GPs’ attitudes to discussing prognosis in severe COPD: an Auckland (NZ) to London (UK) comparison

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Background. A palliative care approach, as used routinely in cancer, is also valid for incurable chronic illnesses such as chronic obstructive airways disease (COPD). However, a London study recently reported that general practitioners (GPs), who provide most end-stage care for COPD patients, do not routinely discuss prognosis with these patients.

Objective. To compare the views of GPs in Auckland, New Zealand (NZ) and London, United Kingdom (UK) on discussions of prognosis in severe COPD.

Method. A postal questionnaire of 509 randomly selected Auckland GPs. The questionnaire was almost identical to the UK one. Comparisons were made with aggregated statistics for the London sample as reported in published findings and personal communication with the London authors.

Results. The Auckland response rate of 56% was similar to that of the London study (55%). Most GPs in both samples stated that discussions on prognosis are necessary in severe COPD and that GPs have an important role in discussing prognosis. Smaller proportions of both samples reported usually having such discussions, although Auckland GPs (55.6%) were more likely to hold the discussions than were London counterparts (40.7%). Auckland GPs were also more likely to agree that patients with severe COPD want to discuss prognosis and that patients value these discussions. One-third of the Auckland GPs and nearly half the London GPs believe that some patients with severe COPD who want to discuss prognosis are not given the opportunity to do so.

Conclusion. Auckland GPs are more open than their London counterparts to discussing prognosis in severe COPD. There is increased scope for GPs in London to discuss prognosis with these patients. Further support is needed for GPs in both countries who do not routinely discuss prognosis in severe COPD, but consider it is necessary to have these discussions.

Keywords. Chronic obstructive pulmonary disease, communication, comparison, palliative care, prognosis.

Introduction

Patients with end-stage chronic obstructive pulmonary disease (COPD) have high symptom loads and, in the UK, frequently unmet needs for palliative care. GPs have a potentially important role in offering palliative care including open communication, based on need rather than diagnosis. This study compared the previously reported views of London GPs on discussions of prognosis in severe COPD with those of Auckland (New Zealand, NZ) GPs. In contrast to the capitation-based system of the UK’s National Health Service, NZ has operated a largely fee-for-service health system, with longer mean GP consultation lengths for booked appointments (15 minutes) than in England and Wales (7.5 minutes). However, the UK and NZ have similar prevalences of COPD and established specialist palliative services supporting general practice care.
Methods

The University of Auckland Human Subjects Ethics Committee approved the study. Primary care doctors in the Auckland region were randomly selected from a database maintained by the University’s Department of General Practice and Primary Health Care. A structured questionnaire was posted in March 2003, with three follow-ups by telephone or mail. It asked respondents to define ‘prognosis’ in relation to severe COPD, indicate the necessity of discussing the prognosis with severe COPD patients, estimate the frequency of holding such discussions, and report their views on factors influencing their discussions. Simple descriptive and inferential statistics were produced using the statistical software package, Stata Version 7.

Results

Of the 507 eligible GPs, 284 (56.0%) returned useable questionnaires. This rate was similar to that achieved in London (55.0%), as was the distribution of respondents by age, gender and practice size. However, the mean number of years worked in general practice was longer in the Auckland sample (16.3 years) than the London sample [12.6 years; difference (d) = 3.7; 95% confidence interval (CI) 2.2 to 5.2].

Auckland GPs (84.0%) were more likely than London GPs (75.2%) to agree that one meaning of prognosis is ‘what the future might look like’ (d = 8.8%; 95% CI 1.6 to 16.0) and half the GPs in each setting reported that a meaning of prognosis is ‘How long until death.’

Most GPs in Auckland (79.9%) and London (72.5%) considered discussions about prognosis ‘essential’ or ‘often necessary’ in managing severe COPD (d = 7.4%; CI −0.3 to 15.0). A third of each group expressed difficulty in starting discussions, but more GPs in Auckland (55.6%) than London (40.7%) reported ‘often’ or ‘always’ discussing prognosis with severe COPD patients (d = 14.9%; 95% CI 6.1 to 23.7).

Most GPs in both settings believed that ‘GPs have an important role in discussing prognosis’. However, Auckland GPs (90%) were more likely than London GPs (82.1%) to agree with this statement (d = 7.9%; 95% CI 1.6 to 14.2). Auckland GPs were also more likely to agree that ‘patients with severe COPD value discussion on prognosis’ (NZ 70.4% versus UK 60.4%; d = 10.0%; 95% CI 1.4 to 18.5), that most of these patients want to know their prognosis (NZ 45.0% versus UK 36.0%; d = 9.0%; 95% CI 0.4 to 17.7), and that ‘there is enough information in the GP records (including hospital letters) to discuss prognosis’ (NZ 38.3% versus UK 28.5%; d = 9.7%; 95% CI 1.3 to 18.0).

London GPs were more likely to agree that ‘some patients with severe COPD who would like to discuss prognosis do not get a chance’ (NZ 29.1% versus UK 47.4%; d = 18.3%; 95% CI −26.9 to −9.7). Auckland GPs were more likely to disagree that they find it hard to start discussions (NZ 48.9% versus UK 38.8%; d = 10.2%; 95% CI 1.4 to 19.0) and know which patients with severe COPD want to discuss their prognosis (NZ 39.0% versus UK 27.7%; d = 11.3%; 95% CI 1.4 to 19.0).

Two-thirds of both groups agreed that predicting individuals’ prognosis in severe COPD is difficult (NZ 65.2% versus UK 67.5%; d = −2.2%; 95% CI −10.3 to 6.3) and that they were more likely to discuss prognosis with cancer than COPD patients (NZ 61.0% versus UK 60.6%; d = 0.4%; 95% CI 0.4 to −8.3 to 9.1). Over half of both groups disagreed that time constraints prevent them from discussing prognosis (NZ 56.9% versus UK 53.6%; d = 3.3%; 95% CI −5.6 to 12.2). A third in each group reported difficulty starting discussions (NZ 33.0% versus UK 36.8%; d = −3.9%; 95% CI −12.4 to 4.7).

Discussion

Auckland GPs were more likely than London GPs to report both discussing prognosis in severe COPD and confidence in initiating these discussions. In both settings, however, the proportions differed significantly between those saying it is necessary to discuss prognosis and those reporting they usually do so.

Nearly two-thirds of both groups reported more often discussing prognosis with cancer patients than severe COPD patients. Compared with lung cancer, the longer and less predictable disease trajectory of COPD may increase GPs’ difficulty of determining an appropriate time to discuss end-of-life issues including prognosis.

A strength of this study is that the random sample of 507 represents over half of all GPs working in the Auckland region. Moreover, identical questions were asked of the GPs in London and Auckland. A limitation is the response rate of 56%. However, this rate is similar to that achieved by the London study.

This study took place four years after the London study, during which time awareness of the palliative care needs of patients with non-malignant disease had grown in primary and secondary health care. Together with the longer time of Auckland GPs in general practice, and different patient–doctor communication styles between NZ and the UK this may explain some differences between the samples.

Although more Auckland GPs than London GPs appear at ease in discussing prognosis, one-third of the GPs in both samples indicated finding it difficult to know which patients want to discuss their prognosis and to start such discussions. Further research is required to identify what would help GPs to discuss prognosis in severe COPD and to establish if such interventions meet patients’ information needs.
Declaration

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Ethical approval: the University of Auckland Human Subjects Ethics Committee approved the study.
Conflicts of interest: none.

References


