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Advance Directive Communication: Nurses' and Social Workers' Perceptions of Roles

Kathy Black, PhD, MSW, MSG, MPH

As a facet of advance care planning for future health care, advance directive communication represents an important aspect of professional health care practice with older patients. Nurses and social workers routinely discuss advance directives in acute care settings; however, communication practices by discipline are not well understood. This qualitative study explored differences in advance directive communication practices by comparing and contrasting nurses' and social workers' perceptions of their roles. Focus group interviews were conducted with nurses (n = 6) and social workers (n = 5). Five key themes emerged from the data. Findings suggest that both professions perceive primary educational roles, though their

informational practices differed in content. The professionals reported differential pathways that led to their practices with patients. Both disciplines identified advocacy roles with families and providers. The practitioners reported distinct roles with families. There was mutual recognition of interdisciplinary roles. The findings suggest that nurses and social workers engage in both parallel and complementary advance care planning practices with their patients.

Keywords: advance directives; interdisciplinary teams; professional communication; older adults; advance care planning

Advance directive communication is an important aspect of professional health care practice with older patients. As a key component of advance care planning, advance directives represent a formal representation of advance treatment desires in the domain of health care. Advance directive communication between health care professionals and patients is common practice in American hospitals as a result of the Patient Self-Determination Act (Pub L No. 101-508),¹ and research suggests that nurses and social workers frequently engage in advance directive communication with their older patients in the acute care setting.² Distinct areas of practice include initiating the topic, disclosing information about the directives, facilitating reflection regarding the selection of a surrogate decision maker, eliciting the patient's values, discussing treatment options, interacting

with family and significant others, and collaborating with other health care professionals. As primary disciplines involved in advance directive communication, nursing and social work practices are not well discerned. This qualitative study was undertaken to compare and contrast nurses' and social workers' perceptions of their roles in advance directive communication with hospitalized elders. The study focused on practices with older people because elders are hospitalized at higher rates than other age groups³ and practitioners may be more likely to engage in advance care planning for future medical decision making as a result of elders' health needs.

Advance Care Planning and Advance Directive Communication in Nursing and Social Work

Advance care planning for health is highly regarded by the disciplines of nursing and social work; both professional associations underscore the role of practice in this area. As a core principle, the American Nurses Association's *ANA Code of Ethics for Nurses With Interpretive Statements*⁴ and the *National*

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*Association of Social Workers' Standards for Social Work Practice in Palliative and End of Life Care*⁵ emphasize the importance of supporting patient self-determination and decision making. Discussions regarding advance directives enhance autonomy by informing patients and promoting understanding and reflection regarding future care desires. Thus, nurses' and social workers' advance directive communication practices illustrate how both disciplines engage in dialogues and interactions with patients to promote advance care planning for health. Although the documents themselves represent a limited measure of advance care planning,⁵ professionals' perceptions of their roles in advance directive communication are likely to reveal the processes involved in their broader advance care planning practices.

Mounting research regarding professional practice suggests that both disciplines have important roles in advance directive communication.^{2,6-13} Nurses are involved in patient education and advocacy regarding advance directives,^{7,8} initiate advance care plans,¹⁰ and influence care planning among their patients.^{9,11} Social work interventions have been instrumental in older adults' execution of advance directives,¹⁴⁻¹⁷ and in one study, clients identified social workers as the preferred staff member to discuss end-of-life family planning issues.¹² Social work skills have been found to be useful in helping people understand advance directives,¹³ and social workers appear to be well qualified to discuss advance directives, possessing moderate to high levels of knowledge about the directives, and holding positive attitudes about policies that require the documents to be discussed.¹⁸ Although research suggests parallel advance directive communication among nurses and social workers, differential practices between the disciplines are not well understood. To enhance knowledge in this area, this study sought to explore differences by comparing and contrasting nurses' and social workers' perceptions of their roles.

Method

Design

The conceptual framework underlying the study was based on role theory, professional socialization literature, and the vast body of research regarding advance care planning and advance directive communication. The study utilized a qualitative design to elicit the subjective detail needed for this

exploratory research. Focus group methodology was employed to best meet the study's purpose, which was based on perceptions by discipline and not by individual practitioner. Because the research involved the professions of nursing and social work, a nurse and a social worker were involved in the research process. The research team was experienced in acute health care research and qualitative methods. Both perspectives helped ensure that the study design and analysis would not be dominated by a single perspective.

Measures

An interview guide, based on focus group methodology, was used to elicit practitioners' perceptions.¹⁹ Consistent with focus group protocol, the semistructured interview guide included opening, introductory, transition, key, and ending questions.¹⁹ The key question posed to the focus group participants was "Do you see yourself, as [nurse or social worker], having a role in advance directive communication with your older patients?" Participants were encouraged to reflect upon their past personal experiences. Probes were used to elicit participants' views regarding specific practices. An example of a specific probe used was "As you recall your experiences with your patients, can you tell me how your conversations with patients typically began?" After summarizing the study's purpose and focus group responses, an ending question was posed to elicit participants' final thoughts. The focus group interview guide underwent minor wording revisions after pilot testing in the field with acute-based nurses and social workers. The tool and the study received institutional review board approval from the hospital and the university.

Sample

The purposive sample for the focus groups was obtained from a moderate-sized (450-600 bed) acute care facility that was part of a large integrated health care system located in the northeastern United States. The participants were intentionally selected from practice areas with high volumes of older patients, including cardiology, oncology, neurology, orthopedics, respiratory, and intensive care. The study required that the participants be experienced in order to reflect on their roles and advance directive communication practices. After their work experience and status of registered nurse or bachelor/master of social work had been ascertained,

practitioners were invited to participate in the focus groups.

Procedures

The focus group interviews were conducted by the study's primary researcher (KB). Each group lasted approximately 60 minutes. Informed consent was obtained. The focus groups were audiotaped, and the tapes were transcribed and entered into ATLAS.ti.²⁰ Translated from its German title, ATLAS.ti refers to "archive for technology, the life world and everyday language." ATLAS.ti is a software program used for text interpretation and the management of textual data.

Data Analysis

Data analysis was conducted using qualitative approaches. After initial transcription, tapes and content were checked twice for accuracy. The transcripts were examined for significant and recurring themes using the grounded theory approach described by Glasser and Strauss.²¹ This approach involved stages of coding or categorizing the qualitative responses.²¹ To begin the process, the transcripts were read several times, and line-by-line open coding of the transcripts was performed. Key words such as "information" and "health care proxy" emerged during this preliminary analysis. Subsequent reviews of the text and initial codes led to the establishment of additional coding categories by discipline. Data were sorted by coded text and examined for patterns of association such as "communication involving families." Themes relating text both within and across groups (nursing and social work) were identified, and each participant's comments were reexamined verbatim. Findings were shared with a nurse and a social worker participant of each focus group as a source of member checking to enhance trustworthiness of the data.

Results

Focus Group Participants

Two focus groups were conducted: 1 for nurses (n = 6) and 1 for social workers (n = 5). Overall, the participants represented a seasoned group of professionals, with ages for nurses ranging from 39 to 63 years and for social workers from 28 to 51 years. Years of experience for nurses ranged from 15 to 40 and for

Table 1. Participant Characteristics

Characteristic	Nurses (n = 6)	Social Workers (n = 5)	Total (N = 11)
Age			
Mean	49.0	38.8	43.5
SD	8.80	9.62	10.22
Range	39-63	28-51	28-63
Years of experience			
Mean	26.2	14.5	19.8
SD	9.07	10.60	11.24
Range	15-40	3-30	3-40
Gender, %			
Female	100	100	100
Religion, %			
Catholic	100	66.7	81.8
Jewish	0	33.3	18.2
Ethnicity, %			
Caucasian	100	83.3	90.9
Non-Caucasian	0	16.7	9.1
Education, %			
Bachelor's degree	20.0	16.7	27.3
Master's degree	80.0	83.3	72.7

social workers from 3 to 30. All the participants were female. The composition of ethnicity and religion among the sample reflected the predominant characteristics of practitioners in the region (see Table 1).

Perceived Roles by Discipline

The goals of the analysis were (1) to illuminate understanding regarding nurses' and social workers' perceptions of their roles in advance directive communication practices and (2) to compare and contrast similarities and differences between professionals' perceptions of their roles. Consistent with the exploratory and inductive approach of the study, the term *advance directive communication* was defined by the participants. Consequently, participants interchangeably discussed specific documents such as the "health care proxy," aspects of advance directive decision making such as treatment options, and their experiences. Participants' roles were described through the functions, responsibilities, and tasks that they reported in their advance directive communication practices with their older patients. The analysis led to 5 key themes, which are listed in Table 2. The themes that emerged from the qualitative data will be described by illustrating commonalities and contrasting differences between the nurses and social workers. Specific examples of their perceived roles by discipline are presented in Table 3.

Table 2. Themes From Qualitative Study

Theme 1.	Primary educational roles: tailored, informational, and geared to enhance understanding
Theme 2.	Differential pathways leading to advance directive communication practices
Theme 3.	Advocates for patient autonomy with families and providers
Theme 4.	Communicating with and within families
Theme 5.	Mutual recognition of interdisciplinary roles

Primary Educational Roles: Tailored, Informational, and Geared to Enhance Understanding

The nurses and social workers emphatically reported that they viewed their primary role as that of an educator. They cited that their job was to “educate” and “inform” patients about advance directives because, in their opinion, many people were either unaware of or misinformed about the purpose of the documents. According to the participants, it was not uncommon to talk with patients that “didn’t have a clue” or were “way off” regarding the purpose of the directives. In addition, many participants cited that they frequently needed to “counter misinformation” because patients had inaccurate or incomplete information about the directives. In several cases, practitioners reported that people thought the directives were to “appoint a power of attorney.”

Both disciplines described tailoring information in response to patients’ specific needs. The nurses and social workers described individualized approaches with their patients, taking into account the patient’s health status. As noted by the nurses, “What is discussed depends on whether they have end-stage disease or are newly diagnosed,” “You [nurse] decide what to talk about,” and “We don’t go bringing up these things [directives] for someone who is coming in for [elective procedure].” Similarly, the social workers reported that “each case is different” when discussing the directives.

Social workers’ communication was influenced by the patient’s social situation. This was reflected in such comments as, “automatically worry [about surrogate decision maker] if someone lives alone,” “can be a big problem if patient’s spouse has Alzheimer’s,” “important to know about people who are in and out of the patient’s life.” According to one social worker, “If someone has children that they are close to, or live close by, and know what’s going on [patient’s health] . . . that

[knowledge of person’s social situation] helps me to talk about [choosing] a proxy [surrogate].”

Despite the similar individualized approaches with patients, there were differences by discipline regarding the foci and processes in which their educational practices occurred. Nurses’ communication tended to focus on pragmatic information. Many nurses reported providing a lot of medical information to patients in lay language such as “describing what an intervention would look or feel like.” Several nurses explicitly described that they tell people “exactly what to expect” with cardiopulmonary resuscitation (CPR) and respiratory intubation such as “pounding on ribs” and “sticking a tube down . . . throat.” According to the nurses, many people “do not really know” what will happen to them if they choose a specific treatment course such as CPR. Discussing treatments in such detail provides the patient with “the reality” of that intervention and helps the patient envision what they might experience.

Many nurses reported that doctors don’t fully address “what will happen to patients.” They reported that their (nurses’) communication is needed to help patients determine whether they “won’t survive” or “end up as a vegetable” and that their graphic depictions are needed “to give the big [comprehensive] medical picture . . . that doing resuscitation is not going to improve [patient’s] health or likelihood of dying.” The nurses viewed the detailed information that they provided to patients as critical for decision making. According to one nurse,

When we talk to patients about [treatment options], we are really, honestly, telling them . . . and they [patients] need to know [what to expect] to make really informed decisions; somebody has to tell them.

Both groups of practitioners aimed to enhance understanding among their patients. The social workers expressed addressing the “meaning” of the choices faced by patients. To help the patient comprehend the significance of advance directive decisions, many of the social workers reported needing to determine what was important to the patient. This was illustrated through such comments as “exploring the patient’s thoughts,” “asking the patient about how [treatment option] might change their life,” and “whether they [patient] ever considered [treatment option].” The patient’s quality of life was acknowledged in such dialogues. In the words of one social worker,

Table 3. Role Comparisons by Discipline in Advance Directive Communication

Role	Specific Examples	Nurses	Social Workers
Educator	• Provide general information	✓	✓
	• Tailor information	✓	✓
	By patient's health status	✓	✓
	By patient's social status	✓	
	• Explain graphic details	✓	
	• Address underlying concerns	✓	
Initiator	• Note documentation needs	✓	✓
	• Refer/screen patients	✓	
	• Most/all adult patients	✓	
Facilitator	During admission procedures	✓	
	During patient assessment	✓	✓
Advocate	• Encourage patient envisaging of treatments	✓	
	• Encourage patient reflection of decisions	✓	
	• Foster dialogue within family	✓	
Liaison with family	• Discuss pros/cons of directives	✓	✓
	• Support patient desires to health care team	✓	
	• Support patient desires to family	✓	
Liaison with health care team	• Discuss selection of surrogate	✓	✓
	• Clarify family as surrogate	✓	✓
	• Inform surrogate	✓	
	• Support family coping	✓	
Liaison with health care team	• Provide input based on expertise	✓	✓
	• Report between patient, family, and team	✓	✓

If they [patient] were independent, and took care of themselves, drove, went out to eat . . . then I [social worker] can get a better idea of how much they value their life, their abilities . . . and how difficult things might be. That's what's important to the patient.

In the case of decisions involving specific treatment options, social workers' communications were similarly focused on how the patient viewed his or her choices. A social worker recalled a particular conversation with a patient:

She already had [small strokes] and was at risk of a big stroke . . . they [doctors] talked to her about a feeding tube . . . but I [social worker] wanted to know how she really felt about it . . . her beliefs about eating and artificial nutrition.

Social workers conveyed the importance of assisting patients to understand implications of advance directive decision making. This was articulated by such comments as "helping patients to think things

through" and discussing "things that mattered." The social workers reported that conversations sometimes led to issues such as "death and loss." According to the social workers, "grief issues" among patients were common and deeply felt. Identifying and addressing issues expressed by patients required time to "listen" to patients. According to one social worker, "Sometimes when they [patients] think about things that they didn't want to think about, avoided thinking about, it brings up past experiences. . . ."

Differential Pathways Leading to Advance Directive Communication Practices

To better understand the communication practices described by the professionals, the context of their interactions was explored. Although both nurses and social workers reported initiating the conversations, it was clear that there were differential pathways associated with their practices. The paths indicated

the origin of the communication between professional, patient, and family. For nurses, advance directives were addressed routinely with almost all of their patients through institutional admission procedures and routine nursing care. Social workers' advance directive communication practices were limited to patients encountered through screening or referrals that typically did not originate for advance care planning purposes.

Nurses and social workers identified distinct courses that led to their advance directive communication with patients. Nurses reported speaking with patients about advance directives as a matter of hospital policy and during nursing assessment practices. They discussed the directives routinely as required in nursing admission notes for all adult patients. During the admission process, nurses reported informing patients about their "rights" to execute the documents and hospital procedures for documentation such as "copy needed for the chart." However, many nurses reported that people "don't want to talk" about the directives during admission. As a more appropriate time to address advance directives, nurses reported conversing with patients regarding "what they would want" when performing health assessments, and particularly when noting a "change in medical status" such as "neuro[logical] symptoms in patient at risk of a stroke." It is during these interpersonal encounters when the conversation appears to occur more naturally for nurses. The nurses reported that it is a "perfect opportunity" and "makes sense" to talk about treatment options and the patient's desires during the course of patient care. Furthermore, nurses believed that they should "address" and raise likely issues based on ongoing patient assessment such as the likelihood of "vent[ilator] support for patients with respiratory distress." Nurses also reported the importance of assessing patient alertness prior to the communication, to be "careful" that the patient is "not under the influence of medication."

The nurses acknowledged the lack of significance of patient age in their practices. Many nurses reported that they discuss advance directive issues with their older patients on the basis on the patient's medical condition and not because of the patient's age. According to one nurse, there are "very healthy eighty-year-olds" and "some people in their forties with poor prognoses." Some of the health and psychological factors of older patients prompting discussions by the nurses included "poor functional status," key

medical diagnoses such as "congestive heart failure" or "stroke," and patients being "unrealistic" or "in denial" about their illness and its progression. Many of the nurses noted making referrals to social workers to "help patient work through [decisions]" when they sensed such needs among their patients.

Social workers reported that their entrées to patients regarding advance directive communication often began after they received a referral to see the patient. However the social workers noted that the initial reason(s) for the referral tended not to specify advance directive or end-of-life decision-making concerns. Instead, referrals included "any number of reasons" but typically involved discharge concerns such as "patient may be unable to return home," "difficulty coping [with deteriorating health]," or family issues such as "lacks family" and other family concerns.

Social workers indicated facilitating interactions with their patients. They described their communication practices in terms of "processes" and "relationship." They reported that their discussions occurred in the course of multiple encounters. This was illustrated through such comments as "providing initial information to begin thinking about," "coming back to see patient after they had a chance to process the information," and "allowing the patient to synthesize and spend time thinking about their options." The social workers indicated that they did not focus on advance directive discussions as a "task." The social workers acknowledged the amount of time they spent in the "process" as "time well spent." According to one social worker, "The importance of the decisions to the patient and family is enormous; life and death . . . it cannot be rushed or handled quickly."

Advocates for Patient Autonomy With Families and Providers

The nursing and social work participants reported advocacy roles in their communication practices. The participants recognized both the benefits and pitfalls of the directives in their conversations with patients. Both disciplines informed patients about the intended positive outcomes of advance directives as "tools to maintain control" and document "[patient] wishes so [wishes] can be followed." The practitioners also communicated about the consequences of not having directives, such as "family and doctor may not know [patient's] wishes," and encouraged

patients to “talk with their families and doctors” so that their wishes were expressed.

The social work participants indicated an awareness of their roles as advocates in promoting the content of the patient’s wishes with family members as well as with other health care providers. For example, social workers noted that the directives helped “families accept” patient desires. According to the social workers, the lack of the family’s awareness of the patient’s preferences is the source of “problems when the directives come into play.” In some cases “proxies [health care surrogates] do not know [they are appointed],” and at times, adult children are “not in agreement” over what their parent would have wanted or are “unaware” of what has been previously expressed. The social workers reported that clarifying this information in dialogue with the patient assists in supporting the patient’s desires to family members. In addition, the social workers spoke about “documenting” their conversations with patients so that the medical record contained both the patient’s desires and the fact that the issue (such as health care surrogate) had been broached with the patient.

Nurses reported advocating on the patient’s behalf with other providers. According to the nurses, the directives provided all staff with knowledge about “what the patient wanted.” The nurses noted that this information (patient’s desires) is a benefit to both staff and patient. The nurses felt that the directives were best addressed prior to, or early in, the patient’s hospitalization. As one nurse noted:

Having the directives in place provides direction for care . . . so that everything works smoothly. . . . We feel better as professionals advocating for a patient’s wishes if we were involved [in communications regarding the patient’s desires]. It just sets the stage for better understanding. . . . It really is a relief for staff if these issues were previously addressed.

Communicating With and Within Families

The nurses and social workers identified distinct functions in their advance directive communications with patients’ families. When discussing the appointment of a surrogate decision maker, nurses reported urging patients to “choose someone that they trust,” and when the patient identified a family member, their (nursing) “job is to reinforce that

choice.” In contrast, many social workers reported encouraging patients to question the selection of a family member as a surrogate. Several social workers reported stressing to patients to “not automatically choose a spouse or child.” Moreover, social workers reported exploring additional (nonfamily) surrogate options if the patient expressed any reservation regarding the mention of family members. Social workers acknowledged that, in many cases, a family member may not be the best choice as a surrogate “due to personal situations such as health limitations” or “their own [surrogate] issues.” One social worker recalled the following:

The patient had a daughter who was in a wheelchair and never even got out of the house herself. . . . Her daughter’s own experiences [with providers] were bad . . . she couldn’t even separate herself [her own issues] . . . was unable to do what was best for her mother . . . she was way too jaded [to serve as surrogate].

Nurses reported initiating advance directive conversations with family members serving as health care surrogates. Their communication served to confirm, clarify, and inform surrogates about the patient’s status. Upon appointment of the family member as surrogate, nurses inquired “whether the family member knows what the patient would want.” The nurses indicated a need to “touch base with” and “stay in touch” with these family members regarding “decisions that may come up.” Additionally, nurses claimed to deliberately “seek out the family [surrogate] when the patient has a poor prognosis.” Nurses reported communicating with family members serving as surrogates if patients were “unrealistic” or “in denial” about their illness to “help them view the situation more realistically.” Several nurses reported referring such cases to social workers because they (nurses) “don’t have the time” to spend with those families.

Social workers’ advance directive communication practices with families appeared to focus on family issues. Partly in response to referrals by nurses, social workers spoke of being “called in” to meet with patients whose families were “trouble” for the staff. According to one social worker, “it seems like we [social workers] are asked to ‘fix’ family problems.” The social workers felt that there was an “unrealistic” expectation placed on them in such cases, “these problems [communication between patient and family] are so long-standing . . . can’t always be resolved.” Among patients not specifically referred to be seen

regarding family issues, the social workers noted that they were more likely to communicate with families when they sensed polarity among family members, as in the following situation: "They [adult children] had different ideas about what needed to happen, nobody could agree on anything, even though they all knew [patient] was getting worse." Social workers acknowledged that some families had "difficulty coping" with the patient's condition. According to one social worker, "Many times the family member may be afraid to discuss the patient's condition . . . or that their loved one may die."

Mutual Recognition of Interdisciplinary Roles

Both groups of practitioners acknowledged the roles of nursing and social work in advance directive communication. That is, nurses identified distinct functions of social workers and social workers recognized particular expertise among nurses' practices in this area. Their perceptions indicated both common functions, shared by both disciplines of each other, as well as unique differences. Both groups of participants reported that the other performed a "liaison" role, serving as mediums to "facilitate communication" about advance directives between the patient, the family, and the team. They both felt that each discipline exemplified a "team approach" and "reinforced" previous communication from physicians and others. In interdisciplinary meetings regarding patient advance directive issues, both groups noted that each discipline was a "resource" by providing "another viewpoint" that was construed as beneficial.

Nurses perceived particular expertise among social workers as good communicators. This was illustrated through such comments as "good approaches with patients," "able to communicate with patients of all backgrounds [including those with limited comprehension]," and able to "connect with patients that were 'hard' to connect with." The nurses believed that the social workers' "specialty" was to "help patients 'work through' difficult decisions." They found the social workers "especially helpful with big families" and "better able to work with 'difficult' families," acknowledging their own (nurses') time limits to devote to such family work.

Social workers acknowledged nurses' primary role with patients. This was illustrated through such comments as "available to patients 24 hours a day," "possess relationship with patient [as a result of the continuity of their relationship]," and "greater

accessibility." As a result of the time nurses spend with patients, the social workers viewed nurses as better able "to assess advance directive needs" such as whether the patient might "end up on the ventilator." In addition, the social workers recognized the "medical expertise" of nurses such as the ability to "describe the intubation process." They thought the nurses were very "qualified to clarify medical issues" and "explain medical procedures." The social workers credited nurses with "noticing family dynamics," which might affect patient decision making regarding advance directive issues. They (social workers) also acknowledged that nurses were "very good" about referring patients to them regarding such matters.

Discussion

The findings of this study provide detailed insights into advance care planning practices as perceived by nurses and social workers. In addition to identifying their own professional roles by discipline, the practitioners recognized the expertise offered by both nursing and social work. This mutual acknowledgment between the disciplines suggests complementary practices with their patients. Although the findings do not verify dyadic practices by the professionals, their interdisciplinary approaches should be further explored. Past literature has tended to focus on unidisciplinary practices,^{22,23} yet it appears that a nursing-social work approach to advance care planning may be particularly beneficial to patients. Consider the tailored information provided by both nurses and social workers to aid patients in decision making or the benefits to patients and families when nurses clarify medical information and social workers facilitate intrafamilial communication to enhance discussions regarding advance care planning issues. Clearly, research examining the outcomes to patients' receiving both practitioners' involvement in this area is warranted.

The study revealed that practitioners perform multiple roles along a continuum of interactions with patients and families. The practitioners reported initiating the dialogue to patients through a variety of processes, prompted by key patient characteristics such as health status and social support characteristics. Although hospital procedures regarding admission, screening, and referrals may compel initial involvement by the practitioners, nurses and social workers reported tailoring their communication based on patient characteristics to enhance understanding. Educating patients regarding advance

directives and advance care planning issues represents important contributions to “informed decision making” by patients. Both professional associations underscore the role of practice in this area.^{4,5} Although advance directives are increasingly viewed as being of limited utility,⁶ it appears that communication regarding the directives enables the practitioners to advocate on behalf of the patient within the health care team and with families.

The study’s findings suggest that practitioners engage in much communication with families regarding advance care planning issues. Factors prompting professional involvement were illuminating. It appears that practitioners deal with a range of family issues, from limited comprehension of the patient’s health to difficulty coping with deteriorating medical conditions. Nurses reported “lack of time” to work with families and selectively referred patients to social workers. Social workers reported spending much time with some families and acknowledged “unrealistic expectations” in response to some referrals. Further research may illuminate specific factors that lead to referrals involving families and how meetings with families lead to successful outcomes.

Although the study has advanced our understanding regarding professional practice in this area, the research has limitations. Though this is not a goal of exploratory qualitative research, data from these practitioners may not be reflective of others in their profession. Indeed, many of their responses reflected the specific institutional practices of the site at which the participants were employed. In addition, the participants were experienced practitioners. At the participating institution, all of the professionals had patient assignments that allowed for continuity of providers. It is unknown to what extent these findings reflect the practices of those with fewer years of experience, noncontinuous patient assignments, or more varied patient populations. Comparisons of advance care planning practices with professionals employed in nonacute settings may yield additional findings of interest as well.

Conclusion

Advance care planning for future health care represents an important area of communication between patients and their providers throughout American hospitals. Although there is a growing body of knowledge regarding professionals’ advance directive communication practices,^{2,6-13} little is known about

how the practitioners view their behavior. This study explored social workers’ and nurses’ perceptions of their roles in advance directive communication with older patients. Both disciplines reported initiator, educator, advocate, and liaison roles in their communication practices. The findings underscore the importance of interdisciplinary practice and the need for future research to enhance understanding regarding communication practices in this area.

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