Original Article

Factors Influencing Australian General Practitioners' Clinical Decisions Regarding Advance Care Planning: A Factorial Survey

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Abstract

Context. Primary care physicians are well placed to identify patients in need of advance care planning (ACP) and initiate ACP in advance of an acute situation.

Objectives. This study aimed to understand Australian general practitioner (GP) clinical decision making relating to a patient's "need for ACP" and the likelihood of initiating ACP.

Methods. An experimental vignette study pseudorandomly manipulated factors thought to influence decision making regarding ACP. Patient-level factors included gender, age, type of disease, medical severity, openness to ACP, doctor-patient relationship, and family support. An accompanying demographic survey assessed health professional-level factors, including gender, years of experience, place of training, place of practice, caseload of patients with ACP, direct personal experience in ACP, and self-reported attitudes toward ACP. Seventy GPs were recruited, and each completed six unique vignettes, providing ratings of patient need for ACP, importance of initiating ACP in the coming months, and likelihood of initiating ACP at the next consultation.

Results. Older patients, with malignant or cardiovascular disease, severe clinical presentations, good doctor-patient relationship, female gender, and poor family support were more likely to receive prompt ACP. Positive GP attitudes toward ACP were associated with greater likelihood of initiating ACP promptly.

Conclusion. Patients with presentations suggesting higher mortality risk were identified as being in need of ACP; however, the likelihood of initiating ACP was sensitive to GP attitudes and psychosocial aspects of the doctor-patient interaction. Training materials aimed at encouraging GP involvement in ACP should target attitudes toward ACP and communication skills, rather than focusing solely on prognostic risk. J Pain Symptom Manage 2016;51:718–727 © *2016 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

Key Words

Advance care planning, palliative, prognosis, general practitioner, vignette, factorial survey

Introduction

Advance care planning (ACP) is a process of discussion between patients, family members/carers, and health professionals, aimed at clarifying the patient's preferences for future medical care, to be enacted if they lack capacity to make or communicate medical treatment decisions.[1] Advance care planning has been associated with positive outcomes in end-of-life (EOL) care, including reduced risk of dying in hospital,[2,3] greater concordance between preferred and actual hospital care,[4,5] reduced caregiver burden during EOL care,[2] and reduced psychological morbidity among bereaved caregivers.[6]

Despite these benefits, community ACP uptake in Australia remains low.[7–10] Patients typically prefer to discuss ACP with a trusted doctor, in advance of a medical emergency,[11–13] and show increased satisfaction

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with their doctor after ACP discussion.[14] In Australia, general practitioners (GPs) work in primary care settings and typically develop long-term relationships with patients. Hence, GPs are well placed to identify the need for ACP discussions and initiate ACP at an appropriate time in the illness trajectory. Clinical practice guidelines identify the GP's pivotal role in ACP,[15] and the Royal Australian College of General Practitioners endorse integration of ACP in routine practice.[16]

Even with professional ownership of their role in ACP, studies involving Australian GPs have reported barriers, including lack of time,[17] lack of knowledge about ACP,[18] fear that ACP might damage the clinical relationship,[19] and concerns about legal implications of ACP.[20,21] Surveys conducted among nurses and hospital physicians further suggest that health professionals' personal attitudes toward ACP predict their decisions to initiate ACP discussion.[22–24] Baughman et al.[25] used a factorial survey method and found that the strongest predictors of nurse and social worker assessments that a client was "in need of ACP" were the health professional's own attitudes toward ACP, rather than client factors. These findings suggest that factors other than the patient's clinical needs may impact on the clinical decision to initiate ACP discussion. This is of concern, as ACP is understood as a patient-centered process, with initiation in response to clinical need and patient preference, rather than health professional attitudes.[26,27]

This study uses a factorial survey method and aims to understand GP clinical decision-making processes relating to ACP in a range of hypothetical doctor-patient interactions. It also aims to examine whether patient-level or health professional-level factors are more predictive of professional judgments about the need for ACP. Based on previous literature, we predicted that GPs would be more likely to report initiating ACP among patients who are older, have malignant diagnoses,[25] have more severe presentations,[28] show a stronger doctor-patient relationship,[19,28] and are more open to ACP discussion.[29,30]

Methods

The factorial survey method is an innovative, quasi-experimental survey approach to simulating professional judgments.[26] Participants make judgments in response to a number of "vignettes," hypothetical scenarios each containing a number of "factors" (independent variables of interest to the researchers) presented at different "levels." The levels of each factor are assigned randomly across the different vignettes, hence avoiding the intercorrelations that confound real cases drawn from clinical settings. Participants make professional judgments in response to each vignette (e.g., likelihood that they would take a certain course of action). With appropriate sampling procedures, the factorial survey method can combine the strengths of the classic factorial experiment with the generalizability of traditional survey methods.[26,27] This study was a pseudorandomized factorial survey, in which GPs responded to vignettes about hypothetical patients in primary care settings. Ethics approval was granted by the University of Western Australia (RA/4/1/6542).

Survey Development

The survey comprised four sections. Section 1 provided an open-ended definition of ACP adapted from the international literature,[1] describing it as "a process of reflection and communication between patients, family members/loved ones, and health professionals. It aims to identify and share life values, beliefs, and goals that may be relevant if a person is ever unable to make decisions or communicate their wishes relating to medical treatment or health care." In the second section, each participant was presented with six unique vignette cases and asked to make professional judgments in response to each about the patient's need for ACP (NeedACP), the importance of initiating ACP within the coming months (ImpACP), and the likelihood that they would initiate ACP discussion at the next consultation (LikelyACP), reflecting diagnostic (NeedACP, ImpACP) and behavioral (LikelyACP) components, respectively. Each of these responses was scored on a 0–10 scale, where zero reflected a negative response (e.g., for LikelyACP, very unlikely to initiate ACP at the next consultation) and 10 reflected a strong positive response (e.g., very likely to initiate ACP at the next consultation). The third section surveyed demographic and clinical practice information about the GP, including gender, place of medical training (Australia/overseas), place of practice (metropolitan/non-metropolitan), years of experience, percentage of patient caseload with whom ACP was discussed, personal experience in ACP for family/friends, and personal experience completing their own ACP. The fourth section was a six-item questionnaire measuring GP attitudes to ACP on a five-point Likert scale.

Vignettes were designed around a prototypical general practice patient who had not undertaken ACP and had full decision-making capacity. All vignettes described patients who had been seeing the respondent as their primary doctor for approximately five years, to ensure that the doctor would be familiar enough with the patient to realistically know the information presented in each vignette. Patient details were specified by manipulating a number of "factors"

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