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What does the doctor plan to say? Physician-generated plans for advance care planning conversations

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ABSTRACT

Background: Importance of advance care planning or enabling individuals to make decisions regarding their future care is widely recognized. How physicians plan for or approach such conversations remains understudied. **Aim:** Physician plans were examined through a multiple goals theoretical framework. Of interest were the goals present within the plans as well as content referenced within each goal category. **Method:** In an online survey, physicians (n = 45) were provided a hypothetical scenario and asked to design a plan to communicate to the patient about their options for life-sustaining treatment. Providers were asked how they would engage in the conversation and what they would plan to discuss. A content analysis of physician responses was conducted. **Results:** Findings indicated that plans primarily consisted of task and identity goals. Content of reported plans overwhelmingly involved soliciting patient goals, explaining treatment options, and investigating patient knowledge of the medical condition. **Conclusions:** The current study addresses the paucity of research around what content providers prioritize and which conversational goals are present. This information affords role clarity for interdisciplinary teams and gives insight to where other team members can contribute to enhance patient outcomes. Reliance on theoretical frameworks offers a systematic build of this research where cross-study connections can be identified.

KEYWORDS

Advance care planning, goals, health communication, health plan implementation, physician plans

BIOGRAPHIES

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Introduction

Life-sustaining medical care of patients with terminal illnesses at the end of life (EOL) is costly and often difficult on both the patient and their loved ones (e.g., Cherlin et al., 2005). Advance care planning (ACP) in the form of advance directives was created as a means for people to retain autonomy over their medical care by specifying life-sustaining treatment values and choices when they were no longer capable of doing so (Hickman et al., 2005). Advance care planning conversations aim to establish a mutual understanding about a future plan of care in accordance with a patient's values and treatment preferences (Sinuff et al., 2015). Recognizing patient preferences and wishes regarding ACP care through patient-provider discussions is an important means of reinforcing patient autonomy and agency in decision-making during their final days of life (e.g., Billingham & Billingham, 2013; Downey et al., 2013).

Patient-provider discussions about ACP issues are associated with several benefits including patients' perceptions of autonomy and comfort during their final days (Kastbom et al., 2017), increased patient and family satisfaction (Tierney et al., 2001) as well as decreased stress, anxiety, and depression in surviving family members (Detering et al., 2010) and providers (Fakhri et al., 2016; Wright et al., 2008). Effective communication about ACP is also associated with less aggressive and/or unwanted care (Reinhardt et al., 2017; Sutherland, 2019), lower rates of intensive care unit (ICU) admission (Wright et al., 2008), and significantly lower health care costs (Duffy et al., 2006; Zhang et al., 2009).

Despite noted benefits, a wide range of barriers have been shown to inhibit optimal patient-provider ACP conversations (Abarshi et al., 2011; Lewis et al., 2016; Russell, 2015). Healthcare providers are often reluctant and/or are inadequately trained to facilitate ACP discussions (Cousino et al., 2019; Fulmer et al., 2018), resulting in the potential for patients to receive care inconsistent with their preferences. The importance of communication around end-of-life decision making is widely recognized. However, adherence to how physicians plan for or approach such conversations and what content is prioritized remains understudied (Scott, 2014; Van Scoy et al., 2017).

One challenge in investigating ACP conversations is the numerous existent patient and contextual variations that exist (e.g., Considine & Miller, 2010; Scott, 2022). A means to glean insight regarding physician approaches is the use of planning theory (Berger, 1988; 1997) and conversational plans in lieu of actual conversations. Drawing on plans for communicative encounters gives greater information regarding provider orientations to ACP as plans are the general scaffolding (e.g., Wilson, 2002) that providers draw upon for each conversation. While patient and contextual constraints might alter how the plans are implemented (e.g., Russell, 2015), providers are likely to draw on a base set of goals to accomplish their primary objectives.

The purpose of this study is to contribute towards the gap in understanding how physicians broach ACP by exploring communicative goals relevant in conversational plans. To accomplish this aim, physician plans were solicited and examined through a multiple goals theoretical framework. The subsequent sections will overview planning theory (Berger, 1988; 1997) and multiple goals theory (Caughlin, 2010; Dillard et al., 1989) as means for assessing plan content.

Planning theory

Planning is a multi-staged process that produces a strategy to be implemented in action as its end product (Berger, 1997). The planning process can be systematic or based on heuristics and can involve “assessing a situation, deciding what goals to pursue, creating plans to secure these goals, and executing plans” (Wilensky, 1983, p. 5). Planning theory of communication provides a conceptual link between communicative goals and communicative action (Waldron et al., 1995) and posits that communication success is due in part to the communicator’s efforts to formulate and implement plans of action (Waldron & Lavitt, 2000).

Plans are structurally organized cognitive action steps necessary for accomplishing goals (Berger, 1997; Wilson, 2002). Plans are mental representations, as they do not constitute the actions themselves, and thus discrepancies might exist between the actual plans and eventual enactment (Berger, 1988; Berger & Bell, 1988). Drawing on plans allows for strategic navigation of the situation at hand. Investigating physician generated plans can provide insights into relevant goals, emphasized content, and techniques of patient-centered communication adaptation. The plan focus also affords greater insight to general ACP approaches relative to observing a single patient interaction in the context of EOL care. Investigating planned approaches illuminates the enduring cognitive underpinnings driving message production. While patient differences and contextual variations might require adaptation (Considine & Miller, 2010), plans embody the action steps deemed central by the curator to accomplish the goal (e.g., Wilson, 2002).

The purposeful nature of ACP conversations require people to coordinate multiple and possibly conflicting concerns (i.e., goals). As such, deciphering plans can be informed through the theoretical lens of multiple goals. A multiple goals framework provides a theoretical account for how underlying goals guide people’s planning and action (Berger, 2005; Dillard, 1989) and acknowledges that message production and interpretation is motivated beyond simply the desire to exchange information (Sillars, 1998).

Multiple goals theory

In communication literature, goals are conceptualized as cognitive representations of future states of affairs that individuals want to attain or maintain through interaction with others (Caughlin, 2010; Dillard, 2008). A multiple goals perspective encompasses a number of goal-focused theories, but the focus of this study is primarily on the core assumptions. First, communication is a strategic, goal-driven process. Second, people pursue multiple often competing objectives simultaneously in conversations. Third, three broad classes of goals exist across situations: task, identity, and relational goals (Caughlin, 2010) and are salient to EOL health decisions (Scott, 2014).

Task goals involve the primary objective toward which communication is directed (Caughlin, 2010). For instance, a physician might want to accomplish the task goal of informing a patient of common misconceptions about life-sustaining treatments, offering assistance regarding legal documentation, or influencing a patient’s attitude regarding the type of care. Identity goals are objectives related to managing impressions of the self or conversational partner

(Berger, 2005). Individuals that prioritize identity-oriented goals behave in ways consistent with personally held values and beliefs (Caughlin, 2010; Goldsmith, 2004). Such identity goals might be evident in a physician's efforts to preserve patient autonomy, treat a patient as a whole person, or offer professional advice about treatment options that are consistent with the patient's values. Relational goals are associated with the development and maintenance of connections with others. In the context of EOL care and ACP, such relational concerns might manifest in behaviors that emphasize familial bonds, establish trust, or maintain rapport marked in desired reconciliations (Caughlin, 2010; Berger, 2005).

The relevance of goals is shaped by the circumstance in which the interaction takes place (Goldsmith et al., 2007; Wilson, 2002) with some more or less important to healthcare providers during EOL conversations regarding ACP. Even if one goal is dominant in the interaction, additional goals often co-occur and influence the communicative pursuit of the primary goal (Caughlin, 2010; Goldsmith et al., 2007; Wilson, 2002). Multiple goals theorists suggest that in complex communicative situations, the number of relevant goals increase which may account for the difficult nature of ACP discussions (Van Scoy et al., 2017). Moreover, a multiple goals perspective assumes that messages which accomplish the primary purpose of an interaction while simultaneously addressing relevant identity and relationship concerns are evaluated as more competent (Goldsmith, 2004) and sophisticated (Caughlin, 2010) than those adhering to a single goal. Prior research on goal-directed behavior in the context of EOL further demonstrates that communicators who effectively balance multiple relevant goals report higher quality conversations with enhanced conversational satisfaction and hopefulness (Scott & Caughlin, 2014).

Goals are one means to account for message production and evaluate ACP communication. They afford insights into what providers prioritize and consider when producing conversational plans regarding the care of patients nearing death. Considering the frequency of these goals highlights significant patterns of communication. Discussing end-of-life issues raises potentially conflicting task, relational, and identity concerns in which the actions that may facilitate the achievement of one goal conflict with actions that help accomplish other salient goals. A physician may have a (task) goal of persuading a patient to adhere to a specific treatment option but may be worried that doing so will undermine the patient's sense of autonomy (i.e., identity goal). The presence of conflicting, relevant goals can be challenging for communicators to navigate as they assess the appropriateness of their message within the specific context (Wilson, 2002). Research further suggests that unaddressed tensions or conflicting goals might lead to poor patient-provider communication and clinician burnout (e.g., Considine & Miller, 2010; Sisk et al., 2022).

Examining responses for the presence of multiple goals provides evidence for communication skills and offers indicators for conversational quality (e.g. Caughlin, 2010). If a speaker fails to pursue situationally relevant goals in a conversation, their communication is evaluated negatively by others and can potentially influence emotional and relational outcomes (Caughlin, 2010; Scott, 2022). For instance, Scott and Caughlin (2014) found that in family EOL conversations, messages involving relational-oriented goals were associated with higher levels of conversational satisfaction and hopefulness. While research there is research concerning family communication about EOL decisions (Scott & Caughlin, 2014) and provider-reported barriers to conversational engagement (Russell, 2015), there is a paucity of investigation surrounding the goals inherent in physician ACP conversations (e.g., Russell, 2016). As such, one objective of this project is to investigate what types of goals are important

to physicians during ACP discussions. The multiple goals theoretical framework provides an existing taxonomy of goals salient in communicative encounters (i.e., task, relational, identity). To investigate the relationships between goals guiding planned responses regarding ACP, the following research question is posed:

RQ1: What is the relative frequency of task, identity, and relational goals in planning conversations about ACP?

Beyond the examination of general goals present within the provider plans, also of interest is the actual plan content. Examining content evident in plans can identify topics prioritized by physicians when discussing ACP, as well as information physicians' potentially overlook when planning what to discuss. Given the complexity of ACP, plan content could also illuminate different approaches and emphases in the conversation (Parry et al., 2014) while aiding preliminary judgments of effectiveness (Scott, 2014). As such, another research question is posed:

RQ2: What topics are present in physician plans for ACP conversations?

Informed by planning theory and a multiple goals theoretical perspective, the current study aims to illuminate how physicians broach ACP with their terminally ill patients. Taken together, the research questions lay the groundwork for understanding physician goal orientation and content prioritization in constructing plans for ACP conversations.

Methods

Procedures

Physicians were recruited through a variety of online listservs including the Hospice and Palliative Care Association, Coalition for Compassionate Care, California HealthCare Foundation, and the American Association of Case Management to take a survey titled "Advance Care Planning." Respondents were notified that participation was voluntary and that all provided information was confidential. No compensation was offered, and all phases of the study were approved by the Institutional Review Board (IRB).

In the recruitment notice, a link to the online study was provided. The first screen asked respondents to review and indicate their agreement to the informed consent before initiating the survey. Participants were provided with the following hypothetical prompt:

You have a patient living in a skilled nursing facility with a terminal illness. Their spouse is no longer living. They have a remaining life expectancy of less than a year. While they have full capacity to make decisions, you are asked to have a discussion with the patient about his or her EOL treatment options so that the medical staff aiding the patient is clear about what the patient wants.

Next, they were presented with the following:

Please design a plan to communicate to the patient about their options for life-sustaining treatment. In this plan, please write (a) how you would engage in the conversation with the patient and (b) what specifically you would plan to discuss. Please be as detailed as possible in your plan generation.

To conclude, descriptive information including age, sex, race/ethnicity, position, length of time in current position, length of time in health care profession, and frequency of EOL care

discussions (i.e., estimated number of times monthly respondent engages in EOL care conversations) was solicited.

Respondents

Respondents included 45 physicians from the United States who ranged in age from 24 to 80 years old ($M = 52.24$, $SD = 12.21$); 15 (33.3%) were female, 27 (60.0%) were male, and 3 (6.7%) did not indicate their sex. The majority identified themselves as Caucasian (71.1%), followed by Asian/Pacific Islander (13.3%), Hispanic (4.4%), African American (2.2%), and 8.9% indicated other or declined to state. Physicians reported being in their current position for a mean period of 14.01 years ($SD = 10.19$) while in the health care field for a mean period of 24.48 years ($SD = 10.65$). The estimated number of times monthly that respondents engaged in EOL care conversations ranged from 0 to 100 ($M = 12.08$, $SD = 18.78$). Of the physicians, 4 (8.9%) did not produce a plan and as such were excluded from further analyses.

Coding

A content analysis was conducted on all physician-curated plans. The data analysis process occurred in two phases: the provider plans (i.e., qualitative responses) were separated into units of analysis and then topic categories were defined into which the unitized material could be organized. The unit of analysis was one complete thought or action unit. Action units included proposed behaviors or steps physicians indicated within their conversational plans (e.g., solicit goals, inquire about surrogate decision-maker, explain prognosis).

Two independently trained coders first unitized all provider responses using Guetzkow's U (Guetzkow, 1950). A highly reliable U of .06 for provider plans was obtained. After unitizing, efforts transitioned towards the second stage of data analysis: codebook development and establishing coding reliability (Cohen, 1960). The coding scheme for the topics noted in each plan was generated by the coders and researchers for this study. Employing grounded theory-inspired practices, coders first identified categories using constant comparative methodology which involves developing and reworking categories as the data are read and coded instead of having categories prepared beforehand (Glaser & Strauss, 1967; Strauss & Corbin, 1994). In that regard, the physician responses were examined to identify reoccurring concepts, phrases, and themes (Field & Morse, 1985; Owen, 1984). Similarities among themes and categories were then observed to identify meaningful relationships. Next, a systematic codebook was developed and refined including comprehensive descriptions for each code, noted inclusion/exclusion criteria, and examples of how the code emerged.

The aim of the study was to reach saturation, such that further data collection would yield no additional themes or information. The latter end of the data indicated repetition of themes within responses. The occurrence of previously identified themes became redundant and no new information emerged.

Once the codebook was established, trained coders were given 30 action units (open-ended responses derived from 6 physician plans). Coders subsequently met and compared the codes to identify any existent discrepancies. Once adequate reliability was established, the

remaining surveys were coded independently, and a final reliability analysis was conducted. Cohen's Kappa for coding reliability is reported below (Cohen, 1960).

Physician-generated content

Physician plans were coded into ten topic categories: *soliciting patient goals, explaining treatment options, investigating the patients' knowledge of condition, providing written resources, establishing surrogate decision maker, previous plans inquiry, contextual considerations, comforting, offering opinion, and reference to communication approach* (Kappa = .83). Content categories are discussed in terms of broad task, relational and identity goals as defined by Caughlin (2010) and Scott (2014).

Results

Research questions concerned physician goal orientation and content prioritization in planning for ACP conversations. Of curated plans, 92.7% included task-oriented goals that included taking some step or action to take. 90.2% of all plans included identity goals or content concerning patient individuality, autonomy, as well as provider role responsibility. *Relational* oriented goals were present in 58.5% of all plans and encompassed topics with social and communicative implications, working together towards a goal, and reliance on others. Beyond the general presence of goals within plans, of interest were the consideration and negotiation of multiple goals. Of the plans provided, 43.9% encompassed task, identity, and relational elements. Other plans integrated both task and identity goals (36.6%), task and relational goals (7.3%), and identity and relational goals (7.3%). Table 1 details the broad goal frequencies.

Table 1: Broad goal frequencies

Goal orientation	N	%
Task	38	92.7
Identity	37	90.2
Relational	24	58.5
Task & Identity	15	36.6
Task & Relational	3	7.3
Identity & Relational	3	7.3
Task, Identity & Relational	18	43.9

Note. Some plans encompassed multiple goals, and thus, totals will not reflect N = 41.

Research question 2 explored topics present in physician plans for ACP conversations. Topics are presented below in terms of goal orientation. The frequencies of specific topics within goal categories can be found in Table 2.

Table 2: Content frequencies

Category	N	% of plans present
Solicit patient goals	32	78.0
Explain treatment options	23	56.1
Investigate patient knowledge of condition	20	48.8
Provide written resources	19	46.3
Establish surrogate decision maker	16	39.0
Provide comfort	14	34.1
Offer opinion	11	26.8
Contextual considerations	10	24.4
Reference to communication approach	10	24.4
Inquire about previous plans	10	24.4

Note. Some plans encompassed multiple themes, and thus, totals will not reflect N = 41.

Task orientation goals

Task goals involve efforts directed toward accomplishing a specified end. Plans containing topics with a task orientation included: *explain treatment options, investigate the patient knowledge of condition, provide written resources, and inquire about previous plans.*

Physician responses that explain treatment options (present in 56.1% of plans) relied on providing information about available future treatment options to aid patient clarity and assist informed decision-making. Physicians indicated: “I would discuss the options from no code (doing nothing at all) to full code and what that entails (CPR, Intubation, etc.)” and “we would discuss the prognosis and options to control pain at the end of life.” Responses also addressed the specific risks and benefits of treatment options such as “If they choose CPR then I would explain the grim prognosis and high chance of neurologic impairment.” In explaining treatment options, some physicians opted to use scenarios to help patients have a greater understanding. Physicians repeatedly noted the need to be “realistic” and “practical” in explaining what interventions have to offer the patient given their current health status.

Responses that included *investigate the patient knowledge of the condition* (48.8%) included the physician’s intention to assess the patient’s perception of their current medical condition. Responses included: “My first step would be to explore what the patient understands about their illness” and “I would establish her understanding of her current health state and prognosis.” Investigating the patients’ knowledge further integrated soliciting patient expectations about their illness and/or treatment as well as an opportunity to address misunderstandings.

Provide written resources (46.3%) included physician engagement of physical information with the patient such as advance directives and the Physician Orders for Life-Sustaining treatment (POLST) form addressing a limited number of critical medical decisions to guide the conversation. Responses varied on specificity. Some plans included references to ambiguous reading material such as a fact sheet, handout, or pamphlet: “I would ask him to read over a handout and to give it back when he has decided and finished with it.” In these cases,

physicians alluded to the utilization of these written resources without giving indication of what they entailed. In other instances, resources were more explicitly identified: “A full explanation of what the aspects of POLST would follow” and “I would offer them the POLST form as a way of assuring their wishes are carried out.” Written resources also integrated physician intent to document the patient’s wants.

Physicians also noted the need for *inquiring for previous plans* (24.4%). A physician indicated: “I would first ask about conversations the patient has had in the past about decision-making regarding life-sustaining interventions, either with healthcare providers or with family, etc. and whether the patient has been involved in decision-making for others.” Other exemplars included: “Have you thought previously about how much in the way of medical intervention you want when your health deteriorates?” and “Ask if patient has an Advance Directive (AD).” Responses integrated all efforts to solicit information regarding existing plans, directives, or patient thoughts regarding decisions for their end-of-life care.

Identity orientation goals

Identity goals concern portraying or protecting a desired image of the self or conversational partner, preserving autonomy, and navigating roles and value systems. Content within provider-reported plans coded with an identity orientation included: *solicit patient goals*, *establish surrogate decision maker*, and *offer opinion(s)*.

Of physician-generated plans, 78% integrated *solicit patient goals* or the intention to generate a plan of care centered on the wants of the patient. A range of responses emerged from general inquiries about future care such as, “Ask what they would like to have happen as they decline,” to questions of specific preferences: “I would pursue specific value questions...such as how important is it to you that you remain in control of decisions?” and “I would begin the discussion by asking [...] would they want to allow a natural death or [have medical providers] try to intervene with CPR.” Responses addressed what was important to the patient by inquiring about patient values and preferences.

Physicians also commonly addressed the need to designate a patient advocate. *Establish surrogate decision maker* (39.0%) involved physician responses that aimed to identify an individual who would speak on the patients’ behalf regarding end-of-life decisions in the future if the patient is incapable to do so. Plans included: “My first goal is to establish a named proxy, ideally a proper DPOAHC [Durable Power of Attorney for Health Care]” and “I’d ask who would help to make decisions if he/she could not participate?” Surrogate decision makers were also encouraged to be present during ACP care conversations.

Offer opinion (26.8%) involved physicians giving insight and/or their personal beliefs regarding the medical condition. Opinions were predominately qualified by noted expertise: “explain what I know” or “make the recommendation that they NOT be coded when they die since I believe this would cause more harm than good.” Others encouraged patients to opt for specific routes of care: “I would then encourage them to consider the option for limited care in the facility...” or “recommend comfort measures only.” In two cases, physicians indicated that opinions would be offered as a decision-making tool in times of uncertainty: “I make a recommendation if patient [is] not sure.” Patient solicitation was mentioned as a precursor in only one case: “If asked my opinion, give it.”

Relational orientation goals

Relational goals are associated with the development and maintenance of connections with others as well as consideration for social implications and constraints. Plans containing topics with a relational orientation included: *provide comfort*, *contextual considerations*, and *reference to communication approach*.

Provide comfort (34.1%) included offering support and assessing the patient's emotional state with efforts to investigate fears or concerns the patient may have. Example responses included: "How do you feel your life is going currently? Are you happy?" "In the case the patient is disturbed about leaving the body and wants to cling on to life I would calmly discuss with the patient that there is no such thing as dying, only shedding the old and diseased body," and "Reassure patient we are not giving up on her but want to make her comfortable going forward." Such responses aimed to normalize the conversation and reassure the patient that the physician would be present for continual care and support.

Contextual considerations (24.4%) regarded the physician's intent to establish a comfortable environment for discussions with the patient to take place. Responses included: "The pace of the conversation should be set by the patient and setting should be unhurried. You can let them know how much time you have for the visit and advise the patient that this may take several visits to accomplish and that's ok" and "Acknowledge that it may be stressful and offer to have it at another time if that is preferred." Contextual considerations also involved physician emphasis on the openness and availability for conversations with the patient such as "I would set aside sufficient time to answer all questions and concerns of the patient and deal with these issues in the most compassionate and caring way possible." A common theme present in the contextual consideration category was that of time and being mindful of the patient's need to process at their own pace.

Reference to communication approach (24.4%) regarded physician responses centered on the communication style of the physician and patient interaction and how the discussion would take place. Physicians reported: "I would be direct," "Sit and talk to them gently" and "I discuss these face-to-face with the patient." Other references to communicative approaches pertained to strategies for shared understanding, "When I am discussing end-of-life I usually discuss it first with the patient and then ask if the patient would like me to discuss it with their loved ones."

Discussion

Health communication scholars have called for further exploration into health care provider EOL communication (Scott, 2014). Informed by planning theory and a multiple goals theoretical perspective, the current study examined physicians' reported plans of ACP care. Of interest were the prioritized goals present within the plans as well as content referenced within each goal category.

Broad goal orientation

A multiple goals theoretical perspective provides an existing framework of relevant goals inherent across communicative encounters (Caughlin, 2010) and specifically applicable to EOL communication (Scott, 2014). The multiple goals theoretical perspective further suggests that specific goals relevant to ACP conversations shape communicators' behaviors (Caughlin, 2010). Therefore, an important step in understanding communication around ACP is to first assess providers' attention to task, relational, and identity goals.

Findings from the current study reveal that providers prioritized task and identity goals in their hypothetical plans of care. Physicians' task goals, such as providing patients with information about treatment options, reflect their principal focus of the ACP conversation in documenting a treatment plan. These findings are consistent with existing goals-related research describing task goals as the main objective in communicative interactions (e.g., Dillard, 2008; Dillard et al., 1989).

According to the multiple goals theoretical perspective, identity goals pertain to managing impressions of the interactants and can influence how the ultimate task is achieved (Dillard et al., 1989). Identity goals prioritized within the reported plans centered on eliciting information from patients about their personal wishes. While such plans with identity goal orientations incorporated underlying task dimensions, the focus resided on identity concerns such as preserving patient autonomy and reaching an understanding regarding patient beliefs and value systems. In the context of ACP conversations, a physician's ability to provide treatment options to patients (i.e., task goal) while considering a patient's personal values and wishes (i.e., identity goal) is a particularly important communication skill that speaks to the purpose of ACP.

The results further indicated that physicians integrated relational goal components in over half of their reported plans. Relational goals are communicatively pursued by individuals in ways that develop and maintain desired connections with others. Like task-focused plans, relational oriented categories involve an action step. They differ in that the pursuit of relational goals when discussing EOL care emphasize interpersonal and communication implications. For instance, providing comfort, while a task, aids in establishing rapport and trust with the patient and family members. This relational goal integration is noteworthy as studies report patient mistrust of physicians and the health care system as a significant barrier to effective EOL communication (Periyakoil et al, 2015). Physicians' integration of relational goals (e.g., use of comforting language) can foster a sense of trust (Abdul-Razzak et al., 2016) and mitigate patient's feelings of discomfort when engaging in EOL discussions (Deckx et al., 2020). The focus of the relational goals is also of interest. Within curated plans, relational goals were all patient-centered and did not integrate other members of the clinical care team. Given that palliative care integrates a range of professions to comprise the core clinical team (Pesut et al., 2016), the absent reference and/or reliance on these other members in curating a plan is notable. It might be the case that physicians under-utilize other members of the interdisciplinary team in ACP efforts.

Additionally of interest were the number of plans integrating multiple goals. Relevant task, identity, and relational components were evident in just under half of physician-reported plans, whereas a third of plans integrated both task and identity components. The multiple goals framework posits that effective communication is premised on satisfying multiple goals

simultaneously in a communicative exchange (Caughlin, 2010; Goldsmith, 2004). Prior research has linked EOL conversations in which communicators successfully manage multiple goals to positive outcomes, such as, increased patient decision-making efficacy and conversational satisfaction (Scott & Caughlin, 2014; 2015). The ability to recognize how multiple goals are being pursued provides preliminary evidence for communication skill and criteria for conversational quality. While plans do not directly translate into action, physician awareness and consideration of multiple goals suggests improved patient outcomes relative to those with a singular goal orientation. The overwhelming majority of providers structured plans with adherence to at least two goal orientations, suggesting that providers are aware that their approach in achieving the task or end state goal of documenting treatment decisions is in part achieved through patient-centeredness with identity and relational consideration.

Topic categories

In addition to goals present in the plans generated by physicians, several recurring topics or content categories were identified. Many physician responses indicated intentions to solicit patient goals including values and preferences of future care. In addition to being an important means in shared decision-making, eliciting patient values and preferences can extend patient autonomy and promote the delivery of culturally competent care (Price et al., 2019). Discussions between patients and their physicians about their ACP preferences have been linked to fewer aggressive interventions and increased quality of life throughout the duration of the illness (Mack et al., 2012; Wright, 2008). The high rate of physician consideration for patient goals and autonomy, at least in their intentions, points to an understanding of the desired patient-centered approach. To further support the intentions of patient-centered care and autonomy was the topic of establishing a surrogate decision maker. Plans recognized the need to invite patients to designate someone to advocate for them when unable to do so. Including surrogates in the decision-making process can alleviate feelings of uncertainty and better prepare surrogates to make informed decisions when necessary.

Across plans, the need to explain treatment options also emerged as a frequent topic. Such plans were typically framed in a textbook manner and offered objective information relative to treatment options and outcomes. This finding is consistent with previous research suggesting that physicians' communication is overly biomedical in nature, often privileging technical and issues over discussing psychosocial matters relevant to patients (Fine et al., 2010). Though this information-based approach can potentially aid patient clarity, it does not equate with patient understanding. Physicians should also consider a patient's information needs and health literacy to ensure patients are equipped with the appropriate resources necessary to make informed decisions.

Discussions tailored to assessing a patient's understanding of the medical condition and correcting any misconceptions were identified consistently in physician responses. Prior research suggests that patients exhibit a poor understanding of treatment options (Deep et al., 2008). Similarly, patients with limited health literacy often hold unrealistic expectations about ACP and are reluctant to ask questions during encounters with physicians (Periyakoil et al., 2015). Therefore, it is crucial for the physician to assess patient comprehension as a foundation for EOL conversations. Physicians need to be trained to utilize strategies (i.e., "teach back") to assess for the patient's comprehension of information imparted in ACP

conversations. The salience and agreement among physicians in this regard again alludes to the priority of meeting patients where they are to enhance EOL conversational and ACP outcomes.

The commonality for plans to integrate additional resources to supplement conversations offer support that conversational tools are in use and deemed effective at least from the physician perspective. Providers indicated reliance on forms or pamphlets to provide patients with information on treatment options. The POLST document was specifically referenced as a conversational guide to ensure the primary areas of treatment were addressed. While this gives some evidence that physicians rely on these documents in engaging with patients, the question of whether these resources are deemed effective on behalf of patient remains unexplored (Scott, 2014). It might be the case that such written resources, especially those describing treatment options, are deemed effective in that they alleviate provider burden to describe and put the onus on the patient.

Several plans indicated physicians' intentions to offer opinions. This finding is contrary to paradigms in palliative care, where treatment options are intended to be neutral and up to patient preference to either limit or request designated medical interventions (Bomba et al., 2012). In all but one case, the physicians offered an unsolicited opinion. This communication approach can be problematic and may undermine patient autonomy. Previous research suggests that physicians who dominate decision-making encounters influence patient perceptions of their expertise and capacity to participate in treatment planning, which in turn can inhibit shared decision making (Joseph-Williams, et al., 2013) While ultimately the physician has an advantage point in their experience with efficacy rates and outcomes, it is important to ensure the ACP decisions are based on patient goals and not those of the provider.

Several plans demonstrated physicians' focus on relational aspects of patient-provider interactions including providing comfort, desire to adapt to contextual needs, as well as reference to communication approaches or strategies to employ. Prior research demonstrates that addressing patients' emotional concerns is associated with patient and family satisfaction (Fine et al., 2010). These noted considerations on behalf of physicians allude to their awareness of both content and relational dimensions of communication. In other words, providers recognized the importance of not only what they planned to say during ACP conversations, but how that information was conveyed. Interestingly, listening was not referenced in provider plans as part of their reported communicative approach. This speaks to the potential for providers to dominate ACP conversations and miss opportunities for patient input

Limitations and future research

This study's contributions should be considered along with its limitations. First, out of the forty-five respondents, four physicians did not indicate a plan. With exception of plan generation, the remainder of the survey for each was complete. The reason for not indicating a plan is unknown. It might be the case that the physicians did not have enough experience to detail a plan, were not knowledgeable on subject matter, or just pressed for time and unavailable. Future research should continue to explore factors that impede provider planning for ACP conversations.

Another limitation resides in the utilization of online listservs for solicitation of physicians who were vested in palliative care. Given the reliance on listserv recruitment, response rates of those receiving the study information and those opting to participate is unavailable. Additionally, a degree of self-selection is likely, such that, those physicians more invested in “advance care planning” as the survey was titled, would be more inclined to participate.

This recruitment and sampling approach limits generalizability. In spite of this limitation, the findings presented here serve as an initial step in research about physician curated plans. The sample was highly experienced with an average of over twenty years in the healthcare field. Such experience might afford a vastly different plan relative to other providers tasked with the assignment to broach patients regarding ACP. Not surprisingly, previous research has suggested that less experienced physicians experience a lack of confidence and comfort in approaching ACP conversations with patients (Thomas et al., 2020). Additionally, while the current sample focused on physicians, it is important to note that engaging in ACP discussions with patients is often an interdisciplinary team effort and can often be the task of nurses, chaplains, social workers, and medical residents (e.g., Lee et al., 2018). Within such roles, providers might have limited to no existing relationship with the patient and/or minimal to no training in how they would plan for conducting ACP conversations. Future research should consider such contextual factors and broaden the scope of sample recruitment to give voice to this growing cohort, making findings more representative. It is also important to note that the physicians were recruited from the United States and thus, likely operate from a Western biomedical ethical orientation. Providers outside of the Western clinical context might approach such conversations with different priorities integrating varying cultural worldviews. Future research could explore how cultural dimensions might alter physician plans.

Soliciting and examining provider-curated plans also has limitations in drawing conclusions regarding provider practices. This plans-based approach relies on self-report to a hypothetical patient scenario. Physician ability to draft a plan is likely correlated with their grasp of best practices in palliative care. Comprehension of what should be discussed is not necessarily synonymous with provider willingness or ability.

Further, while this study contributes to the lack of research regarding physician approaches for end-of-life conversations, examining intended plans is limited in that they do not translate into behavior. While a physician might be capable of scripting a plan to broach ACP conversations with their patients in a hypothetical situation, the ability to carry that conversation out might be entirely different. The scenario depicted might not align with the physician’s clinical reality or experienced constraints. There are many factors that impact how such plans are ultimately implemented. Patient, provider, family, and institutional characteristics might attenuate or impede the plans to action association. While this research contributes to the existent gap, it is only a first step. Therefore, future research may consider how plans align with actual behavior and associated EOL care outcomes. Investigating plans as they unfold may also provide insight to various factors that influence conversational engagement as well as the content and goals prioritized.

Conclusion

Conversational plans afford scaffolding that physicians draw upon while engaging with patients regarding advance care treatment. The current study addresses the paucity of

research around what content providers prioritize during such conversations and which conversational goals are present (Scott, 2014). Findings have both important theoretical and practical implications.

Findings contribute to the utility of planning theory and multiple goals as a lens to assess approaches to ACP conversations. Theoretical underpinnings of planning theory and multiple goals allow cross-study comparisons to be formulated. While topic categories were identified for the purposes of the existing study, considering those topics in a broader categorization of salient goal orientations as outlined by multiple goal theorists help contribute to a systematic build of this research trajectory in the context of EOL care (Scott, 2022). Findings also gave credence to the utility of planning theory in affording insight to conversational orientation. ACP conversations are inherently complex with a range of contextual variations. Reliance on provider plans gave an opportunity to get at conversational approaches while minimizing extraneous variables. The plans detail the core goals generally prioritized. While potentially limited in direct transfer to action, they remain the cognitive mapping drawn on to engage in ACP conversations.

This insight to physician plans has practical implications, such that informs clinicians, policymakers and clinical educators what is prioritized and what has been overlooked. Curated plans had an overwhelming integration of task and identity goals indicative of patient-centered care. While topics with relational focus had an attenuated presence, it offers a platform for development recognizing the importance of not only what physicians plan to say during ACP conversations, but how that information is conveyed. Given that messages that attend to multiple goals are often rated as more effective, findings from this study can be used to inform the development of interventions aimed to improve physicians' ACP communicative strategies. Last, awareness of content that physicians are more prone to cover affords role clarity. Palliative care teams integrate a range of professions working towards the advancement of the patient's treatment goals (Pesut et al., 2016). Awareness of goal orientation and the content that physicians are more prone to cover provides opportunities to clarify where other interdisciplinary team members can contribute without being redundant. This not only enhances existing resources but affords opportunities for other team members from different specializations (e.g., social work, chaplains) to supplement the conversations and optimize patient outcomes.

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