Does Primary Care Provider Advance Directive Education Influence Attitudes and Practice?

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Abstract. Many people do not have advance directives (ADs) prepared and have never discussed their wishes for end-of-life care. Primary care providers (PCP) who have limited knowledge of ADs contribute to this problem. Does PCP AD education influence attitudes and practice? A convenience, non-random, sample of 76 PCPs were asked to participate in a pre-survey, education, and a post-survey descriptive design using the Transtheoretical Model (TTM) as a framework. The majority responded in the contemplation stage with yes, they believe this is their role to assess and educate patients, but have not added this to their practice yet. Perceived barriers are time, knowledge of the laws, and access to the appropriate forms. Future education should focus on overcoming these barriers.

1. Introduction

Many people do not have advance directives (ADs) prepared and have never discussed their end-of-life (EOL) wishes with family or their primary care providers. ADs are instructions of the wishes concerning medical treatments at the EOL and are legally valid throughout the United States (U.S.). In the U.S. a lawyer is not required to complete the forms. Once signed and witnessed it is valid. Each state has laws governing ADs with varying requirements.

Most people have personal values and opinions of what their wishes would be if they are ever in a situation where a poor prognosis of recovery from a terminal disease or an unexpected accident leaves them incapacitated. People seldom expect bad things to happen to them, nor are they ready to admit they may become incapacitated. This adds a burden on their family and primary care provider (PCP) when end-of-life (EOL) decisions are needed and the patient is incapable of making their wishes known. PCPs are in a position to make this a routine discussion with adult patients who are essentially well. Patients' lack of knowledge about ADs is complicated by PCPs who also have limited knowledge of ADs.

2. Experiment

The design included a pre-survey, educational intervention and a post-survey to determine level of knowledge and beliefs of a non-random sample of PCPs from two family practice clinics. The two clinics had a total of 76 PCPs which included 22 faculty physicians and 54 medical residents also with varying years of experience in a primary care. Following IRB approval from both the university and the medical entity, the study was initiated. No personal identifiers were collected and consent was implied if the PCP decided to participate in the surveys. The AD education included common terminology, federal and state laws impacting advance directives, barriers preventing practitioners from discussing advance directives with clinic patients, principals of good communication when discussing AD, and the future role of PCPs addressing communication of ADs and transportability of the directives in the U.S. A post-survey was completed to determine the influence of education on attitudes and practice.

The Transtheoretical Model [1] was utilized to provide a theoretical framework for this project. This model has been used to determine which stage a person is in when making a change to behavior. The TTM includes five stages to describe the progression of accepting a change in behavior. The stages include precontemplation, contemplation, preparation, action, and maintenance. The beginning stage, precontemplation, there is no knowledge of a problem or no intent to change. Contemplation is when the person acknowledges a problem but is not ready to change. Preparation is when the person is beginning to incorporate a change in behavior but not completely. The action stage is when the person has made the change. The maintenance stage is when the change has continued for more than six

months. For this study the TTM was used to assess the PCPs attitude towards including AD assessments in their routine practice with their clinic patients.
Descriptive statistics (frequency & percentage) were completed for each individual question with a frequency of the total number of responding participants, the frequency of the actual responses, and the percentages of participants who responded to each question. The frequency of responses from the pre-survey to the post-survey were compared using a cross tabulation of nominal by nominal data on selected responses and ordinal by ordinal on other responses. The specific questions that were compared are as follows: (1) experience in PCP and formal training in AD, (2) formal training in AD and experience as a PCP were separately compared with knowledge of state laws, beliefs on who should initiate AD discussions, beliefs about patient's right to autonomy when deciding in advance their wishes for healthcare if they become incapacitated, state law on notarization of the forms, (3) where the discussion should be initiated, (4) belief about the PCP being responsible for patient education in an outpatient setting, and (5) type of patient who should be asked about AD during a routine office visit.

3. Results

Participants included 45 pre-survey and 35 post-survey with all 76 PCPs receiving the education. When asked the PCP's role in educating patients on AD the majority, 64.4% pre-survey and 80% post-survey responded in the contemplation stage of the TTM. When asked about PCP role in assessing for AD planning the majority, 62.2% pre-survey and 82.9% post-survey were in the contemplation stage of the TTM. There was not a significant correlation between the nominal measure of PCPs level of formal training on AD and the interval measure of their belief about the role of PCPs in education of patients on AD,
χ^2 (4, N = 35) = .385, p =.108
A Spearman's Rank Order correlation was run to determine the relationship between years of experience in the primary care setting and PCPs stated knowledge of the AD state laws. There were 7 ranks of experience ranging from less than 1 year to more than 20 years and 5 rankings of knowledge of AD state laws from a choice of "very well" to "not at all". There was an inversely, significant correlation between years of experience and stated knowledge of the AD state laws
(rho(24) = -.309, p = .039).
According to this sample group, increased experience in a primary care practice and knowledge of specific state laws regarding AD had a significant relationship, but the discussion of AD into their routine on a regular basis did not happen. When asking the PCPs if they believe there are barriers to making AD part of their routine practice, pre-survey responses indicate 95.6% were a yes, and post-survey 88.6% yes. Time is perceived as the main barrier to making AD part of their routine practice with response rates of 91.1% in the pre-survey and 80% in the post-survey.

4. Discussion

The primary purpose of this project was to assess AD knowledge and practices of the PCPs who practice at two teaching family practice clinics and to determine if education on the topic would influence practice. There was a direct relationship between years of experience in primary practice and stated knowledge of the state laws. Education on the topic of AD did not show an influence on practice with this brief project. The pre and post-surveys demonstrated that the majority of providers are in the contemplation stage of TTM, agreeing it was their responsibility to educate and assess patients for AD, but they have not added this to their routine practice yet. In this improvement project as with the research conducted by Yee et al. [2] time was found as a major barrier for the PCPs to include discussions of AD with clinic patients.

5. Conclusions

The survey responses indicated the majority of formal training on AD came from medical school or graduate school. The stated knowledge level was average to minimal so this topic should be added to continuing education meetings to keep the PCPs informed on state law requirements and ways to implement AD into practice. Barriers of time, knowledge of the state laws, and access to forms were elicited from the survey responses. Future education should focus on how to overcome these barriers.

[1]Prochaska, J. O. & DiClemente, C. C. (1982). "Transtheoretical therapy: Toward a more integrative model of change." Psychotherapy: Theory, Research and Practice 19(3): 276-288.
[2]Yee, A., Seow, Y. Y., Tan, S. H., Goh, C., Qu, L., & Lee, G. (2011). What do renal health-care professionals in Singapore think of advance care planning for patients with end-stage renal disease? Nephrology (Carlton, Vic.), 16 (2), 232-238. doi:10.1111/j.1440-1797.2010.014