

Background

Advance care planning (ACP) for people with dementia has been defined as “a process of communication about future care and treatment preferences, values and goals with the person with dementia, family, and the health care team”¹. ACP may include discussion of general values and preferences (e.g., around place of care), as well as specific medical treatment decisions and completion of legal documentation, for example a Do Not Attempt Cardiopulmonary Resuscitation order.

In England, ACP is named as a core component of personalized care planning, delivered as part of an annual dementia review in primary care. Despite this, ACP is not consistently implemented², with communication skills and confidence cited as a key barrier by healthcare professionals³. Previous research has focused on what is communicated, including topics raised or templates used, with less focus on how ACP conversations are enacted⁴.

Aim: To understand how ACP conversations occur in practice between general practitioners (GPs) people with dementia and their informal carers.

Methods

- 12 GPs, 18 people with mild to advanced dementia and 18 carers were recruited to the study, from four general practices in Southeast England.
- Video recordings made of 18 annual dementia or frailty review consultations (mean duration 32 minutes) in which ACP was discussed.
- Video recordings were analyzed using Conversation Analysis; a method using naturally-occurring conversations to examine the organization of talk in close detail.



Fig. 1. Example of pseudonymized video recording

Results

- GPs approached ACP as an interactionally **delicate topic**, requiring special treatment. ACP initiation was characterized by marked disfluency, hesitancy and minimization, for example through the use of “just”:

“the other thing we **just** use this appointment **just** to think about is **just** thinking ahead about the future” PAT02

- GPs attempted to **buffer the possible emotional impact** of introducing ACP by making a positive appraisal of the person with dementia’s current health, or emphasizing that the conversation was happening early:

“it’s kind of end of life... **not that we’re saying you’re anywhere near that.** But it’s talking about this **really early** so that we understand” PAT13

- GPs **neutralized the conversation** through referring to generalized ‘other’ people, emphasizing the routine nature of ACP, as well as presenting it as a professional obligation:

“So sometimes (...) **people** (...) they document the things they would love in terms of their future care” PAT03

“It is something medically **we are asked to** kind of initiate in a frailty review” PAT08

Conclusions

Although the features described may serve to reduce the emotional impact of ACP initiation, it is possible that buffering may obscure the relevance of ACP to people with dementia and their informal carers. This may inhibit their ability to plan for the future.

GPs would benefit from guidance and training to improve confidence and clarity in ACP delivery.

References

