Why, when and how do secondary-care clinicians have emergency care and treatment planning conversations? Qualitative findings from the ReSPECT Evaluation Study

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Abstract

Background: The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is an emergency care and treatment planning (ECTP) process, developed to offer a patient-centred approach to deciding about and recording treatment recommendations. Conversations between clinicians and patients or their representatives are central to the ReSPECT process. This study aims to understand why, when, and how ReSPECT conversations unfold in practice.

Methods: ReSPECT conversations were observed in hospitals within six acute National Health Service (NHS) trusts in England; the clinicians who conducted these conversations were interviewed. Following observation-based thematic analysis, five ReSPECT conversation types were identified: resuscitation and escalation; confirmation of decision; bad news; palliative care; and clinical decision. Interview-based thematic analysis examined the reasons and prompts for each conversation type, and the level of detail and patient engagement in these different conversations.

Results: Whereas resuscitation and escalation conversations concerned possible futures, palliative care and bad news conversations responded to present-tense changes. Conversations were timed to respond to organisational, clinical, and patient/relative prompts. While bad news and palliative care conversations included detailed discussions of treatment options beyond CPR, this varied in other conversation types. ReSPECT conversations varied in doctors' engagement with patient/relative preferences, with only palliative care conversations consistently including an open-ended approach.

Conclusions: While ReSPECT supports holistic, person-centred, anticipatory decision-making in some situations, a gap remains between the ReSPECT's aims and their implementation in practice. Promoting an understanding and valuing of the aims of ReSPECT among clinicians, supported by appropriate training and structural support, will enhance ReSPECT conversations.

Introduction

Emergency care and treatment planning (ECTP) processes aim to facilitate patient-centred discussions about cardiopulmonary resuscitation (CPR), among other treatment recommendations. ECTPs emphasise patients' values and preferences in the decision-making process,[1] and may overcome ethical shortcomings and harms associated with DNACPR processes.[2-8]

In the UK, one prominent ECTP is the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), developed in 2016. The ReSPECT process is supported by the ReSPECT form, a patient-held document completed by clinicians (figure 1).[9] Designed for treatment planning conversations, the ReSPECT form prompts the inclusion of patients' values and preferences in ReSPECT conversations, and is transferrable across settings. Based on our team's freedom of information request (n=186), 22% of the acute National Health Service (NHS) Trusts that responded adopted ReSPECT by December 2019.

ReSPECT conversations aim for patients and clinicians to develop shared understandings of the patient's condition and preferences, agree on a direction of care, and make shared recommendations about treatment options, including CPR.[10] This study aims to understand how ReSPECT conversations unfold in practice, examining why, when and how clinicians enact the ReSPECT process in hospital settings.

Methods

Data collection

ReSPECT conversations were observed in six acute NHS trusts, within the first two years of ReSPECT implementation in each. Through interviews with ReSPECT implementation leads at these sites, we learned that ReSPECT implementation was accompanied by training in at least four sites. However, training was developed locally, with some offering mandatory training and others offering optional training.

Observations were designed to include medical, surgical, and orthopaedic ward areas. In the first round of observations (two sites, August to December 2017), CO, a public health researcher, shadowed consultant clinicians during ward rounds. Preliminary findings from these interviews have been published[11]. Based on these findings, the study team expanded the observational framework. In the second round (four sites, April 2019 to January 2020), KE, a medical anthropologist, observed ReSPECT conversations during ward rounds, after ward rounds or multi-disciplinary team meetings, and during afternoon visiting hours. The researchers were treated as part of the clinical team, often joining ward round groups of students and junior doctors. In one case, a doctor initiated a ReSPECT conversation because a researcher was present.

Before each observed conversation, the clinician asked the patient and/or the patient's relative(s) if they agreed for the researcher to be present; none declined. Following each observation or set of observations, the researcher interviewed the clinician, usually within 72 hours. While we aimed to interview clinicians as soon as possible, interviews were sometimes delayed due to the clinicians' and/or the researchers' work schedules. However, both the researchers and the clinicians had good recollection of the observed conversations.

Interviews explored clinicians' reflections on observed ReSPECT conversations, conversations they chose not to hold, and their experiences of the ReSPECT process.

The researcher took handwritten notes during observed conversations, later typed up using Microsoft Word. Interviews were digitally recorded and transcribed; one interview was recorded in writing, due to participant preference. The interviewed clinicians provided written informed consent. All data have been anonymised; participant IDs indicate site number, clinician number, and grade (C=consultant, M=middle-grade, J=junior).

Data analysis

Key observation data concerning each conversation were extracted onto a spreadsheet. KE open-coded 21 ReSPECT conversations, using an inductive thematic analysis approach.[12] The codes focused on the themes addressed (e.g. resuscitation, other treatments, patient's wellbeing) and on the conversations' progress (e.g. from discussion of patient's condition to discussion of treatment options).

Based on the codes, the study team agreed on five attributes to categorise ReSPECT conversations (Table 1). Using these categories, KE identified candidate conversation types. AMS, FG and CAH reviewed these and agreed on a ReSPECT conversation typology. Interview extracts in which clinicians reflected on the observed conversations were analysed thematically to examine how conversation types related to the research question: why, when and how do secondary care clinicians enact the ReSPECT process? These included nine interviews analysed in our previous publication[11]; however, the analysis presented here is new.

Findings

Descriptive findings

Forty-nine ReSPECT conversations were observed. The conversations were conducted by 34 clinicians, of whom 31 were interviewed, reaching data saturation[13]. Two hospitals used digitized ReSPECT forms. Observed conversations varied considerably in length, with some as short as 2 minutes and others longer than 30 minutes. Additional details are presented in Tables 2 and 3.

The following conversation typology was developed and applied to the observed conversations (Table 4):

1. Resuscitation and escalation: conversations whose key aim is to reach a decision relating to resuscitation and/or other elements of escalation of care (e.g., ventilation, ICU admission); these conversations could be either open (exploratory) or closed (persuasive).

2. Confirmation of decision: conversations whose key aim is to confirm with a patient and/or their relative whether they still agree with, or would like to revise, a previous ReSPECT or community resuscitation recommendation;

3. Bad news: conversations focused on delivering poor prognostic news. While recommendations relating to resuscitation and other escalation decisions are discussed, the prognosis is central;

4. Palliative / future care: conversations whose focus is on decision-making regarding future hospital admissions, care in the community, and transitioning to comfort care;

5. Clinical decision: conversations between colleagues, where only clinicians are involved.

Thematic findings

Across conversation types, three themes were identified: Planning for the possible and the inevitable; responding to organisational, clinical, and patient/relative prompts; and engaging with treatment options, patients and relatives.

1. Planning for the possible and the inevitable

Clinicians held ReSPECT conversations to plan for possible future deterioration, or to respond to deterioration in the present. These temporal divisions corresponded to the conversations' key aims.

Resuscitation and escalation conversations: planning for possible futures

Conversations whose key aim was to record a decision to withhold resuscitation (and/or other elements of escalation of care) concerned possible futures. These were usually held with elderly patients with multiple comorbidities, whom clinicians identified as at-risk for short-term deterioration.

Alongside concerns over patient benefit, resuscitation and escalation conversations aimed to record a resuscitation recommendation. An example occurred on a Friday afternoon when a doctor conducted a ReSPECT conversation because

> *if [the patient] were to deteriorate over the weekend he, you know, there'd be a much clearer plan for the on-call team...* (Site 4, C05J)

Because conversations about resuscitation and escalation were often held when patients were acutely unwell, clinicians sometimes revisited these conversations. These confirmation of decision conversations followed a possible-future framework, but aimed to confirm the patient's agreement with previously recorded decisions:

> *I double check the conversation because quite often the ReSPECT conversation has been had in a crisis… So, I think it's good medical practice to just review that decision just to make sure that they fully understood.* (Site 6, C06C)

Palliative care and bad news conversations: responding to changes in the present

Palliative care and bad news conversations were present-oriented, held in response to a deterioration in the patient's condition. Reflecting on a palliative ReSPECT conversation, a geriatrician explained that

> *…he's got a terminal diagnosis, we've exhausted all the treatment options and all our focus now is… on his symptom control. And so, the process of ReSPECT is, is the all-important question: "What's important to that patient right now?"* (Site 3, C07C)

When acute and unexpected deterioration was observed, or when a medical test/scan revealed terminal illness, the main aim of the ReSPECT conversation was to deliver bad news and plan subsequent treatment. Following a conversation where an intensivist informed a patient's partner the patient was not responding to treatment, then ascertained the patient's wishes for resuscitation, the doctor reflected:

> *The patient was deteriorating significantly. And the patient was at risk of dying that day. (…) And, you know, it was a fact-finding conversation as well to determine what the patient's previously expressed wishes may have been.* (Site 4, C02C)

2. Responding to organisational, clinical, and patient/relative prompts

ReSPECT conversations took place throughout the day: (1) during post-take ward rounds (or upon admission); (2) after the multi-disciplinary meeting (MDT/board round), when patients who needed ReSPECT conversations were identified; and (3) during afternoon visiting hours. The timing of ReSPECT conversations was sometimes linked with conversation prompts.

Organisational prompts

Hospital policies and ward initiatives prompted some resuscitation and escalation conversations. One site used a bright red reminder on digitized patient records to prompt doctors to record CPR recommendations for all patients. Accordingly, an acute medicine consultant said that asking about CPR became part of the 'mental checklist' for the post-take ward round. An acute geriatrics consultant explained that only CPR was discussed during the post-take ward round because

> *…that's clearly the thing that we're changing the banner of on the top of [the patient record system]*. (Site 6, C05C)

In palliative care conversations, organisational prompts included a patient's imminent discharge or move to another ward, hospice, or nursing home. A patient's move to another ward also prompted the observed clinical decision conversation:

> *…effectively you're going to hand them over to maybe another lead consultant or another lead team, and in the back of your mind you're thinking, "So what if they were to get more unwell again, acutely deteriorate to the point of needing to come back to Critical Care?"* (Site 5, C03C)

Clinical prompts

In most cases, the patient's condition – possible deterioration, or any significant change – prompted ReSPECT conversations. Rarely, these changes were for the better, as seen in this confirmation of decision conversation:

> *[H]e's improved in here, he's now starting to eat… he's progressing so I obviously wanted to explore the issue with him.* (Site 1, C04C)

More often, where a patient's condition had changed, this entailed a bad news conversation, usually held with some urgency:

> *[I]t was only yesterday when I, we had some developments… So at that point yesterday it looked like we need to make a decision, an informed decision with the team, care team, and the patient, and the family.* (Site 4, C07C)

Clinicians' interpretations of which patients' conditions required a ReSPECT conversation varied. Some initiated ReSPECT conversations only for end of life patients or those deemed at imminent risk of arrest. Others initiated conversations for patients with a terminal diagnosis who were not at imminent risk. For example, an acute medicine consultant held a resuscitation and escalation conversation because a gravely ill patient's admission presented an opportunity to discuss treatment planning:

> *It's not going to get better and… nobody else has done that discussion yet. And we've got patients who are quite a short time on the wards, so if we don't do it then, it probably won't happen.* (Site 5, C01C)

Patient/relative prompts

Several palliative care conversations were prompted by patients' expressed wishes to have modified or no treatment, or by relatives' requests for information. One doctor described holding a palliative care conversation in response to relatives' distress over having received no information:

> *...[the] family is very upset and they don't know what's been happening. No doctor has told them anything about it and there are no decisions [being] made about this lady at all.* (Site 3, C01M)

3. Engaging with patients and their relatives

ReSPECT conversations varied in the extent to which doctors spoke about treatment options beyond CPR, and in the extent to which doctors engaged with patients' or relatives' preferences. Paper ReSPECT forms were used to engage with patients/relatives in only six conversations. Clinicians did not ask patients/relatives if they wished to discuss ReSPECT, but rather approached them directly with the conversation.

Limited conversations beyond CPR

Many resuscitation and escalation conversations were limited to discussion of CPR, with some also including mentions of ICU or ventilation. These conversations were conducted either during ward rounds, or as quick conversations after the ward round/during visiting hours. After conducting a resuscitation-focused conversation, a doctor explained why no other treatments were mentioned:

> *The main reason for this is I didn't want to overwhelm him, you know. (…) I wasn't sure he was able to understand what ICU might have meant or all this sort of things. But he's [an elderly patient] who is stable and going home today, so it's very unlikely that he might need escalation...* (Site 4, C03J)

Similarly, after a resuscitation-focused conversation with an elderly patient, a consultant explained they only asked about CPR during the post-take ward round to mitigate patients' "*information overload*" (Site 6, C05C).

Detailed conversations about treatment options

In all palliative care and bad news conversations, and in some resuscitation and escalation and confirmation conversations, doctors mentioned treatments other than CPR/ICU, including active treatment patients will receive. An orthogeriatrician described confirming with a pre-operative patient his preference to be not-for-CPR but have active treatment:

> *I am assuming that you would allow me to give you antibiotics if you developed a chest infection, or a urine tract infection, or if you needed a bit of kidney support, some intravenous fluids. (Site 6, C06C)*

Treatment option discussions were broader in palliative care conversations, focusing on shared decisions about future hospital admissions, specific treatments to be administered in the community, and comfort care.

Persuasive conversations

In most resuscitation and escalation conversations, doctors spoke persuasively, with the goal of recording a particular treatment recommendation. For example, two junior doctors on the same ward used the same persuasive line with their elderly patients ("*CPR has a 20% chance of success in someone my age, but much lower in someone your age*" [Site 4, C08J and C09J]) – a line their peers had agreed upon as part of the ReSPECT conversation script. In another case, an acute medicine consultant asked a patient about his wishes regarding resuscitation, but immediately added that if the patient had CPR, he'd be "*so debilitated*" if he survived, "*so I would suggest not to do it*". Likewise, after mentioning ICU, the consultant said that witnessing "*these treatments would be painful for your family*" (Site 5, C01C).

Bad news conversations, despite being detailed and deeply involving the patient's relatives, could be persuasive in orientation. In two of the four observed conversations, the consultants were keen to record a DNACPR decision – an emphasis that led to conflict between the relatives and the clinicians.

Exploratory conversations

In exploratory resuscitation and escalation conversations, doctors asked open-ended questions, encouraging patients to express their wishes. In the following reflection, a consultant emphasized the patient's preference mattered most:

> *That was her wish not be resuscitated, so even if she did, she had potential for resuscitation and if that was her wish, I would respect her wish anyway.* (Site 2, C01C)

In two bad news conversations, the CPR decision was left open to the patient/relative. Following a conversation with a patient who had just received an end-stage diagnosis, the doctor explained his open-ended approach:

> *So as a doctor, it's my duty… to respect my patient decisions. Even if she comes to say to me she will like the full treatment, she wants the CPR, I, it's my duty, I'm duty-bound, it's, I'll be happy to do it.* (Site 6, C07C)

Incomplete conversations

Conversations remained incomplete when doctors and patients/relatives disagreed about treatment recommendations, particularly where doctors recommended against CPR or other interventions. We know of two conversations where disagreement was followed by a clinician offering or a relative seeking a second opinion.

In other cases, patients requested more time, or experienced distress or indecision. For example, a consultant left a blank ReSPECT form for a patient to review, after the patient said she could not believe she was unwell:

> *…it often happens over a, over a couple of steps. But, and I'd be happy to complete that process if the patient had been receptive to that. (…) I didn't feel as if I was going to be welcomed to take that further with her myself.* (Site 2, C05C)

Discussion

Through observing hospital-based ReSPECT conversations, we found the ReSPECT process is used to address a range of patients' treatment planning needs – from CPR to palliative care. However, our findings demonstrate that doctors' use of ReSPECT does not always align with its developers' intentions. While ReSPECT was designed as a universal process, most ReSPECT conversations were held with patients who were either terminally ill or at risk of imminent deterioration, and CPR remained a focus. Additionally, although ReSPECT aims to engage patients and/or their relatives, the observed conversations varied in the extent to which doctors sought patients'/relatives' views. Palliative care conversations explored patients' wishes, whereas many resuscitation and escalation conversations did not, implying differences in clinicians' mind-sets when approaching different conversation types. Moreover, some conversations were incomplete because patients/relatives disagreed with doctors' recommendations, or because of indecision or distress. Incomplete conversations highlight a key challenge for ReSPECT: how to involve patient values and preferences in decision-making, while ensuring patients and relatives have clarity about the next steps.

The wide variation in patient/relative engagement was consistent with previous studies on doctor-patient conversations in ACP, DNACPR and similar processes.[7 8] This implies not only variability in clinicians' endorsement of ReSPECT's aims and in their skills and opportunities to enact ReSPECT conversations that meet these aims, but also gaps in ReSPECT process implementation. To understand this, we draw on Normalization Process Theory (NPT), which postulates that healthcare innovations become embedded through shared meanings, clinician engagement and enskillment, the capacity of new practices to integrate into existing clinical work, and stakeholders' assessment of these practices.[14] Using NPT, previous studies found that lack of coherence, i.e., clinicians' disagreement about the purpose and value of healthcare interventions, hindered their implementation.[15 16] Our findings suggest that promoting shared valuing and understandings of patient/relative engagement is essential to ReSPECT implementation. This can be enhanced by organizational practices that support collective action, including improving ReSPECT form guidelines and prompts, promoting ReSPECT training, and auditing ReSPECT conversations and forms to establish good clinical practice.

The study has several strengths and limitations. Through grounding data collection in observations of ReSPECT conversations, the study presents an important contribution to a field where most research relies on questionnaires, retrospective interviews, focus groups, and record reviews,[5 8] and where evaluation of care planning as multi-dimensional is still

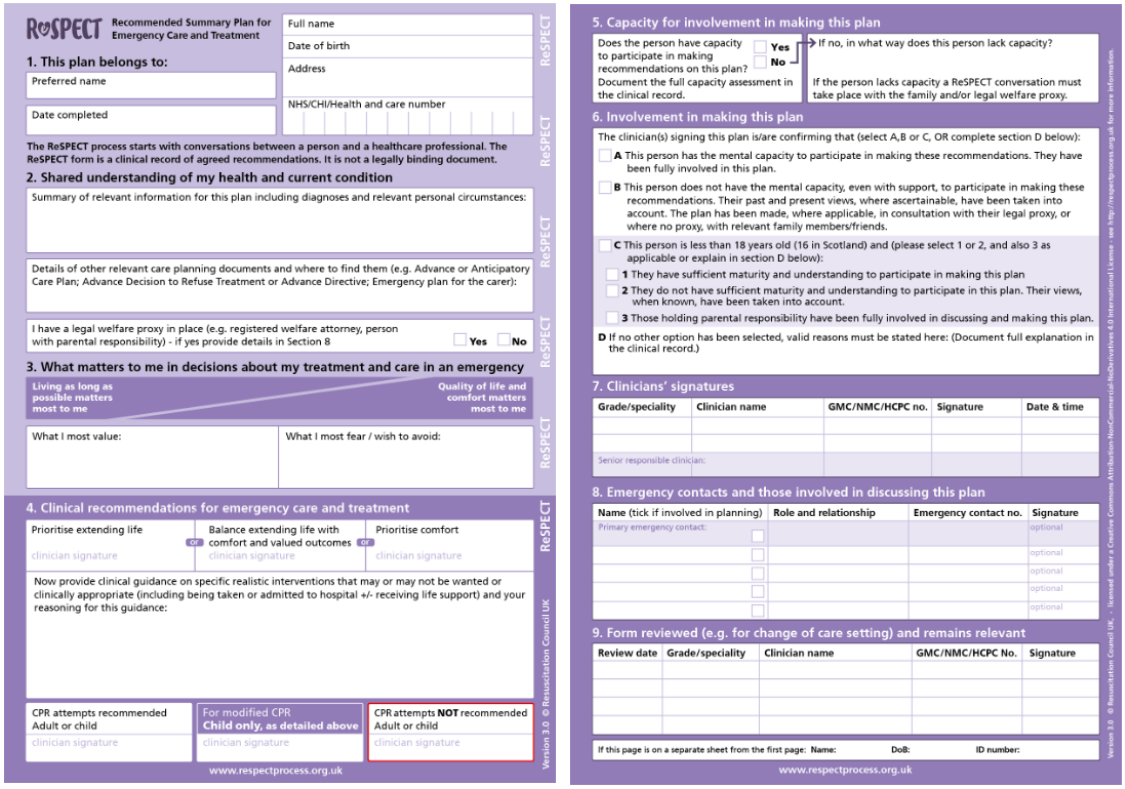
lacking.[17] By including a variety of ward areas in each site, the study identified ReSPECT conversation types in a range of clinical contexts. This contrasts with previous qualitative research on CPR-related conversations, which focused on particular settings, such as palliative care or acute medicine.[4 18 19] However, because the local site PIs selected the participating wards, acute wards predominated in some sites, while receiving wards (e.g., respiratory) predominated in others. In the first two sites, observations were limited to ward rounds, inadvertently privileging resuscitation and escalation conversations. Finally, due to the study's cross-sectional design, we could not follow up on incomplete ReSPECT conversations.

Conclusion and implications

ReSPECT is used in hospitals for different types of decision-making, from CPR to palliative care. However, doctors' use of ReSPECT does not always align with its developers' intentions. Clinicians vary in the extent to which they seek patients'/relatives' views, and in the extent to which they speak about treatment options, with CPR dominating many conversations. Moreover, most ReSPECT conversations are held with terminally ill patients or those at risk for imminent deterioration. Potential reasons for these findings include time constraints, which make clinicians more likely to focus on deteriorating patients and on CPR decisions; lack of shared valuing/understanding of ReSPECT's aims, e.g., engaging patients/relatives and conducting a holistic assessment of treatment options; and lack of sufficient ReSPECT training in implementing trusts.

Improving clinicians' understandings and valuing of ReSPECT's aims is key to the ongoing implementation of ReSPECT. This would involve a culture change in implementing trusts, with improved ReSPECT training for clinicians and the promotion of public-facing materials (e.g., leaflets) that empower patients to express their preferences. Additionally, organizational changes should be enacted, such as employing hospital-based prompts to support good practice (e.g., using audits of conversations and forms for quality improvement), eliciting patient/relative feedback to inform education, and implementing changes in the ReSPECT form, to emphasise further patient/relative inclusion and holistic assessment.

Figure 1. ReSPECT form, Version 3.0



ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name
Date of birth
Address
NHS/CHI/Health and care number

1. This plan belongs to:
Preferred name
Date completed

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition
Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ Yes ☐ No

3. What matters to me in decisions about my treatment and care in an emergency
Living as long as possible matters most to me / Quality of life and comfort matters most to me

What I most value:
What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

Prioritise extending life	Balance extending life with comfort and valued outcomes	Prioritise comfort
clinician signature	clinician signature	clinician signature

Now provide clinical guidance on specific realistic interventions that may or may not be wanted or clinically appropriate (including being taken or admitted to hospital +/- receiving life support) and your reasoning for this guidance:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

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ReSPECT

Version 3.0 © Resuscitation Council UK

5. Capacity for involvement in making this plan
Does the person have capacity to participate in making recommendations on this plan? ☐ Yes ☐ No → If no, in what way does this person lack capacity?
Document the full capacity assessment in the clinical record.
If the person lacks capacity a ReSPECT conversation must take place with the family and/or legal welfare proxy.

6. Involvement in making this plan
The clinician(s) signing this plan is/are confirming that (select A,B or C, OR complete section D below):
☐ **A** This person has the mental capacity to participate in making these recommendations. They have been fully involved in this plan.
☐ **B** This person does not have the mental capacity, even with support, to participate in making these recommendations. Their past and present views, where ascertainable, have been taken into account. The plan has been made, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends.
☐ **C** This person is less than 18 years old (16 in Scotland) and (please select 1 or 2, and also 3 as applicable or explain in section D below):
☐ **1** They have sufficient maturity and understanding to participate in making this plan
☐ **2** They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account.
☐ **3** Those holding parental responsibility have been fully involved in discussing and making this plan.
D If no other option has been selected, valid reasons must be stated here: (Document full explanation in the clinical record.)

7. Clinicians' signatures

Grade/speciality	Clinician name	GMC/NMC/HCPC no.	Signature	Date & time
Senior responsible clinician:				

8. Emergency contacts and those involved in discussing this plan

Name (tick if involved in planning)	Role and relationship	Emergency contact no.	Signature
Primary emergency contact: ☐			optional
☐			optional
☐			optional
☐			optional
☐			optional

9. Form reviewed (e.g. for change of care setting) and remains relevant

Review date	Grade/speciality	Clinician name	GMC/NMC/HCPC No.	Signature

If this page is on a separate sheet from the first page: Name: DoB: ID number:

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Version 3.0 is currently (2020) used in NHS trusts. It was revised based on feedback from early adopting NHS trusts.

Table 1. Key ReSPECT conversation attributes.

Attribute	Options
1. Central purpose	Confirm extant ReSPECT recommendation, establish resuscitation and/or treatment escalation recommendation, deliver bad news, make palliative care decisions, or establish consensus among colleagues about limitations of treatment.
2. Extent of detail	Brief (focus on CPR and/or intensive care admission only) or detailed (discussion of additional treatment options and plans).
3. Outcomes	Complete (leading to a ReSPECT form) or incomplete (ending inconclusively, or leading to an interim, partially completed ReSPECT form).
4. Directionality of conversation	Closed-ended (with the clinician employing persuasive or directive speech) or open-ended (with the clinician opening the conversation to patient/relative wishes and preferences).
5. Conversation prompts	Patient's condition, organisational prompts (hospital or ward initiative), patient's or relative's expressed wishes, or unstated/unclear.

Table 2. Observed ReSPECT conversations.

Total observed conversations	n=49
Ward areas where conversations were observed	n=12 (orthogeriatrics, respiratory, orthopaedics, renal, acute medicine, geriatrics/gerontology, acute stroke, critical care, gastroenterology and general medicine, emergency medicine, acute geriatrics, and hepatobiliary surgery)
Clinicians who conducted the observed conversations	Consultant level doctors: n=22 Middle-grade doctors: n=6 Junior doctors: n=6
Patient characteristics	Female: n=28; male: n=21 Age 80 years and older: n=32

Table 3. Ward types where ReSPECT conversations were observed.

Ward type	**Number of sites where ward type was selected**	**Number of sites where ReSPECT conversations were observed, by ward type**	**Number of ReSPECT conversations observed, by ward type (across sites)**	**Number of doctors observed conducting ReSPECT conversations, by ward type (across sites)**
Acute geriatrics	1	1	2	2
Acute medicine	5	4	5	4
Acute stroke	1	1	2	2
Colorectal surgery	1	0	0	0
Critical care	3	2	3	5
Emergency medicine	2	1	1	1
Emergency surgical admissions	1	0	0	0
Frailty assessment	1	0	0	0
Gastroenterology and general medicine	1	1	1	1
General surgery	1	0	0	0
Geriatrics/gerontology	3	2	7	6
Haematology	1	0	0	0
Hepatobiliary surgery	2	1	1	1
Orthogeriatrics	1	1	5	1
Trauma and orthopaedics	3	3	11	6
Renal	3	2	4	2
Respiratory	4	3	7	3
Total	34	22	49	34

Table 4. Observed ReSPECT conversations by attribute (1-5) and additional context (6-7).

Attribute	Observed conversations (n=49)
1. Central purpose	Resuscitation and escalation: n=31 Confirmation of decision: n=8 Palliative / future care: n=5 Bad news: n=4 Clinical decision: n=1
2. Extent of detail*	Focus on CPR and/or intensive care admission only: n=21 Discussion of additional treatment options and plans: n=27
3. Outcomes*	Complete: n=35 Incomplete: n=13
4. Directionality of conversation*	Resuscitation and escalation: n=18 closed, n=13 open Confirmation of decision: n=8 open Palliative / future care: n=5 open Bad news: n=2 closed, n=2 open
5. Conversation prompts	Patient's condition: n=30 Organisational prompts: n=5 Patient's or relative's expressed wishes: n=4 Unstated/unclear: n=10
6. Timing of conversation	During ward round/on admission: n=30 After ward round / MDT: n=8 During afternoon visiting hours: n=11
7. Conversation preceded by discussion of patient's condition, prognosis, or response to treatment*	Yes: n=36 No: n=12^

* The clinical decision conversation is excluded from these attributes as it did not include the patient and/or the patient's representative(s).

^ In n=4 conversations, the clinician called the researcher into the conversation after first speaking to the patient/relative(s), so the observation relied only on the ReSPECT portion of the conversation, and it is possible that this was preceded by discussion of the patient's condition.

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