

Physicians' Views on Advance Care Planning and End-of-Life Care Conversations

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OBJECTIVES: To evaluate physicians' views on advance care planning, goals of care, and end-of-life conversations.

DESIGN: Random sample telephone survey.

SETTING: United States.

PARTICIPANTS: Physicians (primary care specialists; pulmonology, cardiology, oncology subspecialists) actively practicing medicine and regularly seeing patients aged 65 and older (N=736; 81% male, 75% white, 66% aged ≥50).

MEASUREMENTS: A 37-item telephone survey constructed by a professional polling group with national expert oversight measured attitudes and perceptions of barriers and facilitators to advance care planning. Summative data are presented here.

RESULTS: Ninety-nine percent of participants agreed that it is important to have end-of-life conversations, yet only 29% reported that they have formal training for such conversations. Those most likely to have training included younger physicians and those caring for a racially and ethnically diverse population. Patient values and preferences were the strongest motivating factors in having advance care planning conversations, with 92% of participants rating it extremely important. Ninety-five percent of participants reported that they supported a new Medicare fee-for-service benefit reimbursing advance care planning. The biggest barrier mentioned was time availability. Other barriers included not wanting a patient to give up hope and feeling uncomfortable.

CONCLUSION: With more than half of physicians reporting that they feel educationally unprepared, there medical school curricula need to be strengthened to ensure readiness for end-of-life conversations. Clinician barriers need to be addressed to meet the needs of older adults and families. Policies that focus on payment for quality should be evaluated at regular intervals to monitor their effect on advance care planning. *J Am Geriatr Soc* 66:1201–1205, 2018.

Key words: end of life; serious illness; palliative care; advance care planning

Few people talk to their families, close friends, and healthcare providers about their preferences regarding what they would like for themselves if they are seriously ill or when they are at the end of life. Even fewer have developed an advance care plan and put it into writing as a way to safeguard their choices.¹ Nevertheless, when asked, a large majority of people thought it was important.^{2,3} Advance care planning (ACP) is defined as conversations that cover an individual's specific health conditions, their options for care, and what care best fits their personal wishes, including at the end of life.⁴ It lets people decide what is important to them, express preferences, and make choices.⁵ Lacking such guidance, families are emotionally burdened by having to make difficult decisions for their relatives (often at times of crisis) or become engaged in family discord, trying to decide what course of action to take.^{6–9}

Similarly, when physicians are unsure about what a person's goals for care are or how aggressive to be in treatment, they are unclear about what course of action to offer.¹⁰ Therefore, advance care plans need to be in the form of a written document that is shared with one's physician and family. It provides clarity and direction for physicians so they can be responsive to and respectful of their patients' wishes and values and avoid imposing their own values or being drawn into conflicts between family members.^{11–14}

Notwithstanding the benefits of ACP, lack of reimbursement for the often-considerable time necessary for physicians to establish relationships with their patients and hold meaningful conversations about ACP, especially with older adults, is a barrier.^{15,16} Recognizing the necessity for such discussions, starting in January 2016, the Centers for Medicare and Medicaid Services (CMS) began reimbursing physicians for having ACP conversations with their patients.¹⁵

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DOI: 10.1111/jgs.15374

Table 1. Survey Questions (Excluding Demographic Questions)

Q1	What is your primary medical specialty?
Q2	Do you see patients who are age 65 and older on a regular basis?
Q3	How often do you see patients 65 and older who you would not be surprised if they died within the next year?
Q4	Have you ever had a conversation with your own doctor or health care provider about your wishes for your care at the end of your life, or not?
Q5	This year, Medicare will start covering advance care planning as a separate service provided by physicians and other health professionals who bill Medicare using the physician fee schedule. Advance care planning is defined as conversations which cover the patient's specific health conditions, their options for care and what care best fits their personal wishes, including at the end of life, and the importance of sharing those wishes in the form of a written document. In your own opinion, how important is it that health care providers have these conversations with patients?
Q6	How often do you talk to patients 65 and older about issues related to advance care planning or end of life care?
Q7	Do you support or oppose this new Medicare benefit that reimburses providers for these discussions? Is that strongly or somewhat support/oppose?
Q8	Does this new benefit make you more likely to talk with patients who are 65 and older about advance care planning, or not? IF YES: Does it make you much more/somewhat more likely?
Q9	Have you had this conversation and billed Medicare for it this year?
Q10	In general, whose responsibility should it be to initiate these conversations about advance care planning with Medicare patients:
Q11	Do you feel you have enough of the right kind of training to talk to patients about advance care planning and their end-of-life wishes, or not? For Q12-Q16: Here are some potential outcomes of talking with patients about advance care planning, goals of care, and end-of-life wishes. For you personally, how important is each of these as a reason to talk with your patients about these issues?
Q12	You would be better able to honor your patient's values and wishes
Q13	Patients and family members may be more satisfied with their care
Q14	It could save health care costs
Q15	It could increase the number of patients who receive hospice care
Q16	It could reduce unnecessary or unwanted hospitalization at the end of life
Q17	In your practice or health care system, is there a formal system for assessing patients' end-of-life wishes and goals of care, or not?
Q18	Is there a place in your electronic health record system that indicates whether or not a patient has an advance care plan? This might be a check box or a yes or no indicator.
Q19	Does your electronic health record system allow you to see the actual contents of a patient's advance care plan? For Q20-Q27: Think about your patients 65 and older with a serious illness. Have any of the following ever gotten in the way of talking to them about their end-of-life wishes? IF YES: how often does this get in the way for you. . . .
Q20	You don't want a patient to feel that you are giving up on them
Q21	You don't want a patient to give up hope
Q22	You're not sure the time is right
Q23	There's disagreement between family members and the patient
Q24	You don't have time with everything else on your plate
Q25	It might be an uncomfortable conversation
Q26	Someone else should be having the conversation with them instead of you
Q27	You may be unsure what is culturally appropriate for the patient
Q28	In general, do you consider conversations about end-of-life care to be more challenging, more rewarding, both, or don't know?
Q29	During conversations about end-of-life care, how often do you feel unsure of what to say?
Q30	Have you had any training specifically on talking with patients and families about end-of-life care, or not?

Now that the question of payment has been addressed for Medicare beneficiaries, the John A. Hartford Foundation, Cambia Health Foundation, and California Health Care Foundation commissioned PerryUndem Research/Communications to conduct a national survey of primary care physicians and specialists such as pulmonologists, oncologists, and cardiologists who regularly see patients aged 65 and older. Other specialists, such as surgeons, have important roles to play in discussing goals of care, but the survey was restricted to the 3 subspecialties that generally provide longitudinal care for the 3 leading causes of death in older adults.¹⁷ The objective of the survey was to evaluate physicians' views about ACP and end-of-life conversations. The survey also reviewed current experiences with billing Medicare for these conversations, motivations to have conversations, and barriers.

METHODS

PerryUndem conducted the national telephone survey of 736 physicians from February 18 to March 7, 2016. All

physicians reported actively practicing medicine and regularly seeing patients aged 65 and older. The sample included 470 internists and primary care providers and 266 physicians in 3 specialties: oncologists ($n = 85$), pulmonologists ($n = 87$), and cardiologists ($n = 94$). The survey also included an oversample of 102 physicians in California, for a total of 202 California respondents.

Survey questions, which the staff of the sponsor organizations and PerryUndem Research developed, with review by external advisors, are included in Table 1. The survey is descriptive, and only summary statistical analysis was conducted.

The margin of sampling error for the total was ± 3.6 percentage points. The margin of sampling error was ± 4.5 for the internist–primary care provider sample, ± 6.0 for the specialist sample, and ± 6.9 for California physicians. A Likert scale format was used for continuous data and a yes–no format for dichotomous data. Z-tests were performed for all comparisons of percentages and T-tests for mean scores. Statistical significance for differences between groups was set at

$P < .05$. Statistical analyses were performed using SPSS Statistics (IBM Corp., Armonk, NY).

Sample

A random sample of physicians was drawn from the American Medical Association (AMA) Physician Masterfile, which documents all residents and tracks them throughout their career. To further ensure that the sample represented currently licensed physicians, other verified sources of data included the American Board of Medical Specialties, state and government agencies, licensing boards, hospitals, residency programs, medical and specialty societies, medical schools, AMA membership and subsidiaries, and Drug Enforcement Administration and Unique Provider Identification Number numbers. Physicians are sorted according to primary specialty, secondary specialty, type of practice (e.g., office, hospital, resident), present employment, age, geography, and board certification.

All 50 states were included in fielding the survey. Data were weighted appropriately to reflect demographic characteristics based on the Association of American Medical Colleges 2013 State Physician Workforce Data Book. The data were not weighted according to specialty, and the total results combined primary care physicians, internists, and specialists.

RESULTS

Physician Views and Experiences with ACP Conversations

Participants were 81% male, 75% white, and 66% aged 50 and older. The majority of respondents reported that they were seeing older patients near the end of life and talking to those patients about matters related to ACP and end-of-life care choices. Fifty-three percent of survey respondents reported seeing patients aged 65 and older every day or almost every day who they would not be surprised to see die within the next year. Only 21% reported that they talked frequently about matters related to ACP or end-of-life care.

Ninety-nine percent of physicians surveyed reported that it is important for healthcare providers to have conversations about ACP with their patients (Figure 1). Respondents who had had formal training on talking about end-of-life care, those with a formal assessment system in place, younger physicians, and specialists were most likely to report that conversations about ACP were extremely important.

Physicians working in a hospital setting, those who had formal training on end-of-life conversations, and those whose practice or health system had a formal mechanism for assessing patients' end-of-life wishes and goals were most likely to be talking about ACP.

Sixty-eight percent of physicians reported that they had no training specifically related to talking with patients and families about end-of-life care, and 29% reported that they had this type of training. Younger physicians and those caring for a racially and ethnically diverse

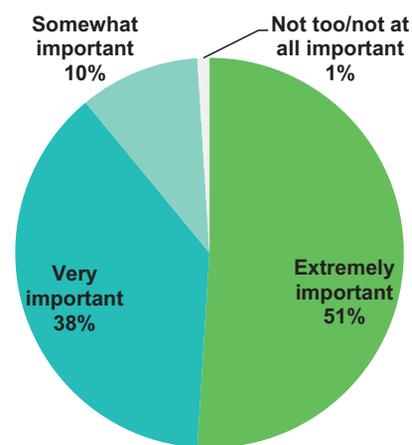


Figure 1. Responses to question: In your own opinion, how important is it that healthcare providers have advance care planning conversations with patients?

population were most likely to have had training. Physicians working in hospital settings were more likely to report having a formal system in place for conversations than those practicing in offices or clinic-based settings.

Forty-eight percent of physicians surveyed reported that they had had discussions about their own wishes for care at the end of life with their providers. By comparison, a 2015 survey of the general public showed that only 17% of respondents reported having these discussions with their providers.¹⁸ Physicians who reported having had this conversation with their own providers were more likely to have had these conversations with their patients and to have billed Medicare (20% vs 7%, $P < .05$).

Billing Practices

Most physicians reported that they had not had a conversation about ACP and billed Medicare in the first year of this new coverage. Of respondents who regularly billed Medicare under fee for service (85% of all respondents), 14% reported that they had used the benefit. Physicians who had had formal training on end-of-life conversations and those who reported having a formal system in place to assess patients' wishes and goals were among the most likely to have billed for the benefit.

Ninety-five percent of physicians surveyed support the new benefit, with 66% expressing strong support (Figure 2). There were no differences according to physician socioeconomic status or practice type. Three in four reported that the new benefit made them more likely to talk to patients about ACP. Seventy-five percent reported that the benefit was an incentive, including 35% who reported that they were much more likely to have conversations as a result of the new benefit.

Racially and ethnically diverse physicians, those younger than 50, and those who were already talking to patients about these questions nearly every day were the ones most likely to report that they had conversations with patients about end-of-life preferences under the new benefit.

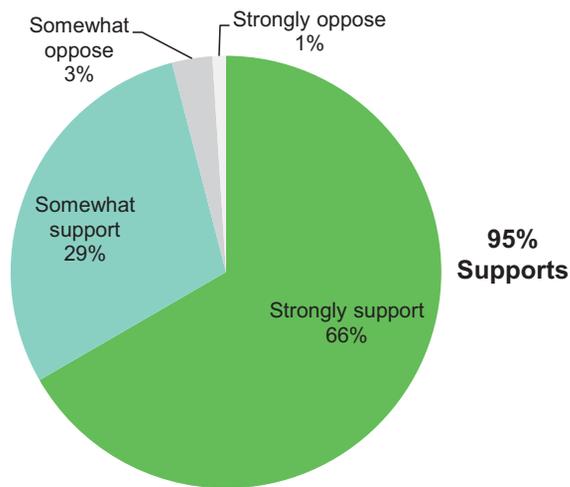


Figure 2. Percentage of respondents who support the new Medicare benefit paying for advance care planning conversations. [Color figure can be viewed at wileyonlinelibrary.com]

Summary of Motivating Factors for Conversations

Overall, patient values and preferences led the list of motivators for having ACP conversations. Female physicians were more likely to have this as their top motivator. Ninety-two percent of respondents reported that values and preferences were very or extremely important. A similar proportion reported that reducing unnecessary or unwanted hospitalization at the end of life was an important reason to have end-of-life conversations. Physicians who work in a hospital were most likely to state this as their priority. Those with training and a formal assessment system were most likely to report that values and preferences were important for talking with patients.

Barriers to Having ACP Conversations

The number one barrier to ACP, which two-thirds of respondents cited, was lack of time. Other top barriers, which were consistent across demographic characteristics, included disagreements between family members and the patient (65%), not knowing the right timing to have the conversation (60%), feeling that the conversation might be uncomfortable (51%), not wanting to give up hope (46%), and feeling unsure regarding what is culturally appropriate for the patient (44%).

Physicians who had not had training, younger respondents, and women were most likely to experience uncertainty about what to say in these conversations. Likewise, 48% of physicians caring for a racially or ethnically diverse patient base reported being unsure of what was culturally appropriate. Racially and ethnically diverse physicians were more likely to report feeling uncomfortable with end-of-life conversations.

Fifty-three percent of respondents reported that they found conversations about end-of-life care more challenging than rewarding. Physicians who had specific training reported that they found these conversations more rewarding than challenging at a higher rate than physicians who reported no specific training (46% vs 41%, $P < .05$). Physicians who regularly talk to patients about serious

illness and end-of-life matters were more likely to report that conversations were rewarding.

Perception of responsibility did not appear to be a barrier for most respondents. Even when given options of a different healthcare provider or another doctor's responsibility, 75% of physicians reported that conversations with patients are the physician's responsibility. Fifteen percent responded that it is the patient's or family's responsibility and 8% that another healthcare provider is responsible for initiating the conversation.

Differences Between Those with Training and Formal Assessment Systems

Physicians who have had formal training or have a formal system in place for assessing patients' goals are more likely than those who have not to report that it is extremely important for healthcare providers to have these conversations with their patients (59% vs 47%, $P < .05$), it is extremely important to talk to patients aged 65 and older about ACP and end-of-life care once a week or more (79% vs 69%, $P < .05$), they find conversations about end-of-life care to be rewarding (46% vs 30%, $P < .05$), and they rarely or not too often feel unsure about what to say when having conversations about end-of-life care (60% vs 52%, $P < .05$).

Physicians who reported that they had a formal assessment system in place were more likely than others to report that it is extremely important for healthcare providers to have these conversations with their patients (61% vs 47%, $P < .05$), it is extremely important to talk to patients aged 65 and older about ACP and end-of-life care once a week or more (81% vs 68%, $P < .05$), they have had a conversation about end-of-life care and billed Medicare for it (22% vs 10%, $P < .05$), they have a place in the electronic health record system that indicates whether a patient has an advance care plan (79% vs 51%, $P < .05$), and they have an electronic health record system that allows them to see the content or the plan (72% vs 47%, $P < .05$).

DISCUSSION

Ninety-nine percent of physicians in this survey agreed that it is important for them to have conversations with their patients about ACP. This high proportion most likely corresponds to general agreement with the overall concept of ACP, despite data showing that clinicians do not always follow advance care plans.¹⁹ Nevertheless, roughly half of these physicians felt unprepared to facilitate these discussions with their patients. Those who reported having formal training were less likely to report feeling unsure about what to say, but the survey did not specify types of formal training, and the best methods and duration of training for incorporation into medical education should be determined. In addition, training must be broadly available to clinicians in practice to meet the needs of older adults.

Training alone, according to physician respondents, is not sufficient. As observed in other studies, conversations were much more likely to occur when the practice or healthcare system has a formal system in place for assessing patients' end-of-life wishes and goals of care,^{20–22} yet fewer than one-third of physicians responding had such a

system in place. This suggests that policymakers should consider additional ways beyond payment to stimulate inclusion of ACP in the practice and health system infrastructure. Examples of potential drivers of systems change could include CMS Conditions of Participation for Hospitals, National Committee for Quality Assurance Patient-Centered Medical Home criteria, or inclusion in the Merit-based Incentive Payment System, a component of the quality reporting program under CMS.

Physicians surveyed broadly supported reimbursement, and the advent of 2 billing codes for ACP discussions creates an opportunity to help healthcare providers focus on the care their patients want and avoid unwanted care, yet just 14% of physician respondents who had Medicare fee-for-service patients reported that they had billed Medicare for this discussion.

This survey provides a unique contribution to the field by asking clinicians directly about their views and experiences related to ACP. Limitations of this study include the limited types of physician specialties included in the sample, the small sample size, insufficient capacity to analyze for geographic variations, and lack of data on specific types of physician education received. In addition, the Medicare benefit paying for ACP conversations was introduced 3 months before this survey, potentially offering a premature reflection of billing code usage.

CONCLUSION

Given the gap between what people want at the end of life and the care they receive, we need to build on available training tools and embed them systematically into practice. Addressing clinician barriers to ACP to meet the needs of their older patients and families requires the integration of existing, proven tools into a 3-pronged strategy that includes education and training, formal systems, and reimbursement for these critical conversations.

ACKNOWLEDGMENTS

Financial Disclosure: Funded by the John A. Hartford Foundation, California Health Care Foundation, and Cambia Health Solutions.

Conflict of Interest: None.

Author Contributions: TF, ME, AB, SH, AH: study content, drafts, revisions. All authors: approval of final draft, submission of manuscript

Sponsor's Role: The poll was funded by the 3 foundations noted here, with independence given to PerryUndem as contractors to conduct the poll.

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