Will Outpatients Complete Living Wills?
A Comparison of Two Interventions

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Objective: To test the efficacy of two intervention methods that aimed to increase the percentage of adult clinic patients who completed living wills and placed them on file with their physicians within a four-month period.

Design: There were one control and two intervention groups. Surveys were separated by age and gender categories and randomly selected for the final sample.

Setting: The internal medicine outpatient clinic of a large tertiary hospital.

Participants: All patients who visited the clinic were asked whether they would be willing to fill out a survey. The final sample included 167 adult patients who comprised three study groups.

Interventions: The first intervention relied solely on a booklet that described the Minnesota Living Will Act, general information concerning advance directives, and medical interventions that could be considered extraordinary if used for a patient in a terminal condition. The second intervention relied on both the booklet and repeated physician-initiated discussions with the patient about the probable value of a living will.

Main results: The booklet/physician intervention was found to be significantly more effective than either the booklet-only intervention or no intervention (p < 0.05 and 0.01, respectively).

Conclusions: The physician intervention used in this population could be undertaken in any primary care clinic. Time spent in discussion before a crisis may be significantly shorter and qualitatively better than time spent in discussion with families who must make decisions during a crisis.

Key words: living wills; advance directives; declaration to physicians; terminally ill. J GEN INTERN MED 1991; 6:41-46.

Many journal articles have encouraged physicians to discuss with competent patients their preferences about future health care in various clinical situations that might develop.1-8 Because patients and health care professionals may use ambiguous terms such as "life support" or "heroic measures," clinicians are advised to initiate discussions in which they help patients to articulate their wishes more specifically. Such discussions have been noted to be particularly important for elderly patients and those with chronic life-threatening illnesses who may become incompetent and unable to participate in treatment decisions.4,9 Several studies have revealed that most patients welcome such discussions.10-12 LaPuma and Schiedermayer advise that physicians-in-training should learn how to solicit advance directives from their patients in the office. They note that "... reliable, repeated advance directives may be seen as outpatient preventive ethics for future inpatient ethical dilemmas."12 However, it appears that no investigation has evaluated the outcome of such discussions in terms of whether they result in the completion of written advance directives that specify patients' wishes for future health care.

Therefore, the purpose of this investigation was to test the efficacies of two interventions that aimed to increase the percentage of adult clinic patients who completed a Minnesota living will and placed it on file with their physicians within a four-month period.

The Adult Health Care Decisions Act passed by the Minnesota legislature in the spring of 1989 provided a suggested form for a health care declaration/living will. This document provides the declarant with an opportunity to specify types of health care wanted and not wanted, general care instructions, and a proxy to communicate instructions in the event of a terminal condition and the inability to communicate personal instructions, as well as specific instructions concerning the use of food and fluids in a terminal condition. The written document is then determined to be effective when it is properly witnessed and the declarant becomes unable to make health care decisions and is in a terminal condition defined by the legislature as "... an incurable or irreversible condition for which the administration of medical treatment will serve only to prolong the dying process."

METHOD

A quasi-experimental design was used that included one control and two intervention groups. Demographic data were collected for three weeks for each study group by enrolling consecutive patients at the times of clinic visits until gender and age categories were filled or the three-week period ended.

This study was conducted in a Minneapolis internal medicine outpatient clinic in a large tertiary hospital in which 22 internal medicine residents practiced. During a one-hour in-service, participating residents and nurses were educated in the purposes and design of the study by an internist who directed the clinic and served

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as co-investigator of this study. The residents were then oriented to the Minnesota Adult Health Care Decisions Act, including the Health Care Declaration suggested format. In addition, they were given specific suggestions regarding initiating and conducting discussions of advance directives with their patients. During the enrollment period, all patients who visited the clinic were told by the receptionist or intake nurse that the clinic was participating in a study regarding patients' concerns about health care and illness. Patients were asked whether they would be willing to participate in the study by filling out a survey.

The survey consisted of demographic questions and an eight-item fear-of-death scale. The Leming Fear of Death Scale assesses eight dimensions of death anxiety. However, for purposes of this study, only the three subscales that we hypothesized would be most clearly related to health care decision making were utilized: fear of indignity, fear of dependency, and fear of pain. The scale had been previously determined to be valid in terms of measuring death fear. In this study internal consistency for these three subscales was 0.80. Furthermore, the survey asked whether patients had discussed with their families and/or physicians their wishes concerning future medical treatment that might be necessary under various circumstances. It also asked whether they presently had a completed living will. General questions concerning health care were added to act as distractors to the questions concerning living wills. Completion of the survey represented the day of entry into the study.

A researcher-designed booklet that included a ready-to-use copy of the Minnesota living will was given by the intake nurse to the participants in intervention groups 2 and 3 on the days of entry into the study. The intake nurse encouraged patients to read the booklet and to direct further questions to their physicians. Furthermore, they were encouraged to do the following: 1) make their wishes known to family members/significant others, 2) complete the Minnesota living will, 3) present the document to their clinic physicians and 4) have the document placed in their clinic charts.

Group 1 participants (control group) did not receive the booklet. They were simply asked to complete the survey. No further intervention was given to this group. Intervention group 2 participants received the booklet, but no discussion concerning the living will was initiated by the physician. Each intervention group 3 participant received the booklet and at that visit the physician initiated a discussion with the patient about the value of a living will. In addition, the physician asked the patient to read the booklet carefully at home, to discuss it with family members/significant others, and to complete the document and return it to the clinic to be placed in the chart after discussion with a clinic physician.

During the initial four-month intervention period, any discussion initiated by a participant in any of the study groups was documented in the medical chart. During subsequent visits to the clinic, only intervention group 3 participants continued to receive prompts about the living will by the physician, who initiated a discussion at each visit until the document was received in the clinic or the initial intervention period ended. The residents were specifically directed not to initiate advance directive discussions with patients in groups 1 and 2 for the duration of the study unless deemed urgent.

The initial intervention period closed four months after the last participant had been enrolled in the study. At that time, clinic charts were reviewed. Immediately after that review, intervention group 3 participants received one further prompt in the form of a phone call, or a letter for those unable to be reached by phone. That final prompt asked whether participants were interested in making an appointment for a free clinic visit during which they could discuss and/or complete the living will with their physicians. In addition, a few questions were asked of those who were reached by phone, concerning whether participants had discussed with family members their wishes regarding health care in the event that they were ever in a terminal condition and unable to speak for themselves. One month after phone calls had been made and letters had been sent, the second intervention period for group 3 ended and the study was officially closed.

Data Analysis

The Statistical Package for the Social Sciences (SPSS-X) was used to analyze all data. When the initial