

# Advance care directives: A Herzl clinic quality improvement project

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## ABSTRACT

**Background:** Advance Care Planning has benefits for patients and is often optimal when done in the primary care setting. Unfortunately, it does not occur frequently or routinely. The goal of this project was to understand the challenges and barriers that residents at a Family Medicine training site face in initiating and discussing Advance Care Directives.

**Methods:** An online survey was conducted among 50 Family Medicine residents at the Herzl clinic. Participants were asked about their experience, their comfort level, and their challenges with Advance Care Planning discussions.

A focus group with 12 Family Medicine residents further probed, through open-ended questions, the specific challenges they have faced during Advance Care Planning and ideas to address them.

**Results:** The online survey and focus group identified that most residents perceived a lack of time, inadequate training, and poor uptake of available tools as barriers to have Advance Care Planning discussions in a community setting. Residents also felt that patients were inadequately prepared for these discussions. For improvement, most residents suggested to increase the variety of teaching modalities, to dedicate time for these discussions and to prioritize in-person discussions.

**Conclusion:** The residents in Family Medicine face many challenges and barriers to having Advance Care Directives discussions with their patients but were able to provide avenues for improvement.

## KEYWORDS

Advance care planning; Advance care directives; Family Medicine; Medical education; Quality Improvement; Physicians, family; Ethics

## 1 | INTRODUCTION

Advance Care Planning (ACP) includes the exploration of patient's values, desires, and wishes for end-of-life decisions. It also involves considering a surrogate medical decision maker in case of loss of capacity, and indicating the desired level of care and goals of treatment. ACP discussions and documentation are considered a best practice of medical care. Clearly identified and documented ACP is a priority for the Ministry of Health in Quebec, Canada. La Loi concernant les soins de fin de vie recognizes the importance and primacy of a person's clearly and freely expressed wishes regarding care, notably through the establishment of the system of Advance Care Directives (ACD). (1)

ACP has been shown to have clear benefits for patients and their families. It helps ensure that the patient's consent is respected should the patient be judged incapable of participating in treatment decisions. (2) It allows patients to have better end-of-life care, focused on improving their quality of life. (2, 3, 4) It also reduces unwanted aggressive treatments. (2, 4, 5) Clear ACD benefit patients' family members, lessening the burden of the bereavement process which can be accompanied by much guilt, anxiety, and depression if their beloved one's wishes were felt to not be respected at end of life. (2, 3)

Primary care is an optimal setting for discussing ACD with patients. (6) In many studies, the patients have stated that they prefer to have these conversations in an outpatient setting and with their primary care physician, with whom they already have an established relationship. (6, 7) This minimizes the urgent or life-sustaining treatment decisions that must be made by a physician who doesn't know the patient's values and wishes. (8) It also allows for continuing discussions that happen over time. (9)

Unfortunately, ACP does not occur regularly and frequently, particularly in an outpatient or primary care setting. (4, 6, 9) The greatest barrier brought up by family physicians include a perceived lack of time, discomfort with the topic, and a need for more training and resources. (5, 7, 9, 10, 11, 12). Barriers to ACP for patients

and their families include their reluctance to have these discussions, as well as their lack of knowledge. (7, 11)

The current literature on medical education has identified some similar barriers among resident physicians to implement ACP with patients. These include a perceived lack of time during the encounter, a reluctance to have these discussions with a healthy patient or during an acute care visit, as well a lack of training. (7, 13 14)

This quality improvement project was developed to further explore trainee's perspective on the initiation of ACP discussions with patients in primary care. The overarching objective is to understand the challenges and barriers that Family Medicine residents face when discussing ACD, and what can be done to optimize these discussions with their patients.

## 2 | METHODS

The Herzl Family Medicine Practice clinic is a McGill Family Medicine teaching unit where the mandate is to train residents in the competencies enumerated by the College of Family Physicians of Canada. One such competency is the ACP or planning for end-of-life decisions. (15) Herzl clinic trains about 50 residents who are either in their first and second year of training. Residents follow 2 home care patients in their resident patient practice throughout their 2 years of training.

The Herzl Home Care program had previously developed several resources for residents including an annual 60 minute didactic presentation, an electronic medical record (EMR)- integrated teaching algorithm tool to guide the discussion of ACD (2018), 2 different forms to document ACD ("Advance Directive Living Will" and the "Capacity and Level of Care"), and a resource page in the EMR with multiple resources on the legal procedures and implications of ACD. However, it was recognized that the ACD discussion and form was infrequently or partially documented (<10%) among our 85+ home care patients' charts.

The primary outcome of this study was to identify the challenges and barriers Family Medicine residents at the

Herzl clinic face when initiating and discussing ACD. The secondary outcomes were to identify why the resources provided were ineffective and what measures can be implemented to facilitate their use. A descriptive analysis was done for data collected through an online survey and a focus group discussion.

## 2.1 | Online survey

An online survey was developed to probe the experience of residents as well as their level of comfort with discussing ACD with their patients, whether in an outpatient or inpatient setting. (See Table 1) The survey was administered and hosted by the authors, supervised by MSc candidate Dominic Chu and project supervisor Dr. Hersson-Edery. The email invitation to participate was sent to the 50 Family Medicine residents based at the Herzl clinic. The 12 item survey used a mix of multiple-choice answers and 4-5 point Likert scales. It was available from March 24th 2021 to May 4th 2021. The survey was not pre-tested. No monetary incentive was offered to participants.

The survey began with two questions that explored the frequency and context of ACP. The third question assessed the residents' comfort in discussing ACD with their patients. The following seven questions explored the level of teaching, supervision, role modeling, and timing of ACD discussions. The twelfth question, open-ended, was about any additional comments or other barriers to discussing ACD. Finally, participants were asked if they were willing to participate in a focus group to further discuss the subject.

## 2.2 | Focus group

A 30-minute virtual focus group was organized with interested and available Family Medicine residents, to discuss the specific challenges and barriers they might have faced when having discussions regarding ACD, as well as their suggestions to facilitate these conversations. This focus group took place on May 5th 2021. Participants were invited to respond to the following open-ended questions.

1. What were your personal experiences having discussions about ACD at the Herzl clinic and what challenges did you face?
2. What are factors that made you more or less comfortable discussing ACD with your patients?
3. What resources have you used to help with these discussions?
4. What teaching modalities did you find most helpful in preparing to engage in these discussions with patients and family members? Has exposure in palliative care had an impact on your ability to have these discussions?
5. What could be done to further facilitate these discussions at the Herzl clinic? Do you feel a need for some training earlier in residency (Academic Half-Day, seminar, reading material, videos, etc.)?

## 3 | RESULTS

### 3.1 | Online survey

#### 3.1.1 | Characteristics of survey respondents

25 out of 50 residents in Family Medicine from the Herzl clinic participated in the online survey. Of those residents, 60% were in their first year of residency and 40% were in their second year of residency.

#### 3.1.2 | Experience with having ACD discussions

A total of 12 (48%) responders rarely had and 7 (28%) responders never had any ACD discussions in an outpatient context. In an inpatient context, all residents had ACD discussions at least 3 times, with 20 (80%) responders having had these discussions multiple times in rotations such as Palliative Care and Geriatrics.

### 3.1.3 | Comfort level when discussing ACD

16 (64%) residents felt somewhat comfortable, while none of them felt very uncomfortable.

### 3.1.4 | Resources available in the EMR for ACD discussions

Most residents were either not aware of the available resources in the EMR (n=11, 44%) or were aware that they were available but had never used them (n=8, 32%). 5 (20%) residents had used them and found them helpful. One resident stated that the form in Myle was "very complicated". Finally, 14 (56%) residents didn't know where to access these resources in Myle.

### 3.1.5 | Teaching and supervision on ACD

Only 4 (16%) residents responded never having received any teaching on ACD, although the majority (n=15, 60%) answered that the amount of teaching was very limited. 9 (36%) residents had received didactic teaching and 9 (36%) residents had received bedside teaching.

14 (56%) residents never had supervision while having ACD discussions with patients, although 13 (52%) of them felt that they would have the same level of comfort having these discussions regardless of supervision.

Finally, 14 (56%) residents agree that they have had limited teaching on how to conduct ACD discussions.

### 3.1.6 | Barriers to having ACD discussions

15 (60%) responders agree and 6 (24%) of them strongly agree that they don't have enough time during clinical encounters to have an ACD discussion.

As outlined in Table 2, residents mention difficulties with understanding the legal aspects of ACD and the difference with Levels of Intervention. Residents also perceived that patients were either unwilling, unprepared or surprised when residents initiated discussions on ACP and ACD.

## 3.2 | Focus Group

### 3.2.1 | Characteristics of participants

The participants for the focus group were recruited through the online survey. A total of 12 residents out of the 25 who answered the survey agreed to participate in the focus group. All the participants were in their first year of residency.

A summary of the answers collected from the focus group questions are outlined below, as well as illustrative quotes reported by residents.

1. What were your personal experiences having discussions about ACD at the Herzl clinic and what challenges did you face?

Multiple residents brought up the lack of time when in an outpatient clinical setting, the difficulty of bringing up another discussion topic in addition to the many other health issues that need to be addressed at the visit, as well as the lack of experience with these discussions in an outpatient context.

- "I tried to do a Level of Care discussion... brought it up with the patient's daughter and we planned to have an appointment to discuss this only. At the next visit other things were more urgent and it was brushed to the side..."
- "Our Herzl patients are complex at times and medical issues take up most of the time, usually not on my radar..."

2. What are factors that made you more or less comfortable discussing ACD with your patients?

Multiple residents expressed that it was not ideal to bring up this discussion during their clinical encounters via telemedicine, which was more prevalent at that time due to the Covid pandemic.

- "It was really, really awkward. When you are doing it in person it's very different. Body language is reassuring. Can't see how they are reacting, what they are thinking, if they have any questions."
- "I had to do it over the phone... it felt impersonal. It's such a vulnerable conversation."
- "I think it's not a good idea to do it on the phone."

3. What resources have you used to help with these dis-

cussions?

Some residents found the Serious Illness Conversation Guide helpful, which is introduced in hospital-based Palliative Care rotations, while others found it was too rigid. While Herzl had developed several resources in the EMR to aid ACD discussions, none of the residents had used the resources, either because they were unaware of their existence or did not find them to be useful.

4. What teaching modalities did you find most helpful in preparing to engage in these discussions with patients and family members? Has exposure in palliative care had an impact on your ability of having these discussions? The residents who had completed their Palliative Care rotation expressed having felt significantly more prepared and more comfortable addressing end of life decisions.
- *"I think what helped me most was not so much the structure, but how to bring up the topic with patients and their families..."*

Although not many residents expressed the need to have staff supervision when having this conversation, all of them said they found it beneficial to watch, at least once, an attending physician having this discussion with a patient and family members.

5. What could be done to further facilitate these discussions at the Herzl clinic? Do you feel a need for some training earlier in residency (Academic Half-Day, seminar, reading material, videos, etc.)?

Most residents expressed the need for training earlier in residency, as they anticipated needing these skills in an inpatient hospital setting rather than an outpatient community setting. Discussions around end-of-life decisions were perceived to be less prioritized in patients with stable or chronic illnesses. Many residents identified physicians outside of Family Medicine or Family Physicians working in inpatient domains of care as potential resources, rather than clinic-based physicians.

Participants commented on the desired content of additional education. Content suggestions were often related to timing of ACP discussions. Desired timing-related topics included: when to introduce

the ACP discussions in a family medicine practice, when to revisit the ACP conversation, and whether or not every home-care visit should include an ACD conversation. A few residents expressed interest in doing scenario-type activities to learn different ways to introduce the topic. A few also expressed a desire to learn some of the language that is better received by patients and encourages more openness. Finally, many residents were wondering how this documented discussion or the ACD would be transferred to the new treating team if the patient were to be hospitalized.

## 4 | DISCUSSION

The current literature is clear about the advantages of Advance Care Planning (ACP) for patients and families. People who engage in ACP are more likely to receive medical care that is congruent with their values and personal goals of care. The literature is less clear about why the engagement with ACP directives, uptake of ACP tools and discussions of ACP is low among primary care physicians and especially primary care residents.

This Quality Improvement project helped to identify the main barriers that Family Medicine residents face when having ACP discussions in an ambulatory setting and their suggestions to facilitate these discussions. This confirmed some of the findings in other studies and added to our knowledge of trainees' attitudes towards ACP, their perceptions of confidence, and barriers to ACP in an ambulatory clinical setting.

The survey results demonstrated that most residents had ACP discussions with patients during an acute hospitalized illness or hospitalization for palliative care at end of life, but very few had these discussions in an outpatient context. Much of the resources identified by residents were introduced to them in their hospital-based Palliative Care rotations. The survey and focus group results show that ACP discussions are more difficult for residents to initiate in the outpatient context compared to the hospitalized context.

Focus group discussions helped gather more details

on the specific barriers that residents faced with ACP discussions in both initiation and completion thereof. Challenges included the perceived lack of time during clinical visits, the barrier of telemedicine platform, discomfort with the initiation and maintenance of discussions as well as a poor understanding of how to make sure the ACP documentation will be honored throughout transfer of patient care.

These barriers are reflected in the literature by trainees in other programs and include perceived lack of time during a clinical encounter, the reluctance to bring up ACP discussions and a lack of a standardized process to prepare the patient for the visit. (7, 12, 13, 16) Most trainees will feel more comfortable when they have had prior exposure to ACP conversations and the opportunity to practice having these conversations. (13, 16, 17)

Despite the availability of tools and resources at Herzl, residents were largely unaware of their existence and were not adequately exposed to supervisors or colleagues modeling their use. The uptake of tools into clinical practice is a well-known challenge in clinical medicine.

This Quality improvement study adds to the literature on trainee-generated proposals for improvement of ACP implementation, especially in primary care medical education. Residents proposed various avenues including providing diverse methods of teaching on ACP, such as didactic modules, simulations, and role modeling. As many residents in this study brought up simulations and role modeling to be methods of teaching they would be interested in, it is suggested that trainees acquire communication competence with practice and feedback. (18, 19) This is reflected in other studies that support experiential teaching methods to acquire competence in ACP. Pottash et al (2020) had residents participate in education on serious illness conversation through videos and role plays, followed by a supervised serious illness conversation. (13) All of the residents reported that they found this intervention to be helpful. (13) In another study, Internal medicine residents' comfort levels were significantly improved after they participated in a simulation-based ACP discussion with a standardized patient. (20) Finally, Detering et al (2014) demon-

strated that, among general physicians and trainees, the physicians' self-confidence in having ACP discussions was subjectively improved following a multimodal educational program which included didactic teaching and an interactive patient simulation workshop. (2) Family Medicine residents suggested other practical strategies. These include that timing of discussions could be addressed with in-person, dedicated appointments. A visible reminder to initiate or complete the discussion on the electronic medical record could be helpful. Furthermore, there was a perception among residents that their patients were unprepared for or unwilling to pursue ACP discussion. A better understanding of patients' perspective on the initiation and preparation for discussions would be contributory.

One limitation of our study is the incomplete response rate among the Family Medicine residents at the Herzl clinic. Half of them answered the online survey and about 25% of them participated in the focus group. The focus group consisted exclusively of first year residents; second year residents have had a greater length of training and clinical exposure. There could also be a selection bias, as only participants with an interest in the topic might have answered the survey or participated in the focus group. The survey was released during a time when telemedicine was very prevalent at the Herzl Family Medicine clinic, which could have decreased the number of home-care visits and in-person visits where these discussions usually take place.

This study advances our understanding of the challenges that Family Medicine residents perceive in initiating and discussing ACP with their patients in the outpatient setting. Barriers included limited knowledge of existing tools and resources, a lack of variety of teaching and role modeling of the use of resources, low comfort level with ACP in outpatient settings, competing with other clinical priorities, and patient reluctance to discuss ACP.

Primary care medical education will need to employ multiple strategies to address the competence of trainees to initiate, conduct, maintain, and document ACD discussions. This quality improvement initiative study provides multiple avenues to explore and

advances our understanding of the challenges in ensuring that effective ACP is provided to individual patients, their families and the population served by Family Medicine trainees.

**TABLE 1** Online survey distributed to family medicine residents at the Herzl clinic.

1. How many times have you had an Advance Care Directives discussion in an outpatient (clinic) context?

- Never (0)
- Rarely (1-3)
- A few times (3-10)
- Multiple times (10+)

2. How many times have you had an Advance Care Directives discussion in an inpatient (hospital) context?

- Never (0)
- Rarely (1-3)
- A few times (3-10)
- Multiple times (10+)

3. How comfortable are you discussing Advance Care Directives with your patients?

- Very uncomfortable
- Somewhat comfortable
- Neither comfortable nor uncomfortable
- Very comfortable

4. How familiar are you with the resources for Advance Care Directives discussions on MYLE?

- Not at all, I'm not sure what they are
- I'm aware they're available, but I never used them
- I've used them and found them helpful
- I've used them and I found them unhelpful

5. Do you know where in MYLE you can access the Advance Care Directives documents?

- Yes
- No

6. Did you receive teaching on Advance Care Directives?

- Never
- Didactic teaching (lectures)
- Bedside teaching
- Self-teaching



7. If you have had teaching regarding Advance Care Directives, how much?

- None
- Very limited
- Moderate
- Extensive

8. Have you ever had supervision while discussing Advance Care Directives with a patient?

- Yes
- No

9. If you were supervised while discussing Advance Care Directives with a patient, would you feel:

- More comfortable
- Less comfortable
- Same level of comfort as if I was unsupervised
- I have not previously discussed Advanced Care Directives

10. I have found that I have had limited professional education on how to conduct Advance Care Directives.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

11. I don't have enough time during clinical encounters to have an Advance Care Directives discussion.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

12. Additional comments, or other barriers to discussing advanced care directives you may have encountered:

13. Would you be willing to participate in a focus group discussion on Advanced Care Directives?

- Yes
- No

**TABLE 2** Results of the online survey distributed to family medicine residents at the Herzl clinic.

Questions	N = 25 (%)
1. How many times have you had an Advance Care Directives discussion in an outpatient (clinic) context?	
Never (0)	7 (28%)
<b>Rarely (1-3)</b>	<b>12 (48%)</b>
few times (3-10)	6 (24%)
Multiple times (10+)	0
2. How many times have you had an Advance Care Directives discussion in an inpatient (hospital) context?	
Never (0)	0
Rarely (1-3)	0
A few times (3-10)	5 (20%)
<b>Multiple times (10+)</b>	<b>20 (80%)</b>
3. How comfortable are you discussing Advance Care Directives with your patients?	
Very uncomfortable	0
<b>Somewhat comfortable</b>	<b>16 (64%)</b>
Neither comfortable nor uncomfortable	4 (16%)
Very comfortable	5 (20%)
4. How familiar are you with the resources for Advance Care Directives discussions on MYLE?	
<b>Not at all, I'm not sure what they are</b>	<b>11 (48%)</b>
I'm aware they're available, but I never used them	8 (32%)
I've used them and found them helpful	1 (4%)
I've used them and I found them unhelpful	5 (20%)
5. Do you know where in MYLE you can access the Advance Care Directives documents?	
Yes	11 (44%)
<b>No</b>	<b>14 (56%)</b>
6. Did you receive teaching on Advance Care Directives?	
Never	4 (16%)
<b>Didactic teaching (lectures)</b>	<b>9 (36%)</b>
<b>Bedside teaching</b>	<b>9 (36%)</b>
Self-teaching	3 (12%)

7. If you have had teaching regarding Advance Care Directives, how much?	
None	2 (8%)
<b>Very limited</b>	<b>15 (60%)</b>
Moderate	8 (32%)
Extensive	0
8. Have you ever had supervision while discussing Advance Care Directives with a patient?	
Yes	11 (44%)
<b>No</b>	<b>14 (56%)</b>
9. If you were supervised while discussing Advance Care Directives with a patient, would you feel:	
More comfortable	10 (40%)
Less comfortable	2 (8%)
<b>Same level of comfort as if I was unsupervised</b>	<b>13 (52%)</b>
I have not previously discussed Advanced Care Directives	0
10. I have found that I have had limited professional education on how to conduct Advance Care Directives.	
Strongly agree	1 (4%)
<b>Agree</b>	<b>14 (56%)</b>
Neutral	7 (28%)
Disagree	3 (12%)
Strongly disagree	0
11. I don't have enough time during clinical encounters to have an Advance Care Directives discussion.	
Strongly agree	6 (24%)
<b>Agree</b>	<b>15 (60%)</b>
Neutral	2 (8%)
Disagree	2 (8%)
Strongly disagree	0
12. Additional comments, or other barriers to discussing advanced care directives you may have encountered:	
<i>"Understanding legal aspects of advanced care directions and legal jargon."</i>	
<i>"Difficult to discuss in an outpatient encounter. Some teaching on how best to have these conversations would be appreciated"</i>	
<i>"The majority of these patients are 'healthy,' and are therefore surprised to even have this conversation."</i>	

*"Patients not being ready, not having heard of them before, patient been uncomfortable with these discussions... In an inpatient setting it is a lot easier to explain the need for these discussions, whereas in the outpatient setting it is more difficult to explain the importance of these discussions."*

*"Main barrier is differentiating between Advanced Care Directives, Level of Intervention, serious illness discussion. [There is a] mandatory great teaching from pallium Canada online resources"*

*"Very complicated form in Myle"*

*"Topic rarely breached beforehand with patient. Being first time it is brought up, patient often reluctant to make decision right away."*

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