

Original Article

Defining the Scope of Prognosis: Primary Care Clinicians' Perspectives on Predicting the Future Health of Older Adults

John M. Thomas, MD, and Terri R. Fried, MD

Department of Internal Medicine (J.M.T.), Yale School of Medicine, New Haven, Connecticut; Center of Excellence in Primary Care Education (J.M.T.), Veterans Affairs Connecticut Healthcare System, West Haven, Connecticut; Section of Geriatrics (T.R.F.), Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut; and Clinical Epidemiology Research Center (T.R.F.), Veterans Affairs Connecticut Healthcare System, West Haven, Connecticut, USA

Abstract

Context. Studies examining the attitudes of clinicians toward prognostication for older adults have focused on life expectancy prediction. Little is known about whether clinicians approach prognostication in other ways.

Objectives. To describe how clinicians approach prognostication for older adults, defined broadly as making projections about patients' future health.

Methods. In five focus groups, 30 primary care clinicians from community-based, academic-affiliated, and Veterans Affairs primary care practices were given open-ended questions about how they make projections about their patients' future health and how this informs the approach to care. Content analysis was used to organize responses into themes.

Results. Clinicians spoke about future health in terms of a variety of health outcomes in addition to life expectancy, including independence in activities and decision making, quality of life, avoiding hospitalization, and symptom burden. They described approaches in predicting these health outcomes, including making observations about the overall trajectory of patients to predict health outcomes and recognizing increased risk for adverse health outcomes. Clinicians expressed reservations about using estimates of mortality risk and life expectancy to think about and communicate patients' future health. They discussed ways in which future research might help them in thinking about and discussing patients' future health to guide care decisions, including identifying when and whether interventions might impact future health.

Conclusion. The perspectives of primary care clinicians in this study confirm that prognostic considerations can go beyond precise estimates of mortality risk and life expectancy to include a number of outcomes and approaches to predicting those outcomes. *J Pain Symptom Manage* 2018;■:■–■. Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.

Key Words

Prognosis, primary care, health outcomes, elderly, qualitative research, focus groups

Introduction

A growing literature recognizes the importance of prognostication for older adults, to guide patients and clinicians in making informed care decisions.^{1,2} Most of these studies focus on quantified estimates in the form of mortality risk or life

expectancy, generated by prognostic indices designed for older adults regardless of diagnosis.^{3–5} This non–disease-specific approach can be applied to the broad population of older adults who may have multiple chronic conditions but no single driving diagnosis.

This work was presented as a poster at the Society for General Internal Medicine annual meeting in 2016.
Address correspondence to: Terri R. Fried, MD, Clinical Epidemiology Research Center 151B, Veterans Affairs

Connecticut Healthcare System, 950 Campbell Avenue, West Haven, CT 06516, USA. E-mail: terri.fried@yale.edu

Accepted for publication: January 26, 2018.

However, although life expectancy is an important factor to consider for a variety of clinical decisions,^{1–3} it represents only one facet of a patient's future health. Patients have indicated that a number of health outcomes are more important to them than staying alive, including independence and symptom relief.^{6,7}

Less is known about clinicians' beliefs and practices regarding communication with their patients about their future health. Studies examining the attitudes of clinicians toward prognostication have focused on life expectancy prediction.^{8–10} Eliciting clinicians' perspectives on prognostication in the broadest possible sense has the potential to guide future research in a way that best serves practicing clinicians. The objectives of this study were to describe how clinicians think about prognostication, defined broadly as making projections about patients' future health, and how this informs the approach to care, as well as to understand how clinicians use available research data, especially prognostic indices, to assist them in prognostication.

Methods

Participants

The participants were clinicians who spend more than half their professional time seeing patients in primary care internal medicine or geriatrics practices. We purposively sampled a mixture of community-based, academic-affiliated, and Veterans Affairs (VA) practices to ensure the inclusion of clinicians practicing in diverse settings.

Of the seven practices approached for participation, two community-based practices declined because of heavy clinical responsibilities. A total of five focus groups were conducted between February 11 and May 6, 2014, at which point data saturation was achieved. There were two focus groups involving community-based internal medicine practices, one involving an academic-affiliated geriatrics practice, and two involving clinicians from two firms of a VA primary care facility. The composition of clinicians in each focus group was based on volunteer participation within a given practice. Characteristics of participating clinicians are listed in [Table 1](#). Of the 30 clinicians, 63% were women, and 83% had at least five years of clinical experience. The most common profession was physician (70%), followed by nurse practitioner (20%) and physician assistant (7%).

Data Collection

The interviews averaged about 45 minutes in length. Verbal consent was obtained for all participants, who received no reimbursement other than a meal. A single moderator (J. M. T.) led each focus group

Table 1
Characteristics of Participating Clinicians

Characteristic	Value (N = 30)
Female, no. (%)	19 (63)
Clinical experience of five years or more, no. (%)	25 (83)
Profession, no. (%)	
Physician	21 (70)
Nurse practitioner	6 (20)
Physician assistant	2 (7)
Health psychologist	1 (3)
Clinic practice type, no. (%)	
Veterans Affairs	13 (43)
Community based	11 (37)
Academic affiliated	6 (20)

discussion using a discussion guide to standardize the approach ([Supplemental Table 1](#)). The participants were informed about the moderator's clinical background and position, as well as the identity of the principal investigator for the study. To facilitate a discussion about all the outcomes clinicians consider when thinking about their patients' future health, we avoided the term "prognosis" early in the guide. We did this to avoid the tendency to equate "prognosis" with "life expectancy." Instead, participants were asked open-ended questions about the way they make projections about the future health of their patients and how this informs their approach to caring for patients. This included asking participants what they believe their patients value most about their future health to start a discussion about a broad set of health outcomes. For the remainder of the discussion, the term "prognosis" was used interchangeably with projections about future health. Clinicians were asked whether and how they use research data to assist in clinical prognostication, as well as what types of additional data they would like. They were also shown two existing indices designed to predict four-year¹¹ and nine-year¹² mortality risk and were asked whether they use these tools, or would use these tools, in their clinical practice. These tools were chosen because they were felt to be representative of current research in prognostication for older adults, which is a non-disease-specific approach.

Data Analysis

Audio recordings from the focus groups were professionally transcribed. Using a content analysis approach,¹³ two analysts with contrasting fields of expertise, internal medicine and public health, respectively, independently coded two transcripts. Then they met to discuss differences in the identification of codes until agreement was achieved, with a third analyst serving as a tiebreaker. The two authors inductively developed a coding structure and then met regularly to discuss the application of codes to

Download English Version:

<https://daneshyari.com/en/article/8605517>

Download Persian Version:

<https://daneshyari.com/article/8605517>

[Daneshyari.com](https://daneshyari.com)