Challenges to recognising the dying patient in the acute care setting
Perceptions of senior and newly graduated Scottish doctors

Shaun Peter Qureshi

shaun.quareshi@nhs.net
@shaunquareshi
Contents

• Background
• Aims
• Methods
• Results
• Discussion and Implications
Background

• Best practice guidelines emphasise timely recognition of dying patients and anticipatory planning e.g. (1)

• Medical doctors must be able to recognise the dying patient e.g. (2) – but this is often difficult (3)

(1) NICE. Care of the dying adult in the last days of life. 2015
(2) Parliamentary and Health Services Ombudsman. Dying without dignity. 2015
Background

- Best practice guidelines emphasise timely recognition of dying patients and anticipatory planning (e.g. (1)).

- Medical doctors must be able to recognise the dying patient (e.g. (2)) – but this is often difficult (3).

- Medical learners should develop aptitude in recognition of dying.

- This medical education study investigated challenges to recognising the dying patient in acute hospital settings.

(1) NICE. Care of the dying adult in the last days of life. 2015
(2) Parliamentary and Health Services Ombudsman. Dying without dignity. 2015
Aims

To explore challenges experienced by medical doctors when recognising the patient transition towards the dying phase in the acute care setting, focusing on:

• newly graduated doctors
• senior doctors
Aims

To explore challenges experienced by medical doctors when recognising the patient transition towards the dying phase in the acute care setting, focusing on:

- newly graduated doctors
- senior doctors

To investigate what can be learned from comparing and contrasting perceptions of newly graduated doctors and senior doctors, including potential lessons for medical educators.
Methods

Recruitment

• Invitation by recruitment e-mail
• ‘Newly graduated doctors’ – Foundation (FY) trainees
• ‘Senior doctors’ – Consultant medical staff working across acute specialties
Methods

Recruitment
• Invitation by recruitment e-mail
• ‘Newly graduated doctors’ – Foundation (FY) trainees
• ‘Senior doctors’ – Consultant medical staff working across acute specialties

Semi-Structured Interviews
• One-on-one qualitative research interviews
• Anonymous, Confidential – Pseudonyms given
• Exploring experiences of caring for patients in acute hospital settings, at times when their clinical condition deteriorated and/or they died

Thematic analysis\(^{(4)}\)

(4) Braun V, Clarke V. Using Thematic Analysis in Psychology. Qualitative Research in Psychology. 2006; 3(2):77-101
Results – FY Doctors

• 15 Foundation Doctors from across South East Scotland
Results – FY Doctors

• 15 Foundation Doctors from across South East Scotland

“Obviously the consultant knows all the facts and the figures and what’s going on.”

Perceived roles

• Work under supervision of senior doctors
• Alert senior doctors to deteriorating patients
• Do-ers, followers but not decision-makers
Fulfilling the role

‘...being the F1 I had to call. He came and he said, this is ridiculous, why on earth would you put a central line in someone who has no quality of life already?’

- Being caught in the middle
  - Different specialties
  - Between nursing and medical staff
Fulfilling the role

‘...being the F1 I had to call. He came and he said, this is ridiculous, why on earth would you put a central line in someone who has no quality of life already?’

- Being caught in the middle
  - Different specialties
  - Between nursing and medical staff

‘It took me two days to get the consultant, of me calling, and just annoying him, and he got really annoyed at me, me saying: you need to speak to the patient’

- Feeling unable to provide perceived optimal care
  - Forming own views about whether patient is dying
  - Not in position to make decisions
‘..quite often I have spoken to the medical registrar on call, who, of course, is on call quite often for huge swathes of the hospital, and quite often they’ll say, actually I don’t want to be the one to make that decision

• Making decisions in the middle of the night
• Handover, importance of plans being in place
• Poor continuity
• Documentation
Preparation

‘I think I just saw a fair few situations where they were just withdrawing care slowly.’

• Some accounts of good undergraduate preparation for recognising the dying patient
Preparation

‘I think I just saw a fair few situations where they were just withdrawing care slowly.’

• Some accounts of good undergraduate preparation for recognising the dying patient

‘It was more of a smug, a facetious answer: oh and then there’s nothing else that you can do but palliate – oh this guy clearly knows all there is to know about heart failure. Not this is a very common occurrence you need to consider it as a legitimate outcome.’

• More often recognising dying was not learned about or considered seriously during time as a medical student
Results – Consultants

• 13 Senior Doctors working in acute hospital specialties across South East Scotland
• Includes: Respiratory, Cardiology, Renal, Acute Medicine, Geriatric Medicine, General Surgery, Urology, Oncology, Intensive Care, Emergency Medicine
Results – Consultants

• 13 Senior Doctors working in acute hospital specialties across South East Scotland
• Includes: Respiratory, Cardiology, Renal, Acute Medicine, Geriatric Medicine, General Surgery, Urology, Oncology, Intensive Care, Emergency Medicine

‘Being a consultant, you are ultimately responsible for all the decisions that you take.’

Perceived roles
• Make decisions about goals of care
• Expected – by culture and by the public
• All considered themselves accessible and approachable
Uncertainty

‘I think there is a spectrum and I think that there are those that are more aggressive and those who are less aggressive, not necessarily right or wrong.’

- Consultants do not have all the answers
- Sometimes need to wait and see
- Ideally, relevant specialty should decide
  - Have to know all the options
  - Concern that some patients get dismissed
- Even within one specialty opinions vary about same patient
Influences on recognition of dying

‘When you're looking after the same patient for a long time, it is perhaps difficult to stand back and become emotionally detached and think: yes, they are dying.’

- Information gathered
- Relationship with patient
- Age of patient and social factors
- External criticism
Perceptions of Learning

‘You get to a level where there’s no further escalation for decision support and your decision is the final one.’

• No formal or explicit teaching
• Learning to take on responsibility
• Learning through experience and by example
Perceptions of Learning

‘You get to a level where there’s no further escalation for decision support and your decision is the final one.’
  • No formal or explicit teaching
  • Learning to take on responsibility
  • Learning through experience and by example

‘I think it's quite a safe default position isn't it? Because when you’ve got people who have only been qualified for a very short time they’ve not seen enough to make those decisions.’
  • Learning of juniors
  • If no senior doctor available – juniors should not take responsibility for diagnosing dying
  • Changes in medical training over time
Discussion

• FY doctors
  • Described seniors as able to know the correct course of action
  • Imagined selves as knowing what to do in the future with experience
  • Frustrating and upsetting experiences when plans were not made or communicated
  • Structure and planning of hospital and shifts can contribute to this
Discussion

• FY doctors
  • Described seniors as able to know the correct course of action
  • Imagined selves as knowing what to do in the future with experience
  • Frustrating and upsetting experiences when plans were not made or communicated
  • Structure and planning of hospital and shifts can contribute to this

• Senior doctors
  • Expressed frequent uncertainty but accepted this as a reality of medicine
  • Despite uncertainty were clear that they should be making the decisions
  • Valued subject specialty specific knowledge
  • Not purely influenced by clinical information
  • Did not provide accounts of patients experiencing poor care because of delayed decision making
Discussion

• **FY doctors**
  • Described seniors as able to know the correct course of action
  • Imagined selves as knowing what to do in the future with experience
  • Frustrating and upsetting experiences when plans were not made or communicated
  • Structure and planning of hospital and shifts can contribute to this

• **Senior doctors**
  • Expressed frequent uncertainty but accepted this as a reality of medicine
  • Despite uncertainty were clear that they should be making the decisions
  • Valued subject specialty specific knowledge
  • Not purely influenced by clinical information
  • Did not provide accounts of patients experiencing poor care because of delayed decision making

• **Potential implications**
  • Teaching and assessments at medical schools
  • Expectations of junior and senior medical staff
  • Accessibility of senior medical staff
  • Organisational factors in workplace
Summary

- Medical doctors should learn to recognise dying
- Newly graduated doctors and senior doctors perceive pressures and challenges (but different pressures and challenges)
- Implications for medical educators and service planners
  - Making expectations and responsibilities clear to all levels
  - Organisation and planning
This work was supported by an award from the University of Edinburgh Principal’s Teaching Award Scheme

This work was supported by an award of an ASME Small Grant

Images used in this presentation are owned by University of Edinburgh or otherwise from Pixabay and used under a creative commons license