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Knowledge to advance planning decisions: The role of primary care medical staff

José M. Jiménez-Rodríguez
Servicio Andaluz de Salud. Distrito Sanitario Córdoba y Guadalquivir (España)

Objectives: Determine the knowledge, attitude and level of vital advance planning will medical staff in primary care, and identify associated factors. Material and method: Type of study: Cross-sectional study. Study population: Physicians of 15 Clinical Management Units at Cordoba-Guadalquivir Health District (Cordoba). Sampling: whose simple random sampling (*N*) was used was 150. Tools: Questionnaire on knowledge, attitudes and planning. Analysis: Descriptive statistical analyses were done. Results: The average age was 51.3 years professionals (range 25-63; *SD*=8.36) 52.7% being women. 78.7% were owners and the average (years of service) was 21.6 (*SD*=8.87). 50.7% worked in urban areas. The average knowledge score was 4.9 (*SD*=2.11). 56.8% had not read the document living will and 81.5% had not read the planning guide. 63.3% did not locate the record living will. 88.2% do not plan in the past year living will and advance planning with the patient who makes less than 1 time. And beliefs (mean: 2.88; *SD*=3.6) values seem to influence the decision. Conclusions: Few doctors plan with the patient's life, not identified independent factors associated with the study.

Keywords: Knowledge, attitude, advanced care directives, medicine, primary healthcare.

Del conocimiento a la planificación anticipada de las decisiones: el papel del personal médico de atención primaria. Objetivo: Determinar el conocimiento, actitud y nivel de planificación de la voluntad vital anticipada (VVA) del personal médico en Atención Primaria (AP) e identificar factores asociados. Método: Estudio observacional descriptivo transversal. Emplazamiento: 15 Unidades de Gestión Clínica del Distrito Sanitario Córdoba-Guadalquivir. Muestra: Médicos de AP. Muestreo aleatorio simple cuya *N*=150. Intervenciones: Entrega de cuestionario sobre conocimiento, actitud y planificación. Análisis descriptivo de los datos obtenidos. Resultados: Edad media de los profesionales 51,3 años (rango 25-63; *Dt*=8.36) siendo mujeres el 52.7%. El 78.7% fueron propietarios y la media (años de servicio) fue 21,6 (*Dt*= 8,87). El 50,7% trabajaba en ámbito urbano. La puntuación media del conocimiento fue 4.9 (*Dt*=2.11). El 56.8% no había leído el documento de la VVA. El 81.5% no había leído la guía de planificación. El 63.3% no ubicó el registro de VVA. El 88.2% no planifica en el último año la VVA y quien planifica con el paciente lo hace menos de 1 vez. Las creencias y valores (media: 2.88; *Dt*=3.6) parecen no influir en la decisión. Conclusiones: Pocos médicos planifican con el paciente la VVA, no identificándose factores independientes asociados al estudio.

Palabras clave: Conocimiento, actitud, planificación anticipada de las decisiones, medicina, atención primaria de salud.

Correspondencia: José Manuel Jiménez Rodríguez. Servicio Andaluz de Salud. Distrito Sanitario Córdoba y Guadalquivir. C/ Isla Lanzarote, s/n. C.P.: 14011. Córdoba (España). E-mail: jose.jimenez.rodriguez.sspa@juntadeandalucia.es

For decades, Spain, like many other countries of the European Union, has experimented with important advances in the field of modern medicine, pharmacology and biotechnology amongst others. The development and implementation of resources and medical care and the therapeutic practices of invasive and intrusive nature as first choice, puts on stage and makes us to think of the matter of dignified death and the right of individuals to decide about the treatment in the terminal phases of life (Street & Kissane, 2001; Broggi, 2003). Under this ethical dilemma, the necessity of a legal regulation to guarantee the measures to safeguard the rights and warranties of citizens as patients during the death process arises, when the illness is chronic and the capacity to communicate and decide disappears. From this new approach, advance directives (AD) become the tool to decide the clinical actions before death. The free and informed consent becomes the patient will regarding his/her preferences and the clinical actions to receive in the terminal phases of life, once the capacity for decision making is reduced (Diario médico, 2002). Legally, such AD arises from the judgment rulings by the Court of Minnesota (1905) and New York (1914) which recognise being able to decide about what to do with your body during the final stages of our life as a right inherent to the human being. The judgement ruling by the Supreme Court of California (case *SALGO*, 1957), grants legitimacy to the right of the individual to decide under circumstances when his more evident wishes must be considered (Requero, 2002). In Spain, and as consequence of the Convention for the protection of human rights and the dignity of the human being with regard to the application of biology and medicine (signed up in Oviedo, 1997, coming into force in the Spanish State in January, 2000), it now seems possible that anyone can express his or her will before any medical action. With the Law 41/2002 on the autonomy of patients and rights and obligations with regard to clinical information and documentation, palliative processes began to be legislated, and thus legitimised the right to clinical determination. Such regulation articles recognise the right of the patient to decide (in advance) the treatment and care to be received, according to the law *"lex artis"*. The right to a programmed assisted death far from bitter iatrogenic practices turns the AD into an alternative which the patient and all citizens can take during the illness process and the terminal phases of life (García, 1994; Nebot, Ortega, Mira, & Ortiz, 2010). Focusing on the Andalusian Autonomous Community, the law 2/1998 on Health in Andalusia, recognised decades ago the right to individual autonomy of the patient regarding his or her health status (art. 6). As consequence of the Law 5/2003 on the advance directives statement, such practice became regulated and integrated in the social services offered by the Public Healthcare System in Andalusia as another service to which any individual has a right. That provision includes the contents and format of the theoretical-conceptual and methodological procedure of this service under the current legal framework. Similarly, the Law 2/2007 on the Reform of the Andalusian Statute of Autonomy recognises citizens/patient right to express their AD

according to the current legislation (art. 20.1). The Law 2/2010 on rights and guarantees for protecting the dignity of the dying person (art. 2, 7, 8 and 9)**,** is very explicit that the patient has the right to make decisions and informed consent, refusal and termination of any treatment, as well as the right to do the AD (see table 1).

Table 1. Regulations dignified death in Spain, 2015

State	Specific legislation
Spain	Law 41/2002 on the autonomy of patients and rights and obligations with regard to clinical information and documentation.
Autonomico	Specific legislation
Andalusian	Law 2/2010 on rights and guarantees for protecting the dignity of the dying person.
Navarre	Foral Law 8/2011 on guarantees of the rights and dignity in the process of death.
Aragon	Law 10/2011 on rights and guarantees of the dignity of the person in the process of dying and death.
Canary Islands	Law 1/2015 on rights and guarantees of the dignity of the person before the final stage of his life.
Balearics Islands	Law 4/2015 on rights and guarantees for the individual in the process of dying.
Basque Country	Proposed Law to guarantee the rights and dignity of people in the final stages of his life (26/05 / 2014- in progress).

Since then the AD and dignified death process becomes part of personal and mature decision making, transferable in those cases where there isn't a capacity nor will to decide. Primary care medical professionals, specifically family doctors, have an especially relevant role in the development of the AD and the document which develops it, which can be hindered by methodological prefaces and conditionings regarding to the knowledge, attitude and involvement which those professionals might have (Hahn, 2003). Primary care offices are privileged places to asses the patient on this service and start its process. As a suitable place for empathy, proximity and good atmosphere of confidence, it can be the best place to provide an open dialog on the worries, feelings, preferences, values, etc. of the citizen/patient who wants to state his or her AD (Markson, Clark, Glantz, Lamberton, Kern, & Stollerman, 1997). Several lustrums of cohabitation with the AD invites us to reflect on what the health professionals think, especially family doctors, about a healthcare practice widespread in all the national territory. So as to reach our goal, an analysis based on the degree of knowledge, attitude and planning level of the AD of this group of professionals is necessary, and also explore in depth other variables (beliefs, values: morale) which can have an effect on the actual development of the advance decision making in the primary healthcare field.

METHOD

Multicentre observational cross-sectional study. The study population consists of health professionals: primary care doctors connected to the Health District of Cordoba and Guadalquivir in the province of Cordoba. 15 of the 20 Clinical Management Units attached to such Health District (see table 2) were taken as reference. Whose simple random sampling (*N*) was 150 individuals was used. The inclusion criteria were considered to be on active service and with more than one year of service in the Andalusian Health Care System during the data collection period (year 2014). A questionnaire about knowledge, attitude and planning of the advance directives was provided so as to reach the goal of the study (Jiménez, 2015). The independent variables were sex, age, work place/field, type of contract and service years. The three dependent variables were the knowledge, attitude and planning of the decision making. These were measured by the 17 items which make up the questionnaire with a numeric scale (0-10) as well as dichotomous replies (yes/no, Dk/Da). Data were interpreted by a descriptive statistical analysis by means of frequency distributions, percentage, maximum and minimum, mean and typical deviation. Such analysis was made by using the software SPSS version 19.

Table 2. Clinical Management Units (CMU) attached to such Health District/ Professional percentage of study participants, 2014

CMU	Frequency	Porcent	Valid Percent	Cumulative Percen
Fuente Palmera	8	5.3	5.3	5.3
Palma del Río	17	11.3	11.3	16.7
Posadas	11	7.3	7.3	24.0
La Carlota	10	6.7	6.7	30.7
Montoro	12	8.0	8.0	38.7
Sector Sur	13	8.7	8.7	47.3
Guadalquivir	9	6.0	6.0	53.3
Poniente	3	2.0	2.0	55.3
Santa Rosa	11	7.3	7.3	62.7
Aeropuerto	10	6.7	6.7	69.3
Castilla del Pino	13	8.7	8.7	78.0
Lucano	7	4.7	4.7	82.7
Azahara	10	6.7	6.7	89.3
Bujalance	9	6.0	6.0	95.3
La Sierra	7	4.7	4.7	100.0
Total	150	100.0	100.0	

RESULTS

The average age of the professionals was 51.3 (25-63 age group; *SD*=8.36) being women 52.7%. 78.7% were the incumbents of the position and the mean (service

years) was 21.6 (*SD*=8.87). 50.7% worked in an urban environment and 49.3% in a rural environment.

Table 3. Descriptive analysis of primary care physicians regarding the numerical variables of living will, 2014

		N	Minimum	Maximum	Mean	Std. Desviation
C.1	¿What score would give their knowledge on early life will?	150	.00	9.00	4.95	2.11
C.4	¿Wishes the citizens leaving them plan their health care wishes in writing in advance vital statement will?	150	.00	10.00	7.59	2.34
C.5	¿Considers vital statement will advance a useful tool for health professionals when making decisions about a patient?	150	.00	10.00	7.60	2.29
C.6	¿You would respect the wishes of a patient in a statement early life will?	150	1.000	10.000	8.98	1.67
C.7	¿If the patient believes that appointing a representative in early life will facilitate decision-making for healthcare professionals in situations where the patient can´t speak for yourself?	150	.00	10.00	8.25	2.21
C.8	¿ You as a professional recommend their patients to do early life will?	150	.00	10.00	7.58	2.53
C.13	¿Their religious beliefs conflict with his professional practice when planning early vita will with their patients?	150	.00	10.00	2.88	3.60
C.14	¿ Do you likely do their own will in the vital early next year?	149	.00	10.00	3.02	3.28
C.15	¿Considers religion (beliefs, values) an obstacle to the patient must face when conducting their own early life will?	149	.00	10.00	4.47	3.27
C.16	¿The desire expressed by patients in early life will conflict with the dictates of his Ethics Code?	147	.00	10.00	3.24	3.39
C.17	¿In your health center information about early life it will correspond to the (social workers or administrative staff) non-health professionals?	139	.00	10.00	4.58	3.22
Age		146	25.00	63.00	51.32	8.36
Worked years		142	1.00	42.00	21.66	8.87

The average score related to the knowledge people have on the AC was 4.9 (*SD*=2.11). 56.8% hadn't read the advance directives document and 81.5% hadn't read the health care professionals hand out so as to do the advance planning of decision making. 63.3% didn't place any registration point of the advance directives in the province of Cordoba. Despite the mean on the convenience that citizens plan their medical wishes was 7.5% (*SD*=2.34) and 7.5% on average would recommend it to their patients, 88.2% didn't plan it during the last year and who did it did it at least once. Religious believes and values of doctors (mean: 2.88; *SD*=3.6) seem not to have any influence in the exercise of this planning. An average of 4.5 (*SD*=3.22) considers that in their Clinical Management Unit the patient information on AD corresponds to the Social Worker or administrative personnel (see tables 3 and 4).

Table 4. Descriptive analysis of primary care physicians regarding the categorical variables of the living will, 2014

			Frequency	Percent	Valid Percent	Cumulative Percent
C.2	¿Early life will is regulated by law in Andalusia?	No	1	.7	.7	.7
		Yes	145	96.7	99.3	100.0
		Total	146	97.3	100.0	
		DK/DA	3	2.0		
		Missing Sistem	1	.7		
		Total	4	2.7		
		Total	150	100.0		
C.3	¿Have you read the paper will advance vital Andalusia?	No	83	55.3	56.8	56.8
		Yes	63	42.0	43.2	100.0
		Total	146	97.3	100.0	
		DK/DA	2	1.3		
		Missing Sistem	2	1.3		
		Total	4	2.7		
		Total	150	100.0		
C.9	¿You have read the support guide for health professionals on early planning decisions?	No	119	79.3	81.5	81.5
		Yes	27	18.0	18.5	100.0
		Total	146	97.3	100.0	
		DK/DA	4	2.7		
		Total	150	100.0		
C.10	¿Plans with their patients (previously and in consultation) early life will?	No	127	84.7	88.2	88.2
		Yet	17	11.3	11.8	100.0
		Total	144	96.0	100.0	
		DK/DA	6	4.0		
		Total	150	100.0		
C.10 (Bis)	If yes ¿How many times in the past year?	1.00	1	.7	5.9	5.9
		2.00	4	2.7	23.5	29.4
		3.00	4	2.7	23.5	52.9
		4.00	6	4.0	35.3	88.2
		5.00	2	1.3	11.8	100.0
		Total	17	11.3	100.0	
		Missing Sistem	133	88.7		
		Total	150	100.0		
C.11	¿Where registered early leaves vital willingness of patients on which plans?	Diraya/ Hª Única (*)	17	11.3	94.4	94.4
		Another Record	1	.7	5.6	100.0
		Total	18	12.0	100.0	
		Missing Sistem	132	88.0		
		Total	150	100.0		
C.12	¿Know where the provincial record of early life will?	No	93	62.0	63.3	63.3
		Yes	54	36.0	36.7	100.0
		Total	147	98.0	100.0	
		Missing Sistem	3	2.0		
		Total	150	100.0		

(*) Computer program.

DISCUSSION

Advance directive and the matter of dignified death are a priority for the public policies and health systems that, in a context of legitimacy and respect for the patient's right, make an effort to protect and safeguard the same implementing laws of punitive nature to the clinical practice (Seoane, 2006). Announced and implemented as another service of the ones offered by the Andalusian Health Care System, it remains within the reach of any citizen who requires it (Méndez & Carretero, 2015). The primary care doctor might be considered a key element to put this service into operation as he is who can provide complete and comprehensive information on the development of an illness. There are many scientific researches which show the favourable attitude of family doctors regarding the AD and its document, although just few begin an AD planning together with the patient (Flordelís, 2008; Altisent, 2013). Among the problems stated by the mentioned professionals are the following: the lack of information, ignorance about AD regulations and its content, as well as other limitations related to the ethical dilemma and conflict (Simón et al., 2008; Champer, Caritg, & Marquet, 2010; Jimenez, Huertas, Gómez, Fajardo, & Valverde, 2013; Contreras, Rivas, Castilla, & Méndez, 2015; Fajardo, Valverde, Jiménez, Gómez, & Huertas, 2015). The AD knowledge or discernment is an effective tool to address an issue which should be started in the teaching programme of the social-health area university degrees, and more specifically in the field of ethical and moral philosophy (bioethics). This investigation shows that less than half of the participants have read the AD document, being the mean regarding the AD knowledge less than 5. Despite the fact that family doctors feel convenient that patients plan their health care and the vast majority would recommend their patients this planning, only 11.8% of these professionals has planned AD at the medical office during this last year. Likewise, it has been proved that less than 20% of participants have read the health care professionals hand-out so as to do the advance planning (published in Andalusia in the year 2013), which makes us think about the lack of skills in order to deal with the matter as one of the causes for the low number of advance directive planning done. All this, together with the ignorance of the AD registration points, which prevents the doctor from establishing referrals and compensating deficiencies caused by the lack of discernment of the document and its hand out, highlights the training and motivation of these primary care professionals as the solution to such deficiency (Valle et al., 2009). A positive attitude regarding AD as well as the absence of discrepancies among the segmentation variables in our research, make us think of the culture, knowledge and other organisational components (response time in primary care office, clinical delay) as possible elements responsible for the AD planning during 2014. Due to the reduced number of planning family doctors do, a further training and information and an increase in the level of awareness of these

professionals are clearly necessary, which allows the AD expansion and consolidation (Louhiala, Hilden, & Palo, 2004). From the Andalusian Health Care System, it is essential an action based on formative and awareness-raising guidelines that would guarantee the stimulus and success of a service offered in Spain lustrums ago, and which is recognised as an inherent right of citizens. Not identifying independent factors associated to the research such as beliefs and values (religion) or the same Deontological Code these professionals follow, it is necessary to carry out new researches to determine other possible factors associated to AD planning.

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