OP73 DIFFERENCES BETWEEN ADVANCE DIRECTIVES AND ADVANCE CARE PLANNING IN THE ITALIAN LAW 2019/2017**

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Background The Law 219/2017, entered into force on January 31, 2018, regulated for the first time advance directives (ADs) and advance care planning (ACP) in Italy. We aimed to examine main legal differences between ADs and ACP according to this law.

Methods The Law 2019/2017 was analyzed, and relevant differences between ADs and ACP were described.

Results ADs and ACP differed mainly with regard to subjects involved, legal formalities required, and the healthcare professionals’ duty to respect the patient’s will. ADs may be made by mentally competent adults through notarization or delivery to a municipal office or to a health facility with electronic health record database structure; ADs are, in principle, binding for physicians, but the physician, in agreement with the healthcare proxy, may go against the patient’s will in some circumstances. On the other hand, ACP may be carried out by the patient and the physician with regard to the expected trajectory of a chronic disabling disease or a progressive illness with a poor prognosis; there are no particular legal formalities for establishing the ACP, which should be included in the patient record; ACP is always binding for both the physician and the healthcare staff members.

Conclusion(s) The Italian Law 219/2017 set up a binary approach to guaranteeing patient self-determination in the case of lack of decision-making capacity, establishing the primacy of the ACP carried out with the physician when patients’ outcomes are already predictable.

**OP74 ADVANCE CARE PLANNING BY PROXY: AN ANALYSIS OF THE ETHICO-LEGAL FOUNDATION**

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Background Advance care planning (ACP) in practice often includes conversations with family caregivers of those patients who have already lost decision-making capacity. This approach has been defined as ACP by proxy and rightly been pointed out as a distinct activity, but it blatantly lacks an ethico-legal foundation.

Method Theoretical analysis, drawing from bioethics, philosophical ethics, and international medical law.

Results In contrast to ACP by the patient, ACP by proxy has its core roots not on direct, but indirect patient autonomy. While the patient with his or her autonomous preferences is also at the heart of the process, the epistemological approach to assess these preferences has to pass via surrogates and others close to the patient. As the patient commonly cannot participate in the conversation, his or her preferences cannot be jointly developed by a kind of maieutic process, but have to be approximated by substituted judgment. Another key difference is the ethico-legal responsibility placed on the surrogate decision maker as well as on the health care team and ACP facilitator linked to this substituted judgment.

Conclusion Irrespective of shared values, ACP by the patient and ACP by proxy have distinct ethico-legal features that warrant particular consideration in the practical process of ACP, the qualification of ACP facilitators, and the documents used.

**OP75 THE DECISION MAKING CAPACITY IN AMYOTROPHIC LATERAL SCLEROSIS (ALS)**

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Background From the beginning and during the disease the ALS patients have to take difficult decisions about care and end of life. A sensible and open communication among patient and clinicians is an indispensable tool to ensure the freedom of choice and the recognition of the responsibility for everyone. Any intervention by the health professionals cannot forget the clinical complexity and the subjectivity of the patients who exercises their rights to know and to choose among technology opportunities. The aim of the study is to identify those elements that influence the patient’s choices.

Methods We examined 200 ALS patients taking care by palliative multidisciplinary team for 18 months about: withholding and withdrawing vital supports, mobility and communication aids, rehabilitation care and dying setting. We registered the respect for advance directives, the changing’s patients minds, the making informed choices, the clinicians attitudes about care planning and communication disability.

Results For every choice the decision making involves scientific aspects, patient’s quality of life, and community resources too. We showed that the choices are often not real free but depending on the clinicians’ point of view, the availability of high technology aids and the clinician-patient communication skills.

Conclusion The negotiation is the new aspect of the physician-patient relationship founded on empathy, respect and recognition of different competences. The clinician’ ethical-clinical reasoning could be a useful tool to improve the patient ability to choose on difficult clinical situations.

**OP76 ADVANCE CARE PLANNING: CORE COMPETENCY OF ELDERLY CARE MEDICINE IN THE NETHERLANDS**

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Background From the beginning and during the disease the ALS patients have to take difficult decisions about care and end of life. A sensible and open communication among patient and clinicians is an indispensable tool to ensure the freedom of choice and the recognition of the responsibility for everyone. Any intervention by the health professionals cannot forget the clinical complexity and the subjectivity of the patients who exercises their rights to know and to choose among technology opportunities. The aim of the study is to identify those elements that influence the patient’s choices.

Methods We examined 200 ALS patients taking care by palliative multidisciplinary team for 18 months about: withholding and withdrawing vital supports, mobility and communication aids, rehabilitation care and dying setting. We registered the respect for advance directives, the changing’s patients minds, the making informed choices, the clinicians attitudes about care planning and communication disability.

Results For every choice the decision making involves scientific aspects, patient’s quality of life, and community resources too. We showed that the choices are often not real free but depending on the clinicians’ point of view, the availability of high technology aids and the clinician-patient communication skills.

Conclusion The negotiation is the new aspect of the physician-patient relationship founded on empathy, respect and recognition of different competences. The clinician’ ethical-clinical reasoning could be a useful tool to improve the patient ability to choose on difficult clinical situations.
ACP for frail elderly and patients with complex chronic health problems as well as evidence for ACP interventions in this population. ACP education of Dutch elderly care physicians will be highlighted. The specific challenge for elderly care physicians in ACP for persons with decision-making disabilities will be discussed. Finally, the collaboration between elderly care physicians and general practitioners will be illustrated.

**Content** Introduction ACP in elderly care medicine – by dr. Daisy J.A. Janssen

Specific challenges for elderly care physicians: ACP and decision-making disabilities – by prof. Cees Hertogh

Collaboration between elderly care physician and general practitioner – by general practitioner invited by dr. Annicka van der Plas

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**OP77** THE ADVANCE PROJECT: AN AUSTRALIAN NATIONAL PROGRAM TO SUPPORT NURSES TO INITIATE ADVANCE CARE PLANNING IN GENERAL PRACTICE


10.1136/spcare-2019-ACPICONGRESSABS.77

**Background** Primary care has been advocated as an ideal setting to initiate advance care planning (ACP). Few studies have examined the role of general practice nurses (GPNs) in promoting/initiating ACP. The Advance Project evaluated initiatives to address this gap.

**Methods** This Australian Government-funded program aims to increase GPNs’ confidence in initiating conversations with patients/carers about ACP during routine health assessments with older and/or chronically ill patients using a structured interview. This is part of a broader program enabling GPNs to identify patients at risk of deteriorating and dying and to assess these patients’ palliative/supportive care needs. Identified needs are then addressed in consultation with General Practitioners. The program includes a suite of resources and multi-component training (online, face-to-face and individual tele-mentoring). Pre/post follow-up surveys and qualitative interviews collected GPNs’ perspectives about the training/resources and barriers to implementation in clinical practice.

**Results** As of 31 December 2017, 823 GPNs enrolled in training and 536 completed one or more training components. 27 workshops were held across Australia, including 18 regional/rural participants. 585 pre-training, 384 post-training, and 125 follow-up surveys were received. 20 GPNs were interviewed. There were significant improvements in GPNs’ confidence, comfort, knowledge and attitudes towards initiating ACP post-training that was sustained at follow-up. Participants were significantly more likely to have had ACP discussions with their patients at follow-up (81%) compared to baseline (55%), p<0.001.

**Discussion/Conclusion** GPNs can have an important role in initiating ACP. The evaluation informed refinement/expansion of the resources/training to support team-based initiation of ACP in general practice http://www.theadvanceproject.com.au

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**OP78** REGIONAL (CENTRAL) VERSUS INSTITUTIONAL: COMPETING STRATEGIES FOR NATIONWIDE ACP IMPLEMENTATION

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**Background** Implementing ACP in nursing homes is often essentially done by educating selected n/h staff as ACP facilitators. Recent German legislation covers ACP offered to nursing home residents, and offers an alternative strategy for implementation, i.e. cooperation of participating n/h with a regional (central) partner that employs a team of facilitators. Which of these two strategies should be preferred?

**Methods** 1. Follow-up of facilitator training effectiveness in Germany in 2015–2017, 2. review of the literature, 3. theoretical analysis of the competing rationales.

**Results** Of some 270 facilitator trainees attending our ACP courses, only few report ongoing practice as an ACP facilitator. A number of important publications describe facilitators and barriers, or essential elements, of successful ACP implementation, but few if any compare regional versus institutional implementation strategies of ACP yet. Similarly, while regional ACP coordination is described as an important precondition for sustainable ACP implementation, it requires significant resources on top of institutional implementation. A comparative analysis yields a number of strong reasons why regional may well beat institutional implementation strategies, referring to staff aptitude, team building, regional coordination, economic efficiency, and both sustainability and expandibility. Arguments that have been raised against qualifying external staff can be shown not to consider sufficiently the potential of creating regional (central) facilitator teams.

**Conclusion** Regional implementation of ACP, characterised by regional (central) facilitator teams cooperating with nursing homes and other institutions, has yet rarely been described, but poses a substantial potential when compared to conventional institutional implementation strategies that deserves scientific evaluation.

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**OP79** CREATING MOMENTUM AND CONSISTENCY WITH A NATIONAL FIVE YEAR STRATEGY IN NEW ZEALAND


10.1136/spcare-2019-ACPICONGRESSABS.79

**Background** The development of ACP in New Zealand was driven by the ACP Cooperative, a grass roots organisation of clinicians. The Cooperative’s aim was to drive consistency and address the barriers to ACP implementation. Over time, the lack of an official mandate and funding threatened the sustainability of the work of the Cooperative.

**Method** In 2017 the Cooperative partnered with the Health Quality & Safety Commission – a crown agency tasked with supporting the public health sector to improve the quality and safety of services. Together they presented a business case to the district health boards (DHBs) to agree to a national programme with a clear mandate and funding. The DHBs agreed to a five-year strategy and roadmap of national and local actions aimed at increasing ACP activity and addressing sustainability. The key strategy workstreams and their aims are: