ORGANISATION OF PATHWAYS

Essentials of the palliative approach

Key points

Palliative care:

- **does not just mean caring for people in their final days or weeks of life** but is something that can be introduced **earlier on**, during the progression of **a life-limiting illness,** in order to improve the quality of life of the patients and of their family;
- **is the responsibility and the concern of all healthcare professionals and those working social care sector and residential care facilities**;
- **is not the exclusive preserve of dedicated units or teams** and can be given wherever it is needed, whether **in the patient's home, a medical welfare establishment, or a hospital**.

This document is aimed at healthcare professionals and those working in the social and residential care sector, including doctors, pharmacists, nurses, nursing auxiliaries, home helps, and clinical psychologists. It offers tools to help identify adult patients who should benefit from a palliative approach and advice for talking about it.

➊ Definition

The palliative approach is a way of addressing end-of-life issues early on: make time to talk about ethical questions, psychological support, comfort care, the right care, and give a timely thought to the likely palliative care needs of "people approaching the end of life". When specific treatments for a disease are reaching their limits, it makes it easier to gradually switch to administering palliative care[1]. The palliative approach forms part of a patient's overall management.

Palliative care is active and comprehensive care delivered by an interdisciplinary team as part of an overall approach to people in the advanced stages of a serious and progressive life-limiting illness. Their goal is not only to relieve physical pain and other symptoms, but also to try to deal with psychological, social, and spiritual suffering.

Palliative care and support rely on interdisciplinary. They are addressed to a patient as a person, to his or her family and close relatives, whether at home or in an institution. The training of and support for carers and voluntary helpers are part of this approach.

The point is not to separate palliative care from the specific treatments for the illness and to look towards developing a **palliative "approach**", whose purpose is to integrate palliative care skills in clinical practice as a whole rather than seeing palliative care in isolation, as a specialised activity. One of the fundamental skills of the palliative approach is the ability early on to identify the palliative care needs of "people nearing their end of life"

A number of studies[2] have shown that palliative care **started early**:

- improved quality of life, the relief of symptoms, and an understanding of the prognosis;
- in some cases it increased patients' life expectancy;
- reduced the number of depressions;
- helped prevent disproportionate treatments and unscheduled hospitalisations;
- helped keep healthcare costs down.

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[1] The 2015-2018 plan for developing palliative care and end-of-life support.

[2] RB. Parikh, N Engl J Med 2013; 369(24): 2347-51

❷ Contents

- **The palliative approach is for the long term**: it supports patients throughout their illness trajectory and adapts to any improvements or complications right until death.
- It centres around the needs, plans, and expectations of the patients and their families and close relatives.
- It aims to offer the best possible quality of life to patients and close relatives as part of an overall and personalised approach with:
  - an assessment of their needs for care and support;
  - treatment for their physical symptoms: pain, breathlessness, nausea and vomiting, anorexia, etc.;
  - account being taken of patients' psychological suffering and social, spiritual, emotional, and cultural needs.
- It means that this care and these treatments need to be:
  - reassessed on a regular basis;
  - active, continuous, proportionate, and adjusted to the course of the illness;
  - administered, whether simultaneously or otherwise, along with the specific treatments for the illness;
  - coordinated and performed by an interdisciplinary team.
- Throughout the illness, **patients need to be kept informed** to enable them to maintain their autonomy and make their choices known.
- It respects patients' dignity throughout their illness and during the terminal phase.
- It seeks to prevent the administering of futile interventions and to respect **patients' wishes and priorities**, expressed if need be in advance directives.
- After death, it provides support to the grieving **families and close relatives**.

The concept of supportive care is of Anglo-Saxon origin: supportive care and palliative care work together to provide patients with the best possible quality of life (Appendix 1).

❸ Whom it concerns

People approaching their end of life and who find themselves in one or other of the following situations should, in the face of clearly identified needs, be able to have early access to palliative care, whatever their state of health or loss of autonomy, wherever they happen to be, and provided they agree to it:

- general frailty coupled with serious comorbidities;
- or advanced, progressive, incurable illness;
- or at risk of dying from a sudden acute crisis arising during the course of a pre-existing illness;
- or life-threatening acute conditions caused by sudden catastrophic events.

▸ How to identify them

All professionals involved in giving care or support have a part to play in this identification; it could be provided by the team that is managing the patient wherever he or she happens to be living (sharing information at multidisciplinary meetings).

Sometimes, it is the patients themselves who ask for palliative care. And not just the patients: the families or close relatives can draw attention to the suffering and needs of patients.

Since it is not always easy to know if patients are in need of palliative care, certain tools described in the guidelines can prove useful:

- the SPICT tool can be used in the community or in hospital and is available in several languages (Appendix 2);
- the question "would I be surprised if this patient were to die in the next 12 months?" can help doctors intuitively predict the prognosis: this in addition to other prognostic factors relating to the patient and to the illness;
- the tools Pallia 10 and Pallia 10 Géronto (available on the SFAP website[3]) can help identify these patients;
- Dr Renée Sebag-Lanoë's ethical questionnaire guides ethical thinking in teams and can help in assessing the situation of elderly people (Appendix 3).

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[3] SFAP: Société française d'accompagnement et de soins palliatifs [French Society for Supportive and Palliative Care]. www.sfap.org

❹ Professionals and actors involved

All healthcare professionals are encouraged to integrate the palliative approach in their practice, regardless of their speciality and where they work: it is multidisciplinary and is not restricted to dedicated units or specialist professionals.

Professionals may need to develop their skills through some initial or ongoing training in generalist palliative care, including: identification of people whose health is deteriorating, basic palliative needs assessment, communication, and the approach to ethical questioning.

▶ At home and in medical welfare establishments and departments, in particular in residential care institutions for dependent adults

- Treating doctors (specialists in general medicine, geriatricians, and other specialists) and the nurse are the initial points of contact.
- Other professionals, both medical and otherwise (paramedical staff, pharmacists, psychologists, etc.), home nursing services, home helps, and supportive-care services, etc. are very much involved in the palliative approach.

The introduction of palliative care into patients' living environment means that they are able to benefit from genuine collaboration between professionals, whatever their area of care (in outpatients, at home, in medical welfare establishments, in hospitals) or how and where they practice (as individual or multidisciplinary practitioners, in a group practice or alone); the professionals and the facilities (network, HAH, etc.) that treating doctors can call upon are described in the protocol available on the HAS website[4].

▶ In hospital

The offer of care is graduated to meet patients' needs according to the severity, complexity, and degree of stability of their condition:

- first level: support in a hospital ward (acute medicine, rehabilitation medicine) when the situation does not present any special clinical, social, or ethical problems;
- long-term care units that accept dependent elderly adults whose state of health requires either daily care or constant supervision;
- second level: designated palliative care beds when the ward is faced with frequent end-of-life patients or deaths;
- third level: palliative care units that handle the most complex and/or unstable situations;
- mobile palliative care teams: these can also respond at the request of professionals, particularly in support of the first and second levels.

These facilities are listed in a directory: http://www.sfap.org/annuaire.

▶ At home and in hospital

Volunteer support organisations may step in, depending on the patient's wishes (http://www.sfap.org/annuaire).

The professionals aside, close relatives and the substitute decision maker, where such exist, can play an important role with the patient.

❺ When and how to talk about it with your patient

▶ When?

Everyone has the right to be informed about their state of health and to accept or refuse care and treatment (Appendix 4).

Communication is a vital feature of any relationship with people who are ill throughout the course of their illness: the doctor will sense when the time is right for the given person and for the given illness.

It is important to start talking about palliative care **early on**, well before the end of life, in particular to give patients support, to allow them to take part in making the medical decisions that affect them, to broach the ethical questions and the right care, and to provide easier and more progressive ways for them to benefit from palliative care.

The dialogue can be established in the follow-up to the announcement of a serious illness or in the event of:

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[4] http://www.has-sante.fr/portail/jcms/c_2655088/fr/comment-ameliorer-la-sortie-de-l-hopital-et-favoriser-le-maintien-a-domicile-des-patients-adultes-relevant-de-soins-palliatifs

- a complication or a deterioration in the patient's condition;
- hospitalisation;
- the appearance of a comorbidity or other pathological condition.

In certain cases, sick people can voice their concerns, ask questions about the likely outcome, or about future care.

The doctor too should be ready to propose this palliative approach to their patients.

▸ Points to watch out for

The essential points are described in Focus 1.

The doctor and the professionals involved will keep an eye on the following points:

- **Know what people can and want to hear**, **what their expectations are**; they should satisfy themselves in advance and regularly throughout the conversation that patients want to hear this information, check that the patients have understood their illness and their state of health, without worrying about repeating information that they may have already given.
- **Not delay giving this information**: information about their illness, specific treatments for the illness (objective, undesirable effects), palliative care and treatments, possible responses to these treatments, management of symptoms.
- Show consideration when faced with the task of giving information, show tact, moderation, and empathy.
- Adjust to emotional reactions, possible distress, and give patients assurance of support.
- **Facilitate patients' involvement** in decision-making; advance care planning can help in drawing up a plan for care, treatment, and support that meets patients' end-of-life wishes and possibly to start thinking about advance directives.
- **Don't let patients lose all hope, but don't on the other hand entertain or encourage any unrealistic expectations**, explaining that:
    - **the word "palliative" does not mean "final weeks of life"**;
    - the palliative approach includes **continuous, active care and treatments** that form part of the overall management of the patient and the illness, in parallel with any specific treatments undertaken;
    - the decision to possibly halt specific treatments for the illness is always subject to reassessment and may be temporary if the patient so decides;
    - in cases where an interdisciplinary team specialising in palliative care intervenes, or the patient is transferred to a palliative care unit, continuity and coordination will be maintained.
- Be attentive to **the people around the patient** and watchful as regards the content and the level of understanding of the information that is being exchanged.
- Try to make sure that the information you give out is **consistent** with that given out by other professionals having contact with the patient (other doctors, nurses, pharmacists, caregivers, etc.), even if this can take time and be complex. The doctor questions patients about what they have understood from the information given by the other professionals.
- **Share the information** given and received in conversation with other professionals having charge of the patient (traceability in the medical file).
- And as far as doctors are concerned, they should not hide problems they may be experiencing in their own personal or working life.

In conclusion, this approach fits into the broader framework of the resolution on "Palliative Care" adopted by the WHO in 2014 (http://apps.who.int/medicinedocs/documents/s21454fr/s21454fr.pdf).

Focus 1. Tips for taking about the palliative approach

This is best supported by training in communication.

Tip	Method
Adapt to the patient's pace	• look out for psychological defence mechanisms, problems in comprehension; • build a care partnership and avoid letting relationships possibly becoming stalled;
Create the conditions to help the conversation run smoothly	• prepare for the conversation (including familiarising yourself with the person's complete medical situation), **availability of time**; • conducive surroundings: avoid disturbances, quiet location: • initiate the dialogue at a time free of any crisis; • mind the body language: sit at the same height as the patient, respect silences, listening posture, etc.; • watch-out for hearing problems (hearing aid, sit on the side of the "good ear") and people wearing corrective lenses, especially elderly patients;
Take the time to listen to patients and ask them open questions	• assess how knowledgeable they are about their illness and the treatments for it; • **try to get an idea of what their wants and expectations are, whether they are interested in being informed or not, and to what extent**; • understand what their goals are for their health, their wellbeing, their preferences, their priorities; • get a sense of their fears and anxieties, things that worry them, and their emotions; • find out how distressed the patients are; • assess how far family and friends can be involved and the family and social background; • if there is any cognitive impairment, be attentive to body language, ask precise questions requiring a "yes" or "no" answer.
Be a "good communicator"	• convey information simply, with tact and sensitivity, little by little; • use plain language, avoiding jargon and euphemisms, suited to the patient; • check regularly for comprehension; • rephrase if necessary, encourage questions, helping the patient to formulate them if necessary; • be supportive (watch for emotional clues, emotional support, support for decisions, etc.) ; • if there are signs of cognitive impairment, speak clearly, at a slower pace, and use simple sentences; • adjust your communication style to the person: mental disorders, underprivileged populations (poor people, of no fixed abode, inmates, etc.) ;
Trade places **with the family and friends,** with the patient's agreement	• be attentive to the experience of the family and friends; • be in touch with **the substitute decision makers**: with the patient's agreement, that person may be present during the interview; • in the case of patients with dementia, family and friends need to be managed in a special way (information and advice for avoiding exhaustion); substitute decision maker may be the preferred intermediaries who will support patients in the choices they make;
Trade places with other members of the team	• in order to more fully appreciate the patient's condition; • to call on skill resources: palliative care teams, mental healthcare professionals (psychologists, psychiatrists, etc.)

Sample questions: what have you understood about your illness? Can you sum up for me what I have told you? What is giving you the most trouble at the moment? What would make you happy? What could one improve in your life in order to help you? etc.

Appendix 1. Supportive care and planning for future care

Supportive care

Supportive care was defined in **oncology** in Circular DHOS/SDO/2005/101:

“This care is defined in oncology as the whole range of care and support that sick people need throughout their illness, along with whatever specific onco-haematological treatments they may be receiving (…).

Supportive care forms part of the oncology initiative. When necessary, it is important as well to pay special attention to how it ties in with the palliative approach. “

“…are defined as a coordinated organisation of the different skills jointly involved in specific oncological treatments as part of patient management.

Throughout the illness and in the aftermath, backing up the specific cancer treatments, supportive care meets needs that relate primarily to dealing with:

- pain, fatigue, nutritional problems;
- digestive, respiratory, and genitourinary problems, mobility impairments, handicaps;
- dental problems;
- social difficulties;
- mental suffering, distortions of body image;
- and end-of-life support for patients as well as their family and friends. “

Advanced care planning

Advanced care planning (ACP) is a process of reflection and communication about a person’s values and wishes concerning future health issues and personal care preferences regarding their future health and their preferences regarding the care and the treatments they will receive.

It is based on a person’s priorities, beliefs and values, and involves taking time to learn about end of life care options, before a health crisis occurs (*European Society for Medical Oncology*).

It leads to patients being encouraged to:

- make an early statement of their wishes and preferences;
- draft advance directives[5];
- substitute decision maker[6].

To learn more

Circular No. DHOS/SDO*/2005/101 of 22 February 2005 relating to the organisation of care in oncology* http://social-sante.gouv.fr/fichiers/bo/2005/05-03/a0030034.htm

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[5] http://www.has-sante.fr/portail/upload/docs/application/pdf/2016-03/directives_anticipees_concernant_les_situations_de_fin_de_vie_v16.pdf

[6] http://www.has-sante.fr/portail/upload/docs/application/pdf/2016-03/da_personne_confiance_v9.pdf

Appendix 2. Supportive and Palliative Care Indicators Tool: SPICT- ™

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care

Look for any general indicators of poor or deteriorating health

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care, chooses to reduce, stop or not having treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment; or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk, or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless, or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxemia needing long-term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30 ml/min) with deteriorating health.

Kidney failure complicating other life-limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic-resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible

Other conditions

Deteriorating and at risk of dying with any other conditions or complications that is not reversible

Review current care and care planning

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making is likely.
- Record, communicate, and coordinate the care plan.

Appendix 3. Ethical questionnaire, Dr Renee Sebag-Lanoë

- What is this patient's primary disease?
- How far has it progressed?
- What is the nature of the current additional episode?
- Is it easily curable, or not?
- Has there been any recent repetition of acute episodes close together or a multiplicity of various attacks?
- What does the patient say, if he/she is able to?
- What is he or she indicating through his or her body language and cooperativeness with care?
- What is the quality of his or her comfort currently?
- What does the family think? (Take … into account)
- What do the carers who are around him or her most often think?

Appendix 4. Reminder of the legislation

▸ Law of 9 June 1999

“Any patient whose condition demands it is entitled to palliative care and support. “

▸ Law of 4 March 2002 on patients’ rights and the quality of the health system (Kouchner Law)

- “Everyone has the right to be informed about their state of health. “
- “Everyone, along with the healthcare professional and mindful of the information and recommendations that he gives out, takes decisions about their health.

  Doctors must respect people’s wishes after informing them of the consequences of their choices. If people wish to refuse or stop treatment and this puts their life in danger, the doctor must make every effort to persuade them to agree to vital care. “
- “Everyone can mandate a substitute decision maker (…). “
- “Pain must be relieved whenever possible. “

▸ Law of 22 April 2005 on patients’ rights and the end of life (Leonetti’s Law)

- It prohibits futile interventions.
- It proposes that every adult should draft **advance directives.**
- If the **treatment to relieve suffering** at an advanced or terminal phase of a severe and incurable affliction can have the side effect of shortening life, the patient, the substitute decision makers, and the family and close relatives should be informed.

▸ Extracts from the law “affording new rights to patients and persons at the end of life” of 2 February 2016

Article L. 1110-5 of the Public Health Code

“(…) Everyone has the right to a **dignified end of life, along with the best possible relief from suffering**. Healthcare professionals use every means at their disposal to ensure that this right is observed.

“The **initial and ongoing training** of doctors, pharmacists, nurses, nursing auxiliaries, home helps, and clinical psychologists includes instruction in palliative care. “

Article 1110-5-1: Futile interventions

“The acts mentioned in Article L. 1110-5 must not be implemented or continued if they result in futile interventions. When they seem **pointless, disproportionate, or when they have no effect other than artificially to prolong life, they can be halted or declined**, in accordance with patients’ wishes and, and if patients are unable to make their wishes known, based on the outcome of a collegial procedure[7], as defined by statute.

“**Artificial nutrition and hydration are treatments** that can be halted, according to the first paragraph of this article.

“When the acts mentioned in the first two paragraphs of this article are halted or not implemented, the doctor preserves the dignity of the dying and ensures quality of life by dispensing the **palliative care** mentioned in Article L. 1110-10. “

Article 1110-5: Sedation

“Article L. 1110-5-2 – At the patient’s request to prevent any suffering and to avoid being subjected to futile interventions, **deep and continuous sedation resulting in altered consciousness that is sustained until death, coupled with analgesia and the suspension of all life-prolonging treatments**, is introduced in the following cases:

“1. In patients with severe and incurable afflictions whose vital prognosis is short-term, if their suffering is resistant to treatment;

“2. In patients with a severe and incurable affliction whose decision to stop treatment is life-threatening in the short term and is likely to entail unbearable suffering.

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[7] https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000032967551&dateTexte=&categorieLien=id

When patients are unable to make their wishes known and, by way of rejecting pointless interventions (…), when a doctor stops a life-sustaining treatment, he or she administers deep and continuous sedation resulting in an altered state of consciousness that lasts until death supervenes, combined with analgesia.

“Deep and continuous sedation combined with analgesia (…) is used, subject to a **collegial procedure** (…)

“At the patient’s request, deep and continuous sedation can be given at the **patient’s home, in a healthcare organisation or medical welfare establishment** (…).

“The entire procedure as followed is recorded in the patient’s medical file. “

“Article L. 1110-5-3- Everyone is entitled to receive treatment and care designed to relieve their suffering. This must at all costs be prevented, taken into account, assessed, and treated.

“Doctors arrange for analgesic and sedative treatments to relieve patients’ refractory suffering in the advanced or terminal phase of their illness, even if this effectively shortens life. Doctors must inform the patients, (…), the substitute decision maker as per Article L. 1111-6, the family or, failing that, the patient’s close relatives. The procedure as followed is recorded in the medical file.

“Everyone is told by the healthcare professionals of the possibility of being **cared for at home**, as soon as their condition permits it. “

Article 1111-4: Respecting patients’ wishes

Article 1111-4 (…) “Everyone has the right to refuse or to not receive a treatment. Patients’ follow-up, including their palliative support, is the responsibility of the doctors.

(…) “Doctors are under obligation to respect people’s wishes after informing them of the consequences of their choices and their severity. If, by their expressed will to refuse or stop any treatment, patients put their life in danger, they must reiterate their decision after a reasonable time lapse. They can appeal to another member of the medical profession. The entire procedure is recorded in the patient’s medical file. Doctors preserve the dignity of the dying and ensure the quality of their end of life by dispensing the palliative care referred to in Article L. 1110-10. “(…)

Article L. 1111-11: Advance directives

“Article L. 1111-11- All adults can draft their advance directives[8] to prepare for the day when they are no longer able to make their wishes known. These advance directives make known people’s wishes relating to their end of life as regards the conditions under which treatments or medical procedures can be pursued, limited, halted, or declined.

“They can be revised or revoked at any time and by whatever means. They can be drafted using a template[9] (…) (which) provides for the situation of someone who, at the time of drafting the advance decision, may or may not be aware that they are suffering from a serious affliction.

“Advance directives are mandatory for doctors when making decisions relating to any investigation, intervention, or treatment, except in cases of life-threatening emergencies during the time needed for the situation to be thoroughly assessed and when the advance directives would appear to be clearly inappropriate or incompatible with the medical situation.

“The decision to refuse to implement an advance directive deemed by the doctor to be manifestly inappropriate or at variance with patient’s medical situation is taken following the outcome of a collegial procedure defined by statute and recorded in the medical file. It is brought to the attention of the substitute decision maker mandated by the patient or, failing that, the family or close relatives.

(…) Advance directives are kept, among other places, in a national registry that is subject to automatic processing. (…) When kept in this registry, a reminder of their existence is regularly sent to their author.

“The treating doctor informs patients of the possibility of and the conditions for drafting advance directives. (…)

Article L. 1111-6: Substitute decision maker

“Article L. 1111-6 – Any adult can mandate a substitute decision maker, who can be a parent, a close relative, or the treating doctor, and who will be consulted any time they themselves are unable to make their wishes known

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[8] Decree No. 2016-1067 of 3 August 2016 relating to advance directives as per Law No. 2016-87 of 2 February 2016 laying down new rights for the benefit of patients and people at end of life

[9] Template laid down by Order of 3 August 2016: Order of 3 August 2016 relating to the template of an advance directive as per Article L. 1111-11 of the Public Health Code Template proposed by HAS http://www.has-sante.fr/portail/jcms/c_2619437/fr/les-directives-anticipees-concernant-les-situations-de-fin-de-vie

and to receive the information necessary to do this. The substitute decision maker's function is to convey the patient's wishes. His or her testimony prevails over any other testimony. This mandating is done in writing and is co-signed by the mandatee. It can be revised or revoked at any time.

(…) "Any time hospitalisation in a healthcare organisation is involved, the patient is advised to mandate a substitute decision maker. (…) This mandating is valid for the duration of the hospitalisation, unless the patient chooses to make other arrangements.

"As part of the follow-up of his or her patient, the treating doctor satisfies him or herself that the patient has the possibility of mandating a substitute decision maker and, if applicable, invite that person to proceed with the mandating. "
(…)

"Article L. 1111-12 – When people in an advanced or terminal phase of a severe and incurable affliction, regardless of its cause, are unable to make their wishes known, the doctor is under obligation to enquire about the wishes expressed by the patient. In the absence of any advance directives as per Article L: 1111-11, the doctor will obtain the testimony of the substitute decision maker or, failing that, any other testimony from family or close relatives. "

https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031970253&categorieLien=id