

Family physicians' perspectives on advance care planning in community-dwelling elderly patients

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Abstract

Objective To explore FPs' self-perceived role in advance care planning (ACP) for community-dwelling elderly patients, including the who, what, when, where, why, and how factors associated with having ACP discussions.

Design Qualitative descriptive methodology with semistructured interviews.

Setting Greater Vancouver region in British Columbia.

Participants Thirteen FPs.

Methods Semistructured interviews were conducted with a convenience sample of FPs. Interviews were independently coded and analyzed by 2 investigators.

Main findings All participants believed that FPs had the responsibility to ensure that elderly patients received ACP. However, practitioners who were comfortable with other specialists taking the lead were more likely to take a passive role. Most participants did not definitively distinguish end-of-life care from ACP, possibly because discussions frequently occurred late in the disease trajectory. While a minority of physicians approached patients based on older age, most physicians (69%) initiated ACP based on the patient's health status. However, the threshold to begin discussions varied greatly among participants. Physicians often talked about the necessity of dedicating time to these discussions and introduced ACP with the following techniques: normalizing the topic, speaking in general terms, and exploring the patient's understanding of his or her prognosis. Participants expressed conflicting perceptions regarding the effect of ACP on the physician, on the patient's current health, on the patient's future care, and on the patient-physician relationship. As most FPs solely practised in the clinic setting, many were unaware of the direct effects of ACP on patients' end-of-life care.

Conclusion Family physicians had varying and often conflicting perspectives on the optimal timing and effects of ACP in community-dwelling elderly patients. More research investigating the effects of ACP on the elderly primary care population is needed.

Editor's key points

- ▶ Advance care planning (ACP) is an important aspect of early palliative care. However, few studies explore the FP's role and the effects of ACP in non-institutionalized older adults.
- ▶ This study explored a range of perspectives on ACP for community-dwelling older patients among a sample of Canadian FPs, most of whom were involved in undergraduate medical education and had received no formal ACP training. All participants believed that it was the FP's role to address ACP with their patients. However, FPs had contradicting opinions regarding the effects of ACP on the physician, the patient's care, and the patient-physician relationship.
- ▶ Participants had various thresholds for initiating ACP; some physicians addressed ACP based on a specific age cutoff while others initiated ACP after a medical diagnosis or a health crisis. However, multiple participants mentioned that they will discuss ACP regardless of their threshold if the patient initiated the topic. This highlights how delivering early palliative care requires a cultural shift not only for providers, but for the general public as well.



Points de repère du rédacteur

► La planification préalable des soins (PPS) représente un aspect important du début des soins palliatifs. Par ailleurs, peu d'études explorent le rôle des médecins de famille et les effets de la PPS auprès des adultes plus âgés non institutionnalisés.

► Cette étude explorait un éventail de points de vue sur la PPS pour des adultes plus âgés vivant dans la communauté, sollicités auprès d'un échantillon de MF canadiens, dont la plupart oeuvraient dans l'éducation médicale prédoctorale et n'avaient reçu aucune formation formelle en PPS. Tous les participants croyaient qu'il incombait aux MF d'aborder la PPS avec leurs patients. Cependant, les opinions des MF étaient contradictoires concernant les effets de la PPS sur le médecin, les soins aux patients et la relation patient-médecin.

► Les participants avaient fixé divers seuils pour amorcer la PPS; certains médecins abordaient la PPS en se basant sur un âge en particulier, tandis que d'autres commençaient la PPS après un diagnostic médical ou une crise de santé. Par ailleurs, de nombreux participants ont indiqué qu'ils discuteraient de la PPS, quel que soit le seuil qu'ils s'étaient fixé, si le patient soulevait le sujet. Ces constatations font ressortir que la prestation précoce de soins palliatifs requiert un changement culturel de la part tant des professionnels que de la population en général.

Points de vue de médecins de famille sur la planification préalable des soins pour les patients plus âgés vivant dans la communauté

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Résumé

Objectif Explorer la façon dont les MF perçoivent eux-mêmes leur rôle dans la planification préalable des soins (PPS) pour les patients plus âgés qui vivent dans la communauté, y compris les réponses aux questions «qui, quoi, quand, où, pourquoi et comment» associées aux discussions sur la PPS.

Type d'étude Une méthodologie qualitative descriptive au moyen d'entrevues semi-structurées.

Contexte La région du Grand Vancouver, en Colombie-Britannique.

Participants Treize MF.

Procédure Des entrevues semi-structurées ont été effectuées avec un échantillon de commodité de MF. Les entrevues ont été codées et analysées de manière indépendante par 2 chercheurs.

Principales constatations Tous les participants croyaient que les MF avaient la responsabilité de faire en sorte que les patients plus âgés fassent l'objet d'une PPS. Par ailleurs, les médecins qui étaient à l'aise avec la notion voulant que d'autres spécialistes s'en chargent avaient tendance à jouer un rôle passif. La plupart des participants n'ont pas fait de distinction définitive entre les soins en fin de vie et la PPS, probablement parce que de telles discussions se produisent souvent tard dans l'évolution de la maladie. Si une minorité de médecins abordaient le sujet en fonction de l'âge avancé des patients, la plupart (69%) d'entre eux le faisaient selon leur état de santé. Toutefois, le seuil fixé pour amorcer les discussions variait considérablement entre les participants. Les médecins ont souvent parlé de la nécessité de consacrer du temps à ces discussions, et abordaient la PPS avec les techniques suivantes: normaliser le sujet, en parler en termes généraux et explorer la compréhension du pronostic par le patient. Les participants ont exprimé des points de vue contradictoires concernant les effets de la PPS sur le médecin, sur l'état de santé actuel du patient, sur les futurs soins au patient et sur la relation patient-médecin. Comme la plupart des MF pratiquaient seulement en clinique, plusieurs n'étaient pas au courant des effets directs de la PPS sur les soins en fin de vie aux patients.

Conclusion Les médecins de famille avaient des points de vue diversifiés et souvent contradictoires sur le moment optimal pour amorcer la PPS et sur ses effets sur les patients plus âgés vivant dans la communauté. Il faudrait plus d'études de recherche sur les effets de la PPS sur la population plus âgée en soins primaires.

Advance care planning (ACP) is the act of defining future preferences for medical care treatments,¹ a process which often involves exploration and incorporation of the patient's wishes. The benefits of ACP in the elderly population include greater awareness of patients' end-of-life (EOL) goals,² increased delivery of care consistent with expressed wishes,³ improved family and patient satisfaction,^{2,4} increased quality of dying,⁵ and decreased family stress, anxiety, and depression in making EOL decisions.²

Despite the crucial role ACP can have among elderly patients, a population known to have sudden health crises,^{6,7} most of the ACP literature focuses on dementia and residential living.^{2-5,8,9} Furthermore, initiating ACP in institutions might be too late, as only up to 36% of nursing home residents have the capacity to engage in EOL discussions.⁸

The family practice setting might be a more optimal locale to initiate ACP, as patients are often healthier and, by extension, more able to actively participate in these discussions.^{10,11} Older adults are often eager and open to discussing ACP during periods of health, but will frequently expect physicians to initiate the discussion.¹²⁻¹⁵ Furthermore, Robinson et al found that patients preferred to hold do-not-resuscitate discussions specifically with FPs, and that the physician's office was a comfortable location to hold these conversations.¹² Because FPs have longitudinal relationships with patients, and are frequently the sole health care provider for relatively healthy elderly patients, they are in an optimal position to initiate early ACP discussions. Unfortunately, despite these factors, only a minority of patients have actually engaged in ACP activities with FPs.¹⁶

Increasing ACP engagement in the family practice setting requires an improved understanding of FPs' perspectives. This is especially pertinent because ACP is an integral part of early palliative care, an area that has been rapidly developing in the past few years.¹⁷ The World Health Organization's definition of *palliative care* has shifted to be "applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life," instead of being limited to an EOL option when active treatment has failed.¹⁸ Thus, FPs can hold various views on palliative care depending on the timing of their training, how closely they follow palliative care literature, and the experiences they have in practice—all of which can influence how they approach ACP for their elderly patients.

The purpose of this study was to explore FPs' self-perceived role in ACP for community-dwelling elders. A secondary aim was to explore the perceived effects of ACP in the primary care population.

— Methods —

Design

We used a qualitative descriptive methodology with semistructured interviews to explore the perspective of

FPs working in the greater Vancouver region of British Columbia. A standard interview guide (available from the corresponding author on request) was created based on common literature themes and our research interests. The interviewer (T.A.J.) used this guide to conduct all interviews and asked follow-up or clarifying questions depending on the interview content. We defined *elderly patients* as older than 65 years of age. Ethics approval was obtained from the University of British Columbia's Behaviour Research Ethics Board.

Sample selection

A convenience sample of FPs practising in the greater Vancouver region was recruited from family practice rounds at a local hospital, and from a list of 48 FPs participating as first-year medical student preceptors for the University of British Columbia. We originally aimed to recruit a minimum of 10 participants to ensure that various opinions were captured in our study. We only interviewed physicians, as most family practice offices lack the presence of other health care professionals.

Data collection

All participants provided written consent. Interviews were conducted between May and June of 2017. All interviews were conducted by the same investigator (T.A.J.) using the interview guide. Data collected regarding ACP resources and barriers will be discussed elsewhere.

Data analysis

The interviews were transcribed, checked for accuracy, and inductively coded. Two researchers (T.A.J., J.H.) independently analyzed the transcripts using open coding. Comparable codes were grouped into categories, and categories with similar content were grouped into themes.¹⁹ We subsequently discussed differences until consensus was reached. Data consolidation was supported by NVivo 11.²⁰ Two other investigators (M.J.M., J.K.) reviewed the analysis and verified the themes.

— Findings —

Thirteen FPs were recruited into this study (**Table 1**); 12 were recruited via e-mail from a first-year medical student preceptor list and 1 from family practice hospital rounds at Vancouver General Hospital. Nine interviews were held face-to-face and 4 interviews were carried out by telephone. Twelve interviews were recorded for transcription; 1 participant refused to be recorded and the investigator took notes to capture the main discussion points. Saturation, where no new themes occurred in the latter interviews, was reached with our sample of 13 participants.

The average interview duration was 20 minutes (range 7 to 38 minutes). We found that categories could be grouped under the themes of who should be responsible for initiating ACP discussions, what topics are

Table 1. Participant characteristics: N = 13.

CHARACTERISTIC	VALUE
Sex, n (%)	
• Male	9 (69)
• Female	4 (31)
Mean (SD; range) age,* y	47 (10; 30-61)
Ethnicity, n (%)	
• White	9 (69)
• Chinese	2 (15)
• Korean	1 (8)
• Japanese	1 (8)
Mean (SD; range) time in practice, y	17 (11; 3-36)
Type of practice, n (%)†	
• FP office	12 (92)
• Full practice	2 (15)
• Nursing home	5 (38)
• Hospital	5 (38)
• Community health centre	2 (15)
• Rural practice	1 (8)
Mean (SD; range) estimated proportion of elderly patients‡	23 (17; 5-50)
Education on ACP, n (%)	
• None	8 (62)
• 1-time workshop	4 (31)
• More than 1-time workshop	1 (8)
Self-rated comfort level in discussing ACP with elderly patients, n (%)	
• Very comfortable	7 (54)
• Relatively comfortable	5 (38)
• A little more comfortable than at the start of career	1 (8)

ACP—advance care planning.
 *Two doctors provided a range of 40-45 y for their age category, and the average of 43 y was used in calculating the mean.
 †Participants could identify more than 1 type of practice.
 ‡Specified to be in the office setting, if applicable.

included in ACP, when it is appropriate to initiate such conversations, where is the best setting, why these conversations are or are not important, and how to introduce the topic. Conflicting opinions from the themes are presented in **Table 2**.

Who: the FP's role in ACP

All participants believed that it is the FP's role to initiate ACP when the discussion becomes necessary. Family physicians cited longitudinal relationships with patients and the belief that patients or families are afraid to bring up this topic as common reasons supporting this approach:

"Most GPs have the longest longitudinal relationship with most of our patients. We are probably the best ones to have or initiate those [ACP] discussions." (Interview 13)

However, FPs expressed conflicting perspectives regarding the involvement of other medical specialists, most notably oncologists (**Table 2**). Some FPs believed that oncologists insufficiently prepared patients for palliation, whereas others assumed that patients had already discussed ACP with a health care professional during the course of their treatment.

What ACP looks like in family practice

Most physicians mentioned that ACP was directed by the patient's goals and wishes for the future. Common discussion topics included resuscitation, intubation, substitute decision makers, death in-home versus in-hospital, and living wills. Family physicians often addressed common misconceptions about the effect of aggressive interventions. Select participants defined ACP as preparing the patient for extended health care benefits, retirement planning, and financial management.

Owing to varying definitions of ACP, from advanced directives to making nursing home arrangements, data from the frequency of ACP follow-up was too heterogeneous and was omitted in the final analysis.

When to initiate ACP

A minority of physicians (4 of 13) initiated ACP based on an age cutoff. Three physicians approached patients in their 70s to 80s, and 1 physician used 65 years of age as the trigger to initiate discussions.

The rest of the participants initiated ACP discussions based on the patient's deteriorating health status, whether it be after an acute event or upon the recognition of a poor prognosis. Some physicians argued that ACP in the healthy lacked value and applicability, as illustrated in the following:

The people that are writing a living will and planning on all of the eventualities that might happen are sort of like people who might be writing a plan for how the stock market is going to go. It is kind of unpredictable and there are lots of variables. (Interview 4)

Two physicians explicitly believed that FPs should mainly focus on active disease management, and discussion of ACP should occur only when death is imminent.

In contrast, other participants thought that early discussions had benefits but were unable to have such discussions owing to other priorities in practice. These physicians also acknowledged that discussions might be initiated too late in the disease course, as shown in the following:

We end up capturing people too close to the end of their life and we might end up missing opportunities for certain things, such as competency, as it is more

Table 2. Examples of conflicting perspectives among the themes

THEME	CATEGORIES	QUOTATIONS (INTERVIEW NO.)
Who: the FP's role	Role of other specialties	<p>Negative</p> <ul style="list-style-type: none"> • "I think the onus is on us completely. I am not going to send them to a specialist to have this discussion I am the person who is their primary care provider" (3) • "I think that typical oncologists and specialists do a poor job, in general, with some exceptions, in preparing patients for end of life. I think they are very focused on disease curing and management and don't stop to think about what happens when treatment fails" (10) <p>Positive</p> <ul style="list-style-type: none"> • "I make referrals to palliative care and geriatricians. They deal with that more on a daily basis" (2) • "We take for granted that they're with the [BCCA] and someone in BCCA would have a protocol to cover it" (9)
When to initiate ACP	Patients' health status	<p>Routine, regardless of health</p> <ul style="list-style-type: none"> • "Once a year I do an annual physical on patients over 65. That is part of their checkup to see what they are thinking" (5) <p>Based on health status</p> <ul style="list-style-type: none"> • "I will bring it up with my patients that have severe chronic heart or lung disease. That is our cue to have those discussions early" (11)
Why: effects of ACP	On the physician	<p>Positive</p> <ul style="list-style-type: none"> • "It makes all health care decisions easier and not just those specific decisions about levels of intervention" (1) • "I'm usually surprised in the end by what the conversations bring out, happily surprised by what information it gives me" (7) <p>Neutral</p> <ul style="list-style-type: none"> • "I don't see patients at nursing homes or when they are in their, so to speak, death bed. I don't see the direct result of that ... because I do office care I don't directly get involved with patient care when they are at the hospital and when they are in their last days of life" (2) • "It isn't gratifying if it doesn't have any impact on their care" (10)
	On patients' current health	<p>Positive</p> <ul style="list-style-type: none"> • "It can be good for everyone to recognize that their health status, at around age 50, things start to break down and your risks go up" (1) • "I think that most patients actually want [ACP] and are glad we have it and are quite relieved that they understand more of [what] that is going to be like" (10) <p>Negative</p> <ul style="list-style-type: none"> • "If a person is very fragile and very anxious ... broaching the subject can sometimes make things worse" (3) • "I can imagine again spending a lot of time on EOL issues with people who are actually coming here looking for a way to be healthier right now in the moment, and it could be a serious buzzkill, for them and for the physician" (4)
	On patients' future health care	<p>Positive</p> <ul style="list-style-type: none"> • "It helps because at least they have thought about it instead of just scrambling when they're sick, and when they're sick then can't really think about it" (9) • "It makes it quite clear to the family. When we do get to the point where things are worse, [the family members] have no qualms about following what they heard their parent say. It's much more difficult when you're trying to guess what their loved one would have wanted. They feel like they are abandoning or betraying or somehow letting down or playing God" (12) <p>Neutral</p> <ul style="list-style-type: none"> • "Not that many clear examples of impact on patient care" (8) • "Even if they filled in a community DNR form, where did they put it? Is it on the fridge, in their wallet? If it is on the fridge, will the EMS attendant see it and take it to the hospital? When they are in the hospital there are often triggers to fax the community GP's office to have any records forwarded. They can request the documentation, but when that happens, I think there is a delay in that by about 5 days It would help if there was some sort of system where that information went where it would actually affect anything" (11)
	On the patient-physician relationship	<p>Positive</p> <ul style="list-style-type: none"> • "I think the relationship is much stronger and the trust builds quickly" (1) <p>Negative</p> <ul style="list-style-type: none"> • "They will be looking for a doctor in the office building next door if you start talking to them about EOL because they turned 65 and have diabetes" (3)

ACP—advance care planning, BCCA—BC Cancer Agency, DNR—do not resuscitate, EMS—emergency medical services, EOL—end of life.

challenging for families to sign off on these forms if not prepared [For early discussions,] those people won't be imminently dying, but it gives us guidance and anticipation of what their expectations are when that time might come. (Interview 10)

Additionally, physicians using either approach commented that they will discuss ACP with patients who bring up the topic themselves. "People wanting to have that conversation, like if somebody brought it up to me, I would absolutely have the conversation with them." (Interview 12)

Where to initiate ACP

Participants commented that the hospital was not the ideal setting to introduce ACP. Instead, these discussions were best carried out in the office or during home visits. Family physicians talked about the necessity of creating time dedicated to this subject, as ACP conversations can be time-consuming in the clinic setting. Furthermore, patients might be upset if the topic is abruptly introduced during a regular visit. "If at all possible I try to have them come in specifically for that reason [ACP]. It is a fairly time-consuming topic and not well served tacking it onto the end of a visit." (Interview 13)

In order to hold discussions in the office setting, FPs often brought patients in for an ACP-specific regular visit, or set aside time during an annual complex care visit. In British Columbia, a complex care visit has a specific billing code for FPs to develop a care plan for complicated patients (defined as having multimorbidity or frailty or both).²¹ The code can be used once per year and allows FPs to allocate a longer time for these appointments. However, even during a complex care visit, physicians might not be able to address ACP if the patient is very unwell. "The advance care discussion is part of [the complex care visit], but as you can imagine, depending on how sick the patient was last year, I may never get to [it]." (Interview 9)

Why: the effects of ACP discussions

The effects of ACP discussions and documentation fell into 4 main categories: effects on the physician, on the patient's current health, on the patient's future care, and on the patient-physician relationship. Physicians often had varying opinions about the effects of ACP in all 4 categories (Table 2).

Because information transfer from the community to the hospital is often lacking, participants also mentioned ways to ensure ACP discussions influenced patient care. Suggestions included providing families with physician support during a medical crisis, preparing family members to inform other care providers about the patient's goals of care, and having hospitals contact FPs by telephone as opposed to fax in order to expedite the transfer of information.

How FPs initiate ACP discussions

Most participants indicated that they would like to have a family member present for the conversation. Of these, 3 physicians indicated they would only have a conversation in the presence of a family member.

Physicians also acknowledged that they were in a position of authority, and patients might mistakenly worry about unsaid implications of the ACP discussion. "When I approach these topics sometimes to young 60-something-year-olds, they are like, 'Is something wrong with me? What were my blood test results?'" (Interview 2)

As a result, physicians expressed the need to be very deliberate in introducing ACP in order to minimize unnecessary anxiety. Common strategies to initiate the conversation included normalizing the topic ("I talk to all my patients about this"), speaking in general terms ("What kind of treatment would you want if you couldn't make decisions anymore?"), and exploring the patient's understanding of their own prognosis ("What do you understand about your disease?").

To guide these conversations, FPs often used the Medical Orders for Scope of Treatment²² and do-not-resuscitate forms. Most physicians (7 of 13) mentioned using the *My Voice* document,²³ a 56-page ACP booklet created by the BC Ministry of Health for the general public.

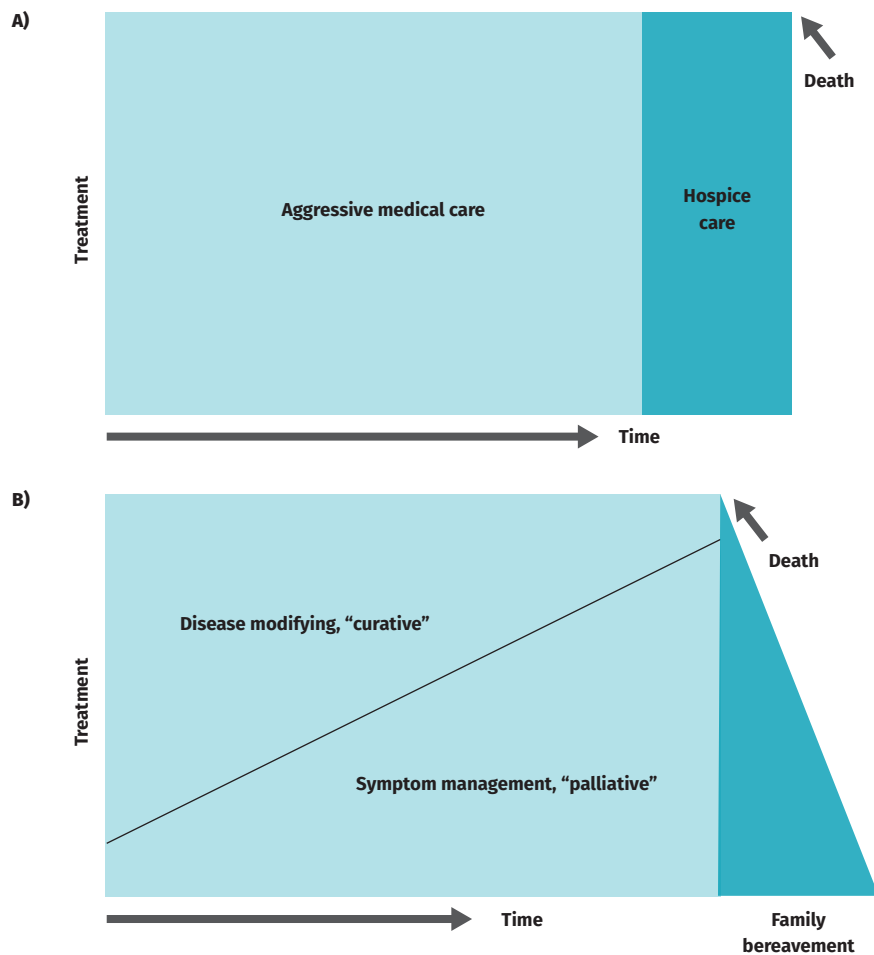
— Discussion —

This study revealed a range of perceptions about ACP among a convenience sample of FPs, most of whom had no formal ACP training. All participants believed it is the FP's role to initiate ACP discussions with patients, which is consistent with findings from other studies.^{14,24} However, FPs who were comfortable with other specialists taking the lead were more likely to take on a passive role, whereas other FPs believed it was their responsibility as the patient's primary care provider to initiate the discussion.

While the content of ACP discussions varied greatly, topics that were almost universal to all conversations included resuscitation and substitute decision makers. This study showed that most participants did not definitively distinguish EOL from ACP, despite such a distinction being emphasized in the palliative care literature. Possible explanations for this confusion include the lack of formal training in ACP, changes in palliative care terminology, and holding discussions late in the disease trajectory.

The optimal time to initiate ACP varied drastically among participants, and could be explained using "transition" and "trajectory" models of palliative care, outlined by Lynn and Adamson (Figure 1).²⁵ Physicians who used the "trajectory" approach initiated ACP upon recognizing a possible or obvious deterioration in health, and would deliver palliative care in conjunction with active treatments. Physicians who used the "transition" approach perceived palliative care and active treatment to be 2 mutually exclusive approaches to care.

Figure 1. Older A) transitional and B) trajectory model of care



Reproduced from Lynn and Adamson with permission.²⁵

Consequently, they often initiated ACP upon recognizing the possibility of imminent death over the next few days to months. Interestingly, the 2 participants in our study who were most adamantly in favour of this approach also had the greatest number of years in practice.

Most of our participants used the "trajectory" approach, but the threshold to initiate discussions varied greatly among physicians. Discussions about ACP were held at various points in the patient's disease trajectory, ranging from meeting a certain age cutoff to being diagnosed with a chronic illness to redirecting care after an acute health crisis. Thus, we were able to subcategorize physicians using the "trajectory" approach into 2 groups: proactive, where ACP discussions were initiated before any health trigger (ie, based on an age cutoff); and reactive, where ACP was initiated after recognizing an obvious deterioration in health.

It is possible that physicians in the proactive group considered age a soft marker for frailty, or believed that ACP was valuable in ensuring patients and families considered goals of care early in the disease trajectory. Conversely, other FPs might see a lack of value in ACP before their threshold, or might find that the benefits of early ACP are outweighed by other priorities in practice. It is also notable that some "reactive" physicians were aware that they might initiate conversations too late and thus miss the opportunity to hold meaningful discussions while patients were still competent.

Of interest, regardless of which approach the FP used, multiple participants commented that they would have a discussion with a patient who initiated the topic, even if the patient did not meet their ACP threshold.

This study also showed a variety of viewpoints on the perceived effects of ACP, some of which are consistent

with findings in other studies. These include the patient's response to ACP (ie, relief at being able to discuss wishes vs being a "buzzkill" to making healthier decisions),²⁶ the effect on the physician-patient relationship (ie, strengthening vs weakening it),^{26,27} and the influence on the patient's future health care. Multiple FPs mentioned difficulty with transferring ACP documents from the community to the hospital or were aware that living wills might not be durable as a patient's health status changes—thus documentation frequently failed to affect future care. Other studies have also shown that ACP documentation was often open to interpretation, which might further limit its usefulness.²⁸ Similar to other studies, ACP discussions were often believed to be more valuable, as they prompted patients to think about their goals and communicate them to family and other care providers.²⁷

Overall, many FPs who worked exclusively in the clinic setting were not present during the patient's final moments owing to transfer of care. Therefore, it becomes challenging to motivate FPs to spend time and energy on ACP when they do not have first-hand experience of the effects of ACP.

Last, physicians recognized that active family participation was a crucial component of ACP; this involvement seemed especially important for frail elderly patients experiencing cognitive decline.

Strengths and limitations

This study supports and updates the perspective that FPs have a central role in ACP. Strengths of this study include having multiple coders to ensure interrater reliability, holding extended face-to-face or telephone interviews, exploring the effects of ACP in the primary care setting, and focusing solely on family practice and on community-dwelling elderly patients.

The main limitation is that our study used a convenience sampling technique to recruit our participants. As a result, all of our participants were urban-based physicians. Although we were able to explore a range of perspectives, physicians who were more interested or actively engaged in ACP might have been more likely to participate. Thus, we might have failed to capture the full range of opinions on this topic.

Conclusion

This study explored a range of perspectives on ACP among a sample of Canadian FPs, most of whom are involved in undergraduate medical education and had received no formal ACP training. We found that FPs felt responsible for playing a leading role in ACP, but this might be influenced by the involvement of other health care providers. Participants also had different thresholds for initiating these conversations, with some physicians addressing ACP before and others during a health crisis. This variation can be attributed to differing ideas about the role and effects of palliative care, previous

patient encounters, and physician-specific factors. For the latter, physicians who solely practised in the clinic setting revealed that they frequently were not aware of the effects of ACP, owing to decreased interaction with patients near the EOL. This is a key aspect to address if FPs are to play an important role in ACP. Multiple participants also mentioned that they will always address ACP if the patient brings up the topic, highlighting how delivering early palliative care requires a cultural shift, not only for providers, but for the general public as well. 🌿

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Contributors

Ms Ji contributed to study conception, protocol development, data collection, data extraction, analysis, and manuscript writing. **Mr Ho** contributed to data extraction, analysis, and manuscript writing. **Dr McGregor** contributed to study conception, protocol development, analysis, and manuscript writing. **Dr Kow** contributed to study conception, protocol development, analysis, and manuscript writing.

Competing interests

None declared

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