



# **Exploring how Disease Context Uniquely Influences Attitudes, Approaches and Processes of Advance Care Planning Engagement for Patients and Healthcare Providers**

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### Background:

Little is known about how disease context may uniquely influence attitudes, approaches and processes of ACP engagement for patients and clinicians.

## **Objective:**

Using cross-contextual data we explored disease context influences on ACP practice in order to generate strategies to enhance the uptake and quality of ACP with respect to contextual factors.

#### Method:

- Qualitative interpretive descriptive (ID)<sup>1</sup> design, applied to multiperspective study
- Data collection consisted of one-on-one semi structured interviews with participants at a time and location of their choosing. Interviews were recorded and transcribed for analysis.

Participants		
	Patients	Clinicians
Supportive Living	10	9
Heart Function out-patient clinic	8	9
Renal out-patient Clinic	7	6
Cancer out-patient clinic	8	9

### Findings:

Variation in attitudes, approaches and processes around ACP were found both across and between contexts

Across all Clinical Contexts	Complex understanding from clinicians of ACP terminology and purpose Patients associate ACP with completion of will.	prognosisin part because we can modify it by giving them drug therapies or device therapiesand some of those therapies, also have a benefit in terms of	LACK OF SHARED UNDERSTANDING	LACK OF CONSISTENT ACP PROCESS	Across all Clinical Contexts  Between Contexts	<ul> <li>Physicians bring own care philosophies to ACP encounters</li> <li>FOCUS OF ACP: for some physicians is completion of Goals of Care Designation medical order; for others focus on elucidation of patient values.</li> <li>HEART FUNCTION: ACP nurse led, not always clear to</li> </ul>	"doctors have different philosophies and some of them just always'oh there's more and more, we can do it, I say there's nothing we can do!'a lot of doctors will offer more and more procedures andwe switch over on the ward. So continuity of medical care is very difficult" (HF Physician).  "we make sure that once a year like when they come in, the patient comes in to see their
Between - Contexts	Perceived ACP engagement for patients, after terminology was explained was context- specific	"Oh, we spent a lot of time thinking about what we wanted. This isn't something you can just sign, you have to really think about it." (SL, Female)				<ul> <li>physicians</li> <li>BMT CANCER: ACP physician-led</li> <li>SUPPORTIVE LIVING: Non-physician clinicians unsure of ACP responsibilities</li> <li>RENAL: ACP passed between clinical staff, ACP nurse and palliative care team.</li> </ul>	nephrologist that the goals of care are up to date and if they're not just letting the nephrologist know, so then that nephrologist can have that conversation with the patient." (Renal)  "we have an advanced care planning nurse so we kind of let her do her thing," (Renal)

# VARIABLE CONVERSATION DRIVERS

Across all Clinical Contexts

Between

**Contexts** 

PATIENTS: main conversation drivers were reflections on quality of life and how this is impacted by treatments and interventions

- "I guess I want to be in control of my life...and if I have to rely on somebody else to feed me and dress me and take me to the toilet, I don't want that. I refuse...that's quality of life" (HF Patient)
- Physician perception of disease burden
   Nature of patient-clinician relationships in each context
   Perceived function of ACP: as an EQI
- "My approach is often to suggest to patients what they would...what they should want in this situation." (BMT Physician)

 Perceived function of ACP: as an EOL activity or process that ensures care reflects wishes, depending on context

# Discussion:

- ACP process and consistency across clinical contexts has not been previously studied in a single study.
- Main significance of our findings is that persistent practice variation related to ACP engagement is not necessarily reflective of a focus on patient quality of life or wishes.
- Important to recognize a universal process is not compatible with the realities of varying contexts, so evidence of best practice from one context may need to be adapted before implementation in another context.
  - Next steps:
    - Engage and empower medical units/clinical settings to evaluate and develop relevant processes around ACP engagement.
    - Promote use of serious illness conversation guide to drive and structure ACP conversations with patients<sup>2</sup>.

# References:

- <sup>1</sup>Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (Vol. 2). Routledge.
- <sup>2</sup>Bernacki, R. et al., (2015) Development of the Serious Illness Conversation Guide. BMJ Open.

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