Challenges to recognising the dying patient in the acute care setting

Perceptions of senior and newly graduated Scottish doctors

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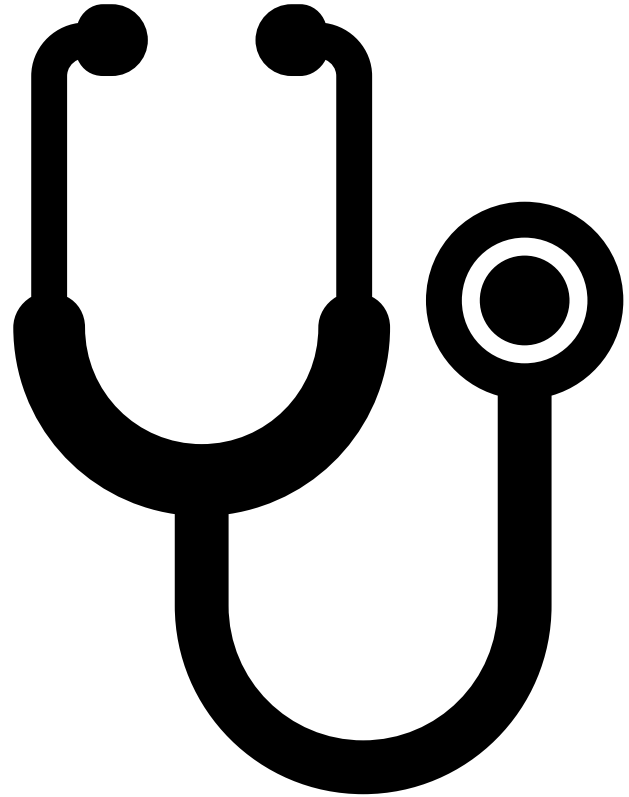

Background

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- 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
(3) Al-Qurainy R, Collis E, Feuer D. Dying in an acute hospital setting: The challenges and solutions. Int J Clin Pract. 2009;63(3):508–15

Background

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- 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

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Aims

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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**

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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

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Recruitment

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

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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

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- 15 Foundation Doctors from across South East Scotland

Results – FY Doctors

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"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

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'…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

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'…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?'

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'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

Organisation factors

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‘..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

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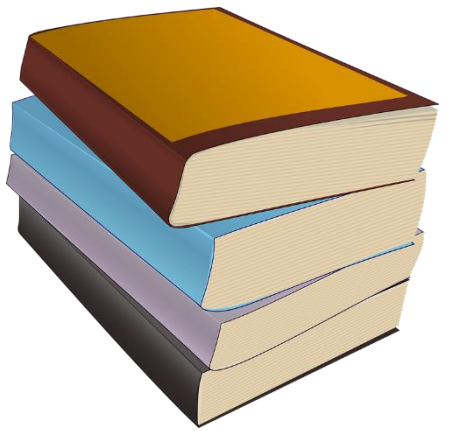
‘I think I just saw a fair few situations where they were just withdrawing care slowly.’

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



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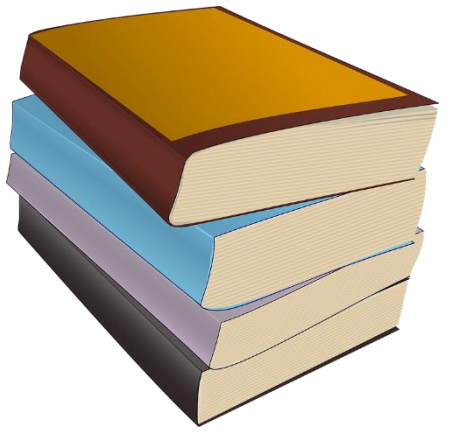
- Some accounts of good undergraduate preparation for recognising the dying patient

‘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

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- 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

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'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

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‘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

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‘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

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‘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

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'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

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- **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

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- **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

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

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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

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