Competing expectations: Advance care planning from the perspectives of doctors and nurses in the South-East Asian context

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ABSTRACT
This study qualitatively examines the perspectives of doctors and nurses on the implementation of the Advance Care Planning program in Singapore. Findings suggest that a combination of structural and conceptual factors hindered the performance of ACP. Themes on structural factors indicated that low awareness of ACP among senior staff resulted in overall lack of buy-in and incorrect implementation of the program due to misconceptions. Conceptual factors pointed to lack of clarity on intended outcomes or roles. Consequently, participants drew meaning through the prism of their profession, resulting in competing expectations and tensions on possible outcomes of the program.

Introduction
In 2011, Singapore launched its national ‘Living Matters’ Advance Care Planning (ACP) program with the purpose of improving quality of end-of-life (EoL) care through enhancing patients’ autonomy and participation in decision-making processes (Agency of Integrated Care, 2017). This intervention offers patients a platform to guide their future EoL care through a series of structured conversations with Healthcare Professionals (HCP) and relatives (Romer & Hammes, 2004). Resulting EoL care preferences are documented for use by healthcare staff and a proxy decision maker, the latter designated by the patient, who may later guide their treatment should they be incapacitated. The program was initially implemented in acute care settings to encourage uptake of services.

Research conducted in the UK, USA and Australia suggests that ACP can improve quality of EoL care through ensuring that patients’ preferences are adhered to (Robinson et al., 2012). Studies evaluating implementation of ACP in these countries demonstrated that it resulted in a reduction of hospitalization and increased utilization of palliative services (Detering et al., 2010). Implementation of ACP has, nevertheless, been beset by a set of intersecting barriers pertaining to the needs of different stakeholders at each phase of the treatment cascade. Uptake of the intervention was influenced by HCPs’ attitudes toward ACP (Murray & Butow, 2016) with some believing that their role did not encompass advocating for the intervention (Ke et al., 2015). Facilitation of ACP conversations could be a complex and challenging task requiring strong interpersonal and communication skills (Boot & Wilson, 2014) to cover sensitive topics. Lastly, completion of an ACP conversation may not inevitably lead to patients’ EoL care preferences being fulfilled due to lack of collaboration from HCPs in other disciplines (De Vleminck et al., 2013).

These studies point to a need for greater understanding of ACP from the perspective of nurses and doctors. There remains a paucity of research on front-line staffs’ experiences of implementing ACP in multicultural Asian countries (Wang & Chan, 2015), wherein HCPs would be required to be culturally competent enough to broach the topic of EoL care to patients from diverse religious and cultural backgrounds.
The purpose of this paper is to explore doctors’ and nurses’ experiences of implementing ACP in Singapore. Data was generated from the qualitative component of a largescale national level mixed methods evaluation of this program (Dutta et al., 2019; Ho et al., 2020). This paper focuses on themes emerging from focus group discussions (FGDs) with doctors and nurses.

**Methods**

**Sampling**

Participants were purposively recruited using the interpretative systemic framework, which encouraged the elicitation of perspectives of a range of stakeholders involved in ACP to derive a comprehensive understanding of the contextual system of healthcare in which the program was founded upon (Fuenmayor, 1991; Ho et al., 2016, 2020). The number of FGDs was determined by respondents’ level of experience working in the ACP program, their role in the ACP process, and the acute care setting in which they worked. It was decided that two members of each healthcare profession from seven acute care settings would attend an FGD. These professional groups were further subdivided according to respondents’ level of experience in the program, which was defined in terms of the number of ACP conversations conducted. Professions involved in implementation of ACP were identified as doctors, nurses, medical social workers, and ACP coordinators.

As noted earlier, this paper focused on themes emanating from FGDs conducted with doctors and nurses. Participants were recruited by on-site Principal Investigators attached to participating hospitals (Tan et al., 2019) resulting in eight FGDs with doctors (n = 12) and nurses (n = 15). Focus groups were organized according to profession, meaning that each FGD consisted solely of one type of HCP. As such, the focus groups were homogenous in nature, which resulted in the research team not observing any significant interactions between respondents.

**Data collection**

Focus groups were moderated and observed by the research team. This research team was multidisciplinary and consisted of members who had extensive experience of either qualitative data collection, implementation science or EoL research. For example, PL has previously conducted qualitative studies evaluating the feasibility of interventions in Southeast Asia, while AH specializes in EoL care.

Content of discussions were guided by an interview schedule which were developed by PL and AH. Questions were structured to correspond with Proctor et al.’s (2011) conceptual taxonomy of implementation outcomes to assess processes involved in the operation of ACP. These implementation outcomes included: a) Acceptability which encompassed HCP’s acceptance of the intervention; b) Adherence that assessed HCP’s fidelity to the program; c) Feasibility which examined barriers and facilitators to implementation; d) Penetration that evaluated HCPs’ adoption of the program; and, e) Sustainability which explored participants’ perception of the long term viability of the program. Table 1 displays the structure of the interview schedule with sample questions.

The research team ensured that perspectives of respondents were adequately represented through creating conditions that would enable them to speak freely. Each FGD was conducted within university premises to ensure that participants were comfortable expressing their opinions without fear of censure. Furthermore, the research team developed rapport between participants through encouraging them to introduce themselves at the beginning of the discussion. Finally, interview technique was standardized through training of research team members.

**Analysis**

Transcripts and audio recordings of FGDs were stored and analyzed through QSR NVivo. Themes were identified through a framework analysis approach.
(Gale et al., 2013) in which data is usually reduced through a matrix comparing categories of data or cases. The research team met regularly to coordinate analysis. Data was analyzed according to phases of analysis identified by Pope, Ziebland, and Mays (2000), starting with the evaluative team familiarizing themselves with transcripts. Following this stage, transcripts were coded according to constructs inherent in the guiding theoretical frameworks of this study. Information generated from the previous stage of analysis was distilled into a chart summarizing themes according to each FGD.

Trustworthiness and credibility of qualitative data analysis was ensured through a carefully maintained audit trail kept by members of the research team, who meticulously recorded each phase of analysis through memos and notes taken during each meeting. This technique of data validation allowed the research team to acknowledge the effect of the research topic and setting on the methods.

**Ethical procedures**

Research for this study received approval from the institutional review boards of Nanyang Technological University [Ref: IRB-2016-05-023] and the National Healthcare Group’s Domain Specific Review Board [Ref: 2016/00603]. Prior to each FGD, respondents were notified of the purpose of the study, selection criteria, their right to withdraw from the study at any point during the discussion and that their confidentiality and anonymity would be maintained. All participants were handed a certificate of consent, further explaining what was discussed earlier with a section for them to sign.

**Results**

Table 2 presents a demographic breakdown of participants ($n=27$). Average age of respondents was 40 years old; majority were female ($n=25$), Christian ($n=12$) and of Chinese ethnicity ($n=22$). Most participants reported that they had not facilitated an ACP discussion ($n=22$), although many had completed training to act as a facilitator over a year prior to data collection (median = 15 months).

| Occupation | Doctor (n=25) | Nurse (n=27) | Total (n=22) |
|------------|--------------|--------------|--------------|
| Sex        |              |              |              |
| Female     | 92           | 73           | 25           |
| Male       | 8            | 27           | 2            |
| Age        |              |              |              |
| 20–29      |              |              |              |
| 30–39      | 59           | 40           | 13           |
| 40–49      | 8            | 20           | 4            |
| 50 or more | 33           | 20           | 7            |
| Marital Status |          |              |              |
| Single     | 42           | 40           | 11           |
| Married    | 50           | 60           | 15           |
| Divorced/Separated | 8 | 0 | 1 |
| Ethnicity  |              |              |              |
| Chinese    | 92           | 73           | 22           |
| Malay      | 0            | 20           | 3            |
| Indian     | 0            | 7            | 1            |
| Other      | 8            | 0            | 1            |
| Religion   |              |              |              |
| Christian  | 58           | 34           | 12           |
| Muslim     | 0            | 33           | 5            |
| Buddhist   | 42           | 20           | 8            |
| None       | 0            | 13           | 2            |
| Years in Practice |          |              |              |
| 0–9        | 25           | 40           | 9            |
| 10–19      | 50           | 33           | 11           |
| 20 or more | 25           | 27           | 7            |
| Years since ACP training |          |              |              |
| < 1 year   | 18           | 33           | 7            |
| 1–2 years  | 28           | 27           | 7            |
| >2 years   | 54           | 40           | 12           |
| Completed own ACP conversation |          |              |              |
| Yes        | 17           | 0            | 2            |
| No         | 83           | 100          | 25           |
| Number of ACP conversations completed |  |              |              |
| 0          | 20           | 27           | 6            |
| >1         | 80           | 73           | 19           |

The four major themes with relevant sub and minor themes emerging from FGDs are presented in Table 2 with quotations. **Structure of Services** explored how respondents’ position within internal hierarchies of acute care settings shaped their behaviors. **Role Perception** examined how respondents’ perception of their professional role influenced how they engaged with the intervention. **Expectations of ACP** encompassed what outcomes HCPs expected from the program. Finally, **Realization of ACP** covered what these predicted outcomes were in reality.

**Structure of services**

The ACP program was mostly conducted in acute care settings, wherein the prevailing institutional philosophy was that of the **Biomedical Model**, in which illnesses were posited to arise from underlying abnormalities within the body. Optimal health was perceived as the absence of all disease, meaning that the role of physicians was often to use their expertise to eliminate patients’ ‘biological defects’ (Good & Good, 1981), resulting in the organization of services being focused on a **culture of curation**.

As key decision-makers, a high value was placed on doctors’ work within these settings, resulting in them
dominating the prevailing hierarchy. Doctors were solely responsible for taking decisions on when to shift from curative care to palliation. Making such a decision was often fraught with difficulties as physicians had to be confident in their level of medical knowledge paired with a familiarity of patients’ current condition. Junior doctors were, therefore, reluctant to discontinue care for patients who were not responding to treatment toward the end of their lives (Table 3, quote 1.1).

Even senior doctors reported difficulties in accurately predicting when a patient may pass away—observing patients who *blurred prognostic boundaries* commonly used to determine need for palliative care. These patients would unexpectedly recover from life threatening illnesses or events (Table 3, quote 1.2), leaving them unsure of when it was best to approach patients for end of life conversations, let alone refer patients for ACP.

Boundaries of prognostication shifted according to participants’ area of expertise as physicians mostly focused on symptomology related to their discipline. Consequently, *physician buy-in* differed according to discipline (Table 3, quote 1.3); a few respondents noted that surgeons did not believe that their role should encompass ACP as patients rarely died within their wards.

In terms of hierarchy of staff, nurses were considered to occupy a lower position than that of doctors as they were not responsible for making decisions on treatment. As such, *nurses were expected to partake in the ACP process* even if it offered little value in terms of their wider role. Some participants were drafted into ACP facilitator training by nursing administrators, although it was unclear when they would need to engage in an ACP discussion. They engaged in menial activities related to the ACP program adding an additional burden to their already high workload (Table 3, quote 1.4), e.g. filling forms online added an additional hour to their workday as it required input of complex details of ACP discussions.

Some nurses commented that they lacked the necessary medical knowledge to answer patients’ complex questions related to treatment preferences. They felt uncomfortable partaking in the ACP program due to the belief that they did not have the requisite communications skills or medical knowledge to approach topics related to death (Table 3, quote 1.5).

**Role perception**

Although participants received uniform training to act as ACP facilitators, it was clear from their narratives that they occupied differing roles within the program contingent on their professional role perception. *Nurses’ role* was described as encompassing multiple competing duties; the most prominent being treatment of patients’ symptoms, followed by *care of patients’ and families’ psychosocial needs* (Table 3, quote 2.1).

Attention to individuals’ psychosocial needs were often given low priority by senior staff, resulting in them being addressed through informal impromptu bedside counseling sessions. Nurses, nonetheless, placed a high level of importance on this component of their role, believing they advocated for the patient through catering to their psychosocial needs. They mediated contingencies of patients’ care plan with those holding power in the ACP decision-making process, including relatives and physicians, which was apparent in their description of the *two-step process of disclosure of a terminal diagnosis*. In the first step, doctors would explain the prognosis in medical terms; the second step involved nurses explaining the diagnosis in lay man’s terms and offering psychological comfort (Table 3, quote 2.2).

Provision of informal psychosocial care involved *nurses’ emotional labor* from sharing personal experiences to establish rapport with patients and caregivers (Table 3, quote 2.3). Respondents believed that this shared experience enabled patients to accept their terminal diagnosis and take appropriate actions afterwards, e.g. entering an ACP conversation.

Palliative care nurses integrated the demands of the ACP program into their already busy schedule through drawing on the psychosocial component of their role to advocate for the intervention and assess patients’ readiness to enter the conversation (Table 3, quote 2.4). Regular ward rounds offered an opportunity to discuss with patients their attitudes toward death and distribute brochures on ACP to patients who expressed interest in the program.

Doctors described their role mostly in terms of diagnosing and treating patients’ symptoms; often *relaying prognosis of terminal illness* to patients and their family in medical language to predict life span and guide patients toward palliative care. They recognized that a terminal diagnosis represented a loss of “hope” for patients who entered acute care settings believing that they would eventually be “cured”. One such doctor managed competing expectations through indirect allusions to palliative care, which served to cushion patients from the harsh reality of eventual death (Table 3, quote 2.5).

Doctors described the process of making decisions related to treatment as being guided by the “patients’
### Table 3. Themes and subthemes with relevant quotes.

| Themes                              | Subthemes                      | Minor themes                  | Quotes                                                                 |
|-------------------------------------|---------------------------------|-------------------------------|----------------------------------------------------------------------|
| Structure of services               | Biomedical Model               | Culture of curation           | “I tend to be very aggressive [with treatment]– I mean when I was younger … in my [medical] school days … And we tried to do CPR even [when] the patient is almost about gasping … because we don’t have a knowledge on palliation … Then, I feel that … in some cases we do need this [training in] palliative medicine … because if before I feel that you have to try to save a life, that’s it,” Female doctor (FGD9DOC1, quote 1.1) |
|                                     |                                 | Blurred prognostic boundaries | “I have friends who run neurosurgical ICU, and … she is often taken by so much surprise. Patients whom she thought would not make it … and then they walk out. In my Burns unit too … they struggle for months … and when they are back in the clinic, oh! They are so cheerful, they are walking! So, you see there is also the miracle of Life!”, Female doctor (FGD13DOC2, quote 1.2) |
|                                     |                                 | Physician buy-in              | “I think in cardiology, we tend to be very aggressive … especially the older school ones, they will be like, ‘nobody should die under our ward if possible’. Then we can do like many things like, we can put pumps in the heart … So I think the concept is harder to grip, even for the physicians, you know, if you switch my seniors, I think a lot of them still feel very strongly about going all out for a 90 year old.” Female doctor (FGD14DOC1, quote 1.3) |
| Hierarchy of staff                  |                                 | Nurses expected to partake in | “I do spend some time trying to type it out [the ACP discussion] and it is always like most of the times after my work time … we need to be allocated time” Female nurse (FGD12NU3, quote 1.4) |
|                                     |                                 | the ACP process               | “You know I will be confused and I will be very stressed about it and I will be like dread to do it! Do I really have to do it? Can I not do it because actually I’m not sure if I can answer their medical questions and all that” Female nurse (FGD12NU3, quote 1.5) |
|                                     |                                 | Nurses lack of comfort in      | “I am a palliative care nurse. So, my day of work is to review patients when they are actually referred to us for consulting. So we pluck the patient from assessment- discussing about discharge planning to the ACP discussion, whether formal or informal.” Female nurse (FGD6NU6, quote 2.1) |
| Role perception                     | Nurses’ role                    | Care of patients’ and families’ | “Usually the first line [of disclosure] are physicians … and then what comes next then we will be there. So like, for example, whatever support that they need … whether its spiritual physical that kind of thing … you just have to be there for them” Female nurse (FGD11NU4, quote 2.2) |
|                                     |                                 | psychosocial needs            | “I will just encourage them. Ok, maybe I give you an insight of my own story. I have a cancer patient … I will share with them, I mean I wouldn’t share with all the patients, I mean if I find if there is a need, I will share [my experience of having cancer] with my patients. So I find that, ah, it will really bless them … after hearing from my heart that they feel much much happier…” Female nurse (FGD8NU2, quote 2.3) |
|                                     |                                 | Two-step process of disclosure | “I will follow doctors’ rounds in the morning. Then I will integrate ACP in the part of the rounds of the patients that we see. We do face patients who are ready or not ready with ACP. So for not for those who are not ready we won’t force them. But for those who are actually ready to talk about it, we will actually ask them to think about what … they want” Female nurse (FGD12NU2, quote 2.4) |
|                                     |                                 | of a terminal diagnosis       | “Sometimes is like you know, is not breaking the news, but they already know … But they come with the hope … [of] … getting the treatment … we don’t directly need to … break the news. They already know, but just confirmation or just explaining what palliative care is. Then they will have sort of assurance that, [there is] something to offer, but not to cure … “ Female doctor (FGD10DOC2, quote 2.5) |
|                                     |                                 | Nurses emotional labor         | “I will always remember this professor that I did rounds with. There was a woman who was 86 and already treated … and then we just had a family conference and … he just very authoritatively said, “The next time it happens we will let her go.” All the family members said, “Yeah, you are correct. That is most comfortable for her”. So, somebody needs to come up and make some decisions for the family too!” Female doctor (FGD13DOC3, quote 2.6) |
|                                     |                                 | Nurses’ integration of multiple |                                                                   |
|                                     |                                 | demands on ward rounds         |                                                                   |
|                                     |                                 | Doctors’ role focused on diagnosis |                                                                  |
|                                     |                                 | and treatment of symptoms      |                                                                  |
|                                     |                                 | Relaying prognosis of          |                                                                  |
|                                     |                                 | terminal illness               |                                                                  |
|                                     |                                 | Decisions made in patients’    |                                                                  |
|                                     |                                 | best interests                 |                                                                  |

(Continued)
### Table 3. Continued.

| Themes                                      | Subthemes                                      | Minor themes                                                                 | Quotes                                                                                                                                                                                                 |
|---------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Expectations of ACP**                     | Positive psychosocial outcomes for patients    | ACP as a platform for patients to express their values and wishes to family members | “So for me, my first ACP was a success ah, ’cause I find that it has benefited the patient because this ACP session makes the patient and the family members … [have the] opportunity to sit down … to open up. Because we rarely see, I mean being Asia ah, we find that talking about death … is a taboo.” Female nurse (FGD6NU2, quote 3.1) |
|                                             | Resolution of conflict                          |                                                                              | “To me, I find that patient and the family members … they have the same value … And family relationship, they are agreeable. So whatever thing that … the patient [is] able to ah, bring out for their family members to know that, ‘these are the areas that you are able to help me out’.” Female nurse (FGD6NU2, quote 3.2) |
|                                             | Psychosocial benefits for HCPs                  | Developing knowledge of patient                                              | “I think a relationship that is founded on trust, with the patient, somebody that they trust and it’s based on compassion, empathy, and um, the feeling that this doctor or this team “knows me”. That will go a long way.” Female doctor (FGD13DOC2, quote 3.3) |
|                                             | Documentation of patients’ wishes               |                                                                              | “The first thing why I want to try ACP is also part of the learning. And then because whenever I talk to the family members, I feel that it would help me, and at the same time help the family members because if you cannot communicate well with the family members, right, everything is not very good.” Female doctor (FGD9DOC1, quote 3.4) |
|                                             | Power relations                                 | Concerns over efficacy                                                       | “I can decide as a patient; ‘Please, make sure any last bit of chance, any last … atom of chance … Give me that chance.’ I am also entitled to that, and that must be emphasized. The only thing is, a lot of people think that, “Wah! that chance comes without pain”. But we practitioner knows … tissues don’t heal … [an], open abdomen cannot close … the public actually, [think] ‘I am sure that they did [this treatment in YouTube].’” Female doctor (FGD13DOC2, quote 4.2) |
|                                             | Need for ACP conversation support               |                                                                              | “Some of our ACP facilitators … are not social workers, neither are they nurses, you know. Some of them are psychology student who has just passed … [their course] and doing this and have no, completely no, experience with medical or healthcare related work. And then they are doing ACP. So then, how we tried to go around it is to … encourage the doctors, maybe at least the junior doctors who know the possible complications that may occur to sit in with them. Because the facilitators know the structured framework [of the ACP conversation], but the doctors don’t, and the doctors know the medical bit. So at least they can work [together] and complement each other.” Female doctor (FGD10DOC4, quote 4.3) |
|                                             | Availability                                    |                                                                              | “You have to grab the chance [for an ACP conversation] … when the family comes together, sometimes, [the] patient comes along … The first appointment if they come is ok even at the ward level. And they finish work by 6,7 right. When we want to do ACP also we have to find … out what is the best time [for us] … we skip our lunch and everything to be present but sometimes it get to be early in the morning … they [the family] have their work to do.” Female doctor (FGD10DOC2, quote 4.4) |

(Continued)
best interests”, which encompassed patients’ treatment needs and their quality of life. This concept was paradoxical as doctors were advocating for their patients’ needs through guiding their treatment; and yet, it was expected that patients should occupy the “sick role” (Parsons, 1951) in which they obediently follow their instructions. The paradoxical nature of their role ensured that they were expected to expend little emotional labor during consultation (Table 3, quote 2.6).

**Expectations of ACP**

Participants strongly endorsed ACP as they expected positive psychosocial outcomes for patients. They believed that the ACP conversation provided patients with a platform to express their values and wishes to family members. Such a platform may not be otherwise available within a cultural climate, wherein the topic of death is rarely approached (Table 3, quote 3.1).

Within ACP discussions, respondents hoped to resolve conflict between patients and family members, who may vehemently disagree on treatment preferences (Table 3, quote 3.2). Such conflict could potentially be resolved through a well-structured discussion on patients’ desired outcomes and how this could be achieved with consideration of complexities involved in their condition and treatment. Consequently, ACP discussions may potentially lead to family members willingly adhering to patients’ wishes as they understand the patient’s viewpoint and treatment needs.

Doctors believed that ACP held psychosocial benefits for HCPs as they would be informed in a timely manner of patients’ treatment preferences, enabling them to avoid the psychological stress of enacting painful and ultimately useless treatments on dying patients. The ACP discussion was also believed to offer doctors the opportunity to learn more about the patient on a personal level and, thus, develop empathy and rapport with them (Table 3, quote 3.3).

Some doctors hoped that training on ACP conversations may improve their communication skills with patients and family members (Table 3, quote 3.4), which may point to a perceived gap in medical education for doctors, in which they receive little training on softer skills (e.g., active listening). Hence, doctors may have a desire to know their patients and caregivers on a more personal level even if they do not perceive tending to their psychosocial needs as part of their role. The ACP program may offer doctors a space for developing their own personal relationship with their patients.
Finally, doctors expressed expectations in terms of implementation, positing that the ultimate outcome of the ACP conversation was to produce a clear documentation of patients’ wishes that would be executable in emergency situations (Table 3, quote 3.5). This could potentially enhance autonomy of the patient, through enabling them to later guide their treatment.

Realization of ACP

Participants experienced multiple challenges implementing the program, with the most prominent being lack of “buy-in” from senior members of staff stemming from low awareness of ACP. For instance, respondents noted they had encountered other HCPs who had “not heard of ACP”. This sometimes led to misconceptions on the purpose of ACP, including the perception that it was a form of euthanasia or being used to manage overburdened resources.

A few nurses reported that such misconceptions may have led senior members of staff to encourage them to use the ACP discussion as a platform to actively direct patients toward treatment plans that could potentially improve their quality of life through avoidance of repeat readmissions. They argued that some doctors had developed a reductive understanding of ACP, considering its purpose being to “get the DNR [Do Not Resuscitate] signed” (female nurse, FGD6NU6). Use of ACP for such purposes was often difficult to justify for these participants, who embraced the underlying philosophy of the program emphasizing respect for “what they [the patients] think they want” (female nurse, FGD6NU6).

This challenge pointed to wider structural forces within the Singaporean healthcare system that resulted in lack of communication between stakeholders (Table 3, quote 4.1). According to some nurses narratives, doctors were keen to learn about patients’ desires in terms of EoL care with a view to developing a treatment plan that could potentially improve their quality of life; and yet, were unable to enter a lengthy discussion with patients on what it should involve. These nurses were, thus, expected to engage in ACP conversations, which increased their workload as they needed to research each patients’ condition to ensure that the discussion addressed their needs. They, also, expended emotional labor through communicating complex medical information in a manner comprehensible to the patient while underlining the importance of engaging in ACP.

An additional challenge was that documentation needed to be approved by a senior doctor. A few nurses reported that doctors refused to sign documents if they believed that the treatment plan was not in the patients’ “best interests”. One nurse stated that a doctor refused to sign ACP documentation as s/he was unwilling to readmit a patient unresponsive to treatment (Table 3, quote 4.2). These incidents resulted in diverging role perceptions and interpretations of the ACP program causing tensions between layers of staff. Nurses tended to interpret ACP through the prism of their perceived role, which was to advocate for the psychosocial needs of patients and their families. Therefore, these events caused distress as it clashed with their own interpretation of the underlying philosophy of ACP and their role perception.

Reluctance to sign documentation may have pointed to power relations within acute care setting as it emanated from doctors’ own reservations on the efficacy of ACP conversations, in which they believed that patients may not have been fully informed of the consequences of their expressed wishes. They posited that patients’ medical knowledge was limited in scope, meaning that they may enter ACP conversations with little awareness of what each medical procedure may involve (Table 3, quote 4.3). Additionally, patients’ perception of medical procedures could have been skewed by media representations of HCPs that set unrealistic expectations of miraculous cures.

A few doctors were concerned that patients could leave ACP conversations without being fully informed about what each treatment required, especially in sessions facilitated by an ACP coordinator who had “no experience with medical or healthcare related work” (Female, Doctor, FGD10DDOC4). Thus, doctors may mistrust the process of the ACP conversation as it may undercut their ability to effectively advocate for patients’ treatment needs when they have not been present.

It was argued that a possible solution to this challenge could be to encourage doctors to attend ACP conversations to support the facilitator (Table 3, quote 4.4). Unfortunately, doctors were often not available for ACP conversations owing to the onerous demands of their role and logistic difficulties in setting up sessions involving all necessary parties, including HCPs, patients and their family members (Table 3, quote 4.5).

From the perspective of some doctors, ACP failed to fulfill its original promise of acting as a platform for patients to express their wishes, particularly when conversations had been conducted solely with a proxy decision maker. They were concerned for patients without family members advocating for their best interests owing to their fraught relationship. In these cases, proxy decision makers could be too estranged
from the patient to know their treatment preferences; for instance, one patient had a history of alcoholism, leading relatives to advocate for comfort care out of concern that s/he could relapse into addiction. These doctors were, consequently, concerned that one ACP conversation may fail to extricate “hidden agendas” (female doctor, FGD10DOC4) of proxy decision makers; hence, it was posited that medical decisions should be “based on patient best interest, the next interest of course, [is] family’s opinion as well. But the ultimate decision is the doctor’s” (female doctor, FGD10DOC1).

Not knowing patients’ preferences, nevertheless, caused “moral distress” (female doctor, FGD10DOC4) for medical teams, especially when proxy decision makers pushed for aggressive treatment due to their religious or cultural beliefs. In one such case, a patient and his family pushed for aggressive treatment without pain relief due to strongly held religious beliefs forbidding any treatment being withheld. These types of demands incurred “moral distress” as the patient was in a lot of pain toward the end of his life. In response, the medical team enacted “social resus”, a performance of cardiopulmonary resuscitation, to appease the patients’ family (Table 3, quote 4.6).

This incident highlights actions that some HCPs may take to circumvent unrealistic demands of patients and their families. Aside from appeasing patients’ families, these performances enabled doctors to preserve their role as key decision makers within their medical teams through completing treatment which they believed served in the patients’ “best interests”. It may have, also, protected members of the medical team from further psychological trauma.

Despite challenges that participants experienced in implementing ACP, both doctors and nurses maintained that the program offered benefits for themselves and the patients if applied correctly. In these cases, the burden of “moral distress” was lifted from medical teams, who were sure that they were adhering to patients’ wishes (Table 3, quote 4.7).

Discussion

This study contributes to literature on ACP through providing insight on HCP’s experience of implementing the program in acute care settings in Asia (Jethwa & Onalaja, 2015; Johnson et al., 2016). Previous studies have suggested ACP may not be wholly applicable to Asian countries owing to death taboos and differing conceptions of autonomy (Zager & Yancy, 2011). In contrast, respondents in this study expressed enthusiasm for the supposedly ‘Western’ concepts underlying ACP, arguing it acted as a culturally appropriate platform for stakeholders to discuss EoL care.

As ACP was mostly implemented in acute care settings at the time of this study, physicians may have conceived it as a form of care planning for patients with advanced illnesses. Their initial enthusiasm for ACP was, therefore, tempered by confusion over when to shift from curative to palliative care- a few participants lacked confidence in their ability to accurately predict the terminal phase of an illness. This could be due to certain types of chronic illnesses having an unclear trajectory toward death (Boyd et al., 2010; Patel et al., 2012), such as Chronic Obstructive Pulmonary Disease. Such prognostic uncertainty was further complicated by the fact that many doctors believed that it was their duty to make decisions based on the “patient’s best interest”. Doctors, thus, seemed unsure of whether it was in the “patient’s best interest” to refer patients for palliative care, let alone ACP. These findings point to a possible gap in doctors training, which may focus on their perception of what constitutes the ‘patient’s best interest’ rather than how the patient may conceptualize it in their own terms.

There was an additional layer of confusion in terms of participants’ perceived roles within implementation. This theme was echoed across multiple studies internationally, with evidence of a distinct lack of agreement over which profession should take charge of the ACP process (Beck et al., 2017) or whether it was within the remit of a certain profession to participate in the program (Ke et al., 2015). Findings of this study highlighted that participants interpretation of the program was shaped by the organization of services (Haras et al., 2015). Respondents practiced ACP according to their perception of their role and where it was positioned within the hierarchical structure of services.

In combination, respondents’ Role Perception and Structure of Services resulted in each profession holding competing Expectations of ACP. Nurses mostly focused on potential psychosocial outcomes of ACP, while doctors aimed to learn more about the patient on a personal level and develop an executable treatment plan. The program faced challenges emanating from wider structural forces that culminated in lack of awareness or misconceptions of ACP. These misconceptions resulted in some clinicians using it as a tool to guide patients toward treatments in their “best interests”. According to nurses’ narratives these demands failed to cohere with the underlying ethos of ACP and clashed with their own role perception as an advocate for stakeholders’ psychosocial needs.
Realization of ACP clashed with doctors’ perception of their role as advocating for patients’ “best interests”. Questions were raised over the efficacy of ACP conversations when patients were not consulted on their treatment preferences due to concerns of possible ‘hidden’ intentions of family members (Beck et al., 2017). Some, therefore, believed that ACP discussions may not offer an appropriate platform for patients to make fully informed decisions on their EoL care, especially if the relevant HCP were not present.

Limitations

This is one of the few studies to seek the perspectives of HCPs engaged in the implementation of the ACP program across several acute care settings in a Southeast Asian country. A particular strength of this study’s sampling approach was that it enabled the research team to elicit the perspectives of a range of stakeholders. This study still had limitations; we did not seek the perspectives of doctors and nurses in other types of care settings (e.g., community hospitals). Furthermore, it was not possible to compare respondents’ experiences of implementation of ACP according to which acute setting they worked in as there were a limited number of FGDs. Finally, it was not possible to sample participants from all acute care settings in Singapore.

Conclusion

This study highlighted structural and conceptual factors hindering the performance of ACP in a Southeast Asian country. The most pertinent structural factor was low awareness of ACP among senior members of staff, resulting in lack of buy-in from other HCP and incorrect implementation of the program due to misconceptions. As such, these structural factors pointed to hierarchical facets within acute care settings, suggesting that future implementation of the program should focus on ensuring that senior members of staff are fully aware of ACP.

Participants’ narratives highlighted that ACP lacked clarity on a conceptual level. The underlying philosophy of ACP is to enhance patients’ dignity in death by offering them autonomy to express their treatment preferences. There remains little clarity on what the intended outcomes of an ACP program should be or which role each HCP should take. Consequently, participants drew meaning from ACP through the prism of their profession, resulting in competing expectations of possible outcomes of the program. Poor implementation, thus, resulted in the program clashing with their own role perceptions. Previous research on ACP has mostly focused on whether HCPs believe that their role should encompass ACP rather than on how their perception of their role shaped their understanding of the program and their possible role in the implementation of it. Findings on Role Perception suggest that nurses might be best suited to roles associated with advocacy and referral to ACP services as they often advocate for patients’ and their families’ wellbeing. Meanwhile, doctors could potentially support ACP discussions through offering advice on how to realize patients’ wishes.

These findings not only offer insight into areas in need of improvement in implementation of ACP within a Southeast Asian country, but, also, highlights possible new avenues of research and intervention development to enhance the practice of ACP overall. Structural factors hindering implementation could be addressed through adding components to ACP that enable interprofessional collaboration through medical education programs (Bridges et al., 2011; Scarvell & Stone, 2010) and open platforms. Meanwhile, conceptual factors could be tackled through ensuring that roles and intended outcomes of ACP have sufficient grounding in theory and evidence. Hence, future ACP programs could follow the Medical Research Foundation’s framework for developing and evaluating complex interventions, which offers guidance on how programs can be established through the identification of relevant evidence and theory (O’Cathain et al., 2019).

Acknowledgements

This study was made possible through the hard work of members of our research team, including Mr. Wong Lok Hang, who assisted in the collection of data. Our research team also received assistance in participants recruitment from on-site Principal Investigators attached to several tertiary-level hospitals, including: Changi General Hospital, Tan Tock Seng Hospital, KK Women and Children’s Hospital, National Heart Centre, Khoo Teck Phuat Hospital, National University Hospital and Singapore General Hospital. Finally, we would like to acknowledge the vital contribution of study participants, who kindly shared their experiences of implementing the ACP programme.

Funding

This study was funded by the Agency for Integrated Care Singapore, which received public funding from the Ministry of Health of the Singaporean Government. The funder has played no role in the study design, collection, analysis or interpretation of data, or preparation of the manuscript.
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