Advance care planning and interpersonal relationships: a two-way street

Joel J Rhee a,b,*, Nicholas A Zwar b and Lynn A Kemp a,c

aCentre for Primary Health Care and Equity, bSchool of Public Health and Community Medicine, and cCentre for Health Equity Training Research & Evaluation (CHETRE), University of New South Wales, Australia.

*Correspondence to Joel J Rhee, School of Public Health and Community Medicine, University of New South Wales, Sydney, NSW 2052, Australia; E-mail: j.rhee@unsw.edu.au

Received 16 May 2012; Revised 7 August 2012; Accepted 4 September 2012.

Background. Advance care planning (ACP) has been gaining prominence for its perceived benefits for patients in enhancing patient autonomy and ensuring high-quality end-of-life care. Moreover, it has been postulated that ACP has positive effects on families and health professionals and their relationship with the patient. However, there is a paucity of studies examining the views of GPs on this issue.

Objective. To explore GP views on the impact that ACP has on interpersonal relationships among those involved in the patient’s care.

Method. Semi-structured, open-ended interviews of a purposive sample of 17 GPs. Interview transcripts were analysed using constructionist grounded theory methodology with QSR NVivo 9 software.

Results. ACP was seen as having both positive and negative impacts on interpersonal relationships. It was thought to enhance family relationships, help resolve conflicts between families and health professionals and improve trust and understanding between patients and health professionals. Negatively, it could take the family’s attention away from patient care. The link between ACP and interpersonal relationships was perceived to be bidirectional—the nature of interpersonal relationship that patients have with their families and health professionals has a profound impact on what form of ACP is likely to be useful.

Conclusion. Our study highlights the importance that GPs place on the link between ACP and the patient’s interpersonal context. This has implications on how ACP is conducted in primary care settings that are considerably different from other care settings in their emphasis on continuity of care and long-term nature of relationships.

Keywords. Advance care planning, advance directives, patient-centred care, primary health care.

Introduction

Advance care planning (ACP) is a process through which patients make decisions about future health care in consultation with health care professionals, family and important others. ACP has gained prominence internationally for perceived benefits in enhancing patient autonomy and ensuring that patients receive appropriate, high-quality end-of-life care. The terminology and legal status of ACP vary considerably among different countries. In Australia, although some states have specific legislations, ACP is mainly recognized under the common law. Australian courts have recently upheld the legal status of advance care directives and clarified the duty of health professionals to respect the patient’s advance refusal of treatments. Despite the increasing interest in ACP from a range of health organizations, evidence to date suggests that the prevalence of ACP remains low in Australia, ranging from 0% to 7.9% for documents and 20.1% for discussions.

In addition to perceived benefits for patient autonomy and improved quality of care, it has been postulated that ACP also has an important impact on the people who provide them with care. A discussion article by Kolarik described the importance of ACP in facilitating communication between the patients and people around them; reducing the burden on the family; fostering trust between the patient, family and health professionals; and decreasing the likelihood of family conflict. Likewise, our previous study of expert clinicians and representatives of health provider organizations, consumer groups and professional bodies identified families and health professionals as important beneficiaries of ACP.
Several qualitative studies showed that GPs also appreciate the positive impact that ACP has on families and health professionals. Thompson and Bern-Klug reported that their participants appreciated the role that ACP plays in reducing the burden on the family and providing them with the psychological comfort that patient’s wishes will be respected. ACP documents were seen as a useful icebreaker to promote doctor–patient and doctor–patient–family communications, thus enhancing patients’ trust in health professionals. However, studies to date have tended to treat ACP as a single entity and have not examined whether different forms of ACP might have different effects on families and health professionals. They have also focused mainly on the effect of ACP on interpersonal relationships and have not examined the impact that differences in patients’ interpersonal context have on ACP and end-of-life care.

As part of a continuing programme of research on ACP, between 2010 and 2011, the authors conducted a series of interviews with Australian GPs to examine how they conceptualize ACP and to explore their views on how ACP should be facilitated and implemented. A theme that emerged from an analysis of the initial few interviews is the important role that patient’s interpersonal context plays in determining how ACP is facilitated and implemented. Therefore, this study explores this theme further, focusing on (i) the effect that difference in the patient’s interpersonal context has on ACP and (ii) what effect, if any, does ACP have on patient’s interpersonal relationships.

### Method

#### Methodology

The coding and analysis was informed by the constructionist grounded theory methodology, incorporating elements of Straussian grounded theory and Clarke’s positional maps and focus on discourses. These were chosen because of their strength in analysing and providing explanations (i.e. context, conditions and contingencies) for people’s actions, interactions and social behaviours. There is an assumption in these methodologies that meanings and actions are located in larger social structures and discourses rather than individuals; thus, the focus of analysis is on discourses rather than representation of individuals.

#### Recruitment of participants

GPs from New South Wales and Victoria were recruited through two approaches. Notices were placed in doctors’ magazines and newsletters of medical organizations. GPs who were already known to the investigators through previous professional contact were approached directly. Participant recruitment was informed by a purposive sampling strategy involving a number of personal and professional characteristics (Table 1). Recruitment continued until these criteria were satisfied. The participants were offered a gift card for taking part in the study and for assisting with the recruitment of patient participants for a related study.

<table>
<thead>
<tr>
<th>GP</th>
<th>Age</th>
<th>Sex</th>
<th>Country of medical training</th>
<th>Practice setting</th>
<th>Sees patients in residential care facilities</th>
<th>Looked after palliative care patients in last 12 months or had further training</th>
<th>Experience with ACP</th>
<th>Consults in a language other than English</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt;40</td>
<td>F</td>
<td>Aus</td>
<td>Rural</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>&lt;40</td>
<td>M</td>
<td>Aus</td>
<td>Urban</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>40–60</td>
<td>F</td>
<td>Aus</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>&lt;40</td>
<td>M</td>
<td>Aus</td>
<td>Rural</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>40–60</td>
<td>F</td>
<td>Overseas</td>
<td>Rural</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>40–60</td>
<td>M</td>
<td>Overseas</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>40–60</td>
<td>F</td>
<td>Urban</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>40–60</td>
<td>M</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>40–60</td>
<td>F</td>
<td>Semi-rural</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>40–60</td>
<td>M</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>&gt;60</td>
<td>M</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>40–60</td>
<td>M</td>
<td>Urban</td>
<td>Rarely</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>40–60</td>
<td>M</td>
<td>Overseas</td>
<td>Rarely</td>
<td>Yes</td>
<td>Yes</td>
<td>Informally</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>40–60</td>
<td>M</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>&gt;60</td>
<td>M</td>
<td>Overseas</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Informally</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>&gt;60</td>
<td>M</td>
<td>Urban</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Informally</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>40–60</td>
<td>F</td>
<td>Urban</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

ACP, advance care planning.
Data collection
Face-to-face, semi-structured, open-ended interviews were conducted at the participants’ offices or their homes by one investigator (JR). The interviews were guided by an interview schedule (Table 2). The interviews were audio recorded with the consent of the participants and then transcribed by a professional transcription service. Transcripts were checked for accuracy against the original recording. NVivo9 software (QSR) was used for coding and analysis.

Analysis
Majority of the coding and analysis was done by one investigator (JR). The transcripts of the first five interviews were analysed and ‘open coded’ for emergent themes relating to ACP and end-of-life care. Concurrently, a process of axial coding identified relationships between the emergent themes. This revealed a number of themes centred on the core category of the relationship between ACP and the patient’s interpersonal context. The selective coding and analysis of the subsequent interviews focused on these themes.

Memoing continued throughout coding and analysis to aid in theory development and integration. Meetings and joint coding sessions (~10% of the transcript) were held regularly among the investigators (JR, NZ and LK) to enhance the theoretical sensitivity and reflexivity of the main investigator (JR).

Coding and analysis utilized a number of techniques to probe the data and stimulate conceptual thinking. These include constant comparisons, flip–flop technique, theoretical comparisons, looking for negative cases and looking at the language.13,16 Flip–flop technique involves looking at an opposite view of a concept to obtain a different perspective of the phenomenon.13 Special attention was paid to discourses. Sections of transcripts were coded for a particular context if implied, even if not explicitly mentioned in that passage.17 Conditional–consequential matrix13 sensitized the investigators to look for contextual, conditional and contingent factors in the data. Positional maps14 highlighted the relationships among different positions in discourses.

Reflexivity
The investigators’ background in nursing (LK) and general practice (NZ and JR) may have sensitized them to appreciate the important role that patients’ families and their social and cultural background have on their health care. This may have influenced the formulation of the research question, conduct of the interviews and the analysis. The potential impact of the investigators’ geographical location in an urban setting on participant recruitment was mitigated through deliberate efforts to interview participants from interstate and rural locations.

Results
The quotations from participants contained in this section are reproduced without alteration in order to preserve their full meaning.

Participant characteristics
Twenty-six GPs were considered eligible for an interview. Thirteen had responded to advertisements. Others were previous professional contacts of the investigators. One GP did not respond and one was too busy to take part. A total of 17 GPs (all from different practices) were interviewed (Table 2). Although ongoing data analysis had indicated that theoretical saturation was reached before the final interview, data collection continued until purposive sampling was completed. The remaining seven GPs were not required for an interview. There was variation in most personal and professional characteristics, except for clinical interest and training in palliative care. This was due to difficulty in finding participants with little interest or training in palliative care but still interested in taking part in this study of ACP and end-of-life issues.

Overview
The participants conceptualized ACP in two broad ways. ACP was sometimes viewed as discussions between the patient, carers, family members and health professionals. Participants also talked about ACP as

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Interview schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What does Advance Care Planning (ACP) mean to you?</td>
<td></td>
</tr>
<tr>
<td>2. Can you tell me about any experiences that you have had with ACP? (Additional prompts may explore the participant’s views on the importance of ACP in their clinical practice and reasons why the participant and their patients, carers and families became involved in ACP.)</td>
<td></td>
</tr>
<tr>
<td>3. What should happen in ACP? (Additional prompts may explore their views on who should be involved in ACP and when should ACP take place.)</td>
<td></td>
</tr>
<tr>
<td>4. How should the outcomes of ACP be used?</td>
<td></td>
</tr>
<tr>
<td>5. What do you think will make ACP process better for you and for your patients?</td>
<td></td>
</tr>
</tbody>
</table>
documents, usually in reference to instructional directives. Documents appointing surrogate decision-makers were not mentioned.

The findings are organized according to three different types of interpersonal relationships: (i) health professional-patient relationship; (ii) health professional-family relationship; and (iii) patient–family relationship. These will be examined in turn and, where relevant, will be considered in relation to differences in (i) the conceptualization of ACP as documents or as discussions; and (ii) the perceived legal standing of ACP.

Health professional-patient relationship and ACP

‘Knowing’ and ‘not knowing’ relationship. The terms ‘knowing’ and ‘not knowing’ were often used by the participants to describe the nature of the relationship between health professionals and patients. The patient or the family can ‘know’ the doctor and the doctor, in turn, can also ‘know’ the patients and their families. Opposite of this is a ‘not knowing’ relationship. This occurs in the context of patients without a regular doctor, or patients who are looked after by a number of different (and changing) health professionals. Hospitalization or sudden changes in the care setting often results in patients being treated by health professionals who are ‘not known’:

GP1: … someone who gets sick suddenly… in an aged care facility, goes to hospital, foreign you know doctors that are foreign to the family don’t really know the patient.

The ‘knowing’ and ‘not knowing’ relationships were seen to differ across four main dimensions (longitudinality, regularity, trust and loyalty). A ‘knowing’ relationship develops over time, with one GP noting ‘it takes a while to get to know them, also what their personality is like…’ (GP4). Regularity of contact and trust is important in a ‘knowing relationship’ because ‘people bond with those that they see every day’ (GP3). A ‘knowing relationship’ is also characterized by loyalty. One participant continued to care for his patients even though he was not remunerated:

Not remunerated at all… because they are not medical visits. They are more or less a social type of and supportive type of visit. (GP13).

GP’s and other community-based health professionals were thought to be in an ideal position to facilitate ACP because they ‘know’ the patients.

Implications of ‘knowing’ and ‘not knowing’ relationship. The ‘knowing’ health professional-patient relationship was seen to have an important impact on ACP and end-of-life care. Participants thought that although ‘it takes a while to get to know [the patients], also what their personality is like’ (GP4), they have a better understanding of the patient. This understanding was considered to be sufficient ACP. Even though the ‘wishes might not be in writing but that’s enough advance care planning for [the GP] to act’ (GP4).

Using the flip–flop technique, we also examined the consequences of ‘not knowing’ relationship on ACP and end-of-life care. ACP documents were considered to be useful when patients see health professionals that they do not know in ensuring that patients receive care that is consistent with their wishes. A participant said, it can be very important for a, a document to be present so that if someone turns up at a hospital and sees doctors they don’t know and that they’ve got very clear ideas about what they do and don’t want to happen… that they actually have the document (GP5).

Health professional-family relationship and ACP: avoiding conflicts

An important theme that emerged in our analysis is the desire of GPs to avoid conflicts with the patient’s family and protect themselves from litigation. Participants spoke about this in the context of distressed family members:

GP16: When your loved one die and, and the reactions of the relatives or the carer or spouse it’s quite extraordinary. They might not be thinking may be normal. They might blame somebody else, blame the hospital, blame the doctor for not doing the right thing.

The flip–flop technique showed that there is less fear of litigation in the context of an established, trusting health professional-family relationship:

GP3: [discussing life-prolonging treatments]… treating doctor who may know a family and a situation very well and a patient very well do less for that individual versus another individual with exactly same situation who could be challenged either by another family member, by the legal system, by court.

Some participants felt that strict adherence to ACP decisions could mitigate the threat of litigation from family members. This was dependent, however, on the perceived legal status of ACP. GPs were more inclined to strictly adhere to ACP if it was considered to be legally binding, a ‘documentation which has been signed by the person, the patient and, and the carer so there’s no argument’ (GP16). When ACP was not considered to be legally binding, participants were reluctant to follow it if it conflicted with the family’s wishes.

Patient–family relationship and ACP: a two-way street

Many participants described the positive impact that ACP can have on the patient’s family. First, it can help the family to prepare mentally, emotionally and physically,
making it ‘easier for the family having to deal with the acute stress’ (GP12) of future end-of-life situations. Second, ACP can ‘help families grieve and bereave after someone dies or even after if they go through something really, really traumatic that, that leaves them badly incapacitated’ (GP1). Third, ACP can help to resolve disagreements between family members. Although both ACP documents and ACP discussions can be helpful, there are differences in their mechanism and timing (Table 3).

The link between ACP and family relationship was thought to be bidirectional. Not only does ACP affect patient–family relationship, patient–family relationship also affects ACP. Patient–family relationship comprises two types: (i) close and trusting relationship; and (ii) distant or mistrusting relationship. The latter consists of people who are emotionally distant from their families; people without close family or relatives; and those with families that are in conflict.

The nature of patient–family relationship was perceived to have an important influence on the effectiveness of different forms of ACP (Table 4). For instance, both ACP discussions and documents were considered useful in the context of distant or mistrusting relationships. One participant said:

GP1: It probably would have been good for her three children to have that conversation. It might have helped their relationship... there was a lot of discord amongst them and there was... conflict about whether they were doing the right thing getting her into care...

ACP documents were considered important for patients who ‘don’t have a support network that knows about their status and what they feel about things, and even their resources’ (GP17) and those who have dysfunctional family. Without documents, their care could be ‘left a bit to the fates, as much as who was on duty that day...’ (GP17). However, ACP documents’ usefulness is modulated by their perceived legal standing. Documents lost their usefulness when they were perceived as not legally binding.

In contrast, ACP documents were not seen as useful in close and trusting relationships unless there had not been previous ACP discussions. Discussions alone could lead to good outcomes in the context of supportive family. One participant said,

I did have a patient who was in his 30s who had a brain tumour that recurred... he did do some advance care planning of sorts. But it wasn’t really formally written down... and they [family] were actually quite good at listening to him and what he wanted. (GP17)

There were concerns that ACP documents could have a negative impact. One participant said,
family member may not agree with each other and then it may cause disharmony, frictions… at… the critical time that… everybody should be focusing… on the well-being of the patient (GP13).

The key findings of the study are summarized in Box 1.

**Box 1 Summary of the key findings of the study**

- The bidirectional nature of the link between ACP and interpersonal relationships
  - The impact of ACP on interpersonal relationships
    - ACP can have beneficial as well as negative effects on patient–family relationships
  - The impact of interpersonal relationships on ACP
    - ‘Knowing’ health professional-patient relationship leads to a less need to rely on documentation; documentation assumes greater importance in ‘not knowing’ relationship
  - GPs’ desire to avoid conflict with the family and potential litigation affects the likelihood of ACP decisions being implemented
  - ACP discussions, not documents, are important in close and trusting patient–family relationships; in the context of distant or mistrusting patient–family relationships, both discussions and documents are important

- The utility of ACP documents and discussions
  - Is influenced by the patient’s interpersonal context

- The perceived legal standing of ACP (particularly documents)
  - Modulates the likelihood of ACP decisions being implemented by health professionals

**Discussion**

The participants thought that ACP has an important impact on people who provide patients with care. Its impact on the family was thought to be positive—for instance, building up family relationships, easing burdens and resolving conflicts; and negative—diverting the family’s attention away from patient care. ACP was also thought to have an important impact on health professionals’ relationship with the patients and their families. For instance, ACP documents could help in resolving conflicts between health professionals and the family.

Many of these findings are consistent with the authors’ previous study and the broader international literature. The authors’ previous study of key informants showed that ACP could help to improve the family’s understanding of the patient’s wishes, improve their ability to make decisions, prepare them psychologically and help in their bereavement.9 The participants in that study also thought that ACP could help health professionals to gain a better understanding of the patient’s wishes, thus leading them to better decision-making and protection from litigation. Studies of community and primary care patients showed that they appreciate the important role that ACP played in easing the burden and stress of decision-making for loved ones, keeping the peace in the family and in building up trust in the family.16–21 Studies of health professionals also show their high regard for the role of ACP in building up relationships. For instance, a Canadian study showed that doctors and nurses value the role of ACP discussions in improving trust and relationship between health professionals, patients and families.22 Likewise, a UK study showed that of the many roles that health professionals play in ACP, they derive the greatest satisfaction as a confidant, described as a ‘true open-ended partnership that involved feeling, without assumptions, agendas or need for closure’.10 However the current study’s finding that ACP can actually have negative impact on interpersonal relationships was not found in our previous work nor does it appear to be prominent in the literature.

This study extends our conceptual understanding of ACP by highlighting the bidirectional nature of the relationship between ACP and the patient’s interpersonal context. Not only does ACP affect relationships, ACP is in turn affected by relationships. Different degrees of trust and closeness in the family were thought to have an important bearing on the effectiveness of different forms of ACP, and health professionals’ response to ACP was found to vary according to their perceived susceptibility to litigation from family members. Health professional-patient relationships were also considered important, with ACP documents assuming a more important role when patients are treated by health professionals that they do not ‘know’.

These findings help to explain the disparity in the literature regarding the patients’ views of the role of ACP in health professional-patient relationships. Some studies found that patients value the role of ACP in strengthening that relationship. For instance, a UK study found that older people value the importance of having ACP discussions in the context of a trusting relationship between the patient and health professionals.23 Similarly, a US study found that many patients value the importance of ‘being known’ and having a pre-existing relationship with health professionals in ensuring that their wishes will be respected.24 However, a number of studies seem to indicate that patients do not regard health professionals as having a major role in ACP. For instance, several surveys showed that patients are much more likely to have ACP discussions with family members than with health professionals.25–26 Likewise, several qualitative studies reported that many patients regard ACP discussions as being of a personal nature that should not be discussed with outsiders but with family and loved ones.27–28

In light of our findings, the differences in patients’ views of ACP across the various studies may simply reflect the differences in relationships that the patients have with their health professionals. It is possible to
observe that many of the aforementioned studies showing patients’ high regard for health professional involvement in ACP were conducted in a primary care or care facility setting, whereas studies with contrary conclusions were often conducted in a specialist or a non-clinical setting. This is an important difference that may reflect primary care’s emphasis on the continuity of care and long-term relationships with patients rather than to a body of knowledge or a treatment modality. Continuity of care is important because it is associated with a greater level of trust between patients and health professionals.

Interpersonal relationships are not always important considerations in how ACP is conceptualized by the legislators, policy-makers and clinicians, who often conceptualize it in individualistic terms. Advance care directive laws in the USA have been described as a ‘strict, legal-tractional approach’ that is akin to signing a will. The recent Australian National Framework for Advance Care Directives makes it clear that the involvement of health professionals in ACP is optional. Our previous study revealed that out of the two views that Australian policy-makers and clinicians have on ACP, one sees it as an individualistic process undertaken by patients in order to meet their own needs, with the family and health professionals playing supportive roles.

However, our study highlights an important need to tailor each patient’s ACP to his or her interpersonal context. This is consistent with our previous recommendation for a patient-centred approach to ACP. This means that in typical primary care settings characterized by continuity of care and long-term health professional-patient relationship, ACP should focus not on documentation but on discussions to build up a mutual understanding of how the patient might be cared for in the future if they were to lose decision-making capacity.

There have been recent concerns about the erosion of the continuity of care in primary care. The trend in many western countries of GPs working fewer hours, working in group practices, and not offering home visits or after-hours care may reduce opportunities for the development of trusting GP-patient relationships. There are also people whose interpersonal context is characterized by lack of continuity of care or trusting relationships. Examples include people who prefer episodic care and choose not to have a regular doctor and residents of care facilities that have a rapid turnover of staff. Our study suggests that formal ACP documents may have a greater role in such situations.

However, a new approach to primary care in the form of the ‘medical home’ has been developed at least partly in response to threats to health professional-patient relationships. A medical home is a model of multidisciplinary primary care practice developed in the USA that provides each patient with a personal physician who provides ongoing first-contact care and care coordination. Complex care needs of the patients are met by a multidisciplinary team consisting of primary care physicians, specialists, nurses and allied health professionals. In this context that is characterized by continuity of care, ACP focused on building trust and understanding through discussions may be appropriate.

Limitations

The findings reflect the participants’ own account of their professional experience with ACP and not necessarily their actual practice or how patients and families experience and respond to ACP. For a fuller picture of what actually happens in ACP and how it is experienced, future studies should focus on direct observations and interviews with patients and families.

This study was undertaken in an Australian primary care context and involved only GPs with an interest in palliative care. The findings may not be generalizable to other contexts due to differences in culture, the legal system, and the health care system.

Conclusion

Our study highlights the importance that GPs place on the link between ACP and the patient’s interpersonal context. The participants appreciated the positive impacts that ACP could have on interpersonal relationships, such as enhancing patient-family relationships, helping resolve conflicts between families and health professionals and improving trust and understanding between patients and health professionals. The negative impact that ACP could have on interpersonal relationships was also recognized. Moreover, the participants thought that the link between ACP and interpersonal relationships is bidirectional—the nature of interpersonal relationship that patients have with their families and health professionals has a profound impact on the utility of different forms of ACP and their effect on end-of-life care. These findings have important implications on how ACP is conducted in primary care that differs from other care settings in its emphasis on the continuity of care and long-term nature of health professional-patient relationship.

Acknowledgements

This work forms part of Dr Rhee’s PhD thesis at the Centre for Primary Health Care and Equity, School of Public Health and Community Medicine at the University of NSW. The authors would like to thank all the GP participants of the study. The authors would also like to thank Dr Patrick Kinsella for his assistance with the recruitment of the study participants.
Declaration

Funding: New South Wales Primary Health Care Research Capacity Building Programme (UNSW); Australian Government’s National Health and Medical Research Council (PhD scholarship to Dr JR, 568909). Ethical approval: University of New South Wales Human Research Ethics Committee.
Conflict of interest: none.

References