Diagnosing Dying: perceptions among junior doctors in training

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RESEARCH WEEK
5-9 OCTOBER 2020
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BACKGROUND

- The Australian Commission for Safety and Quality in Healthcare recognises the importance of diagnosing dying. Recognition of imminent death is an essential first step in improving the care of the dying.[1,2]
- Acknowledging the possibility of death gives time for patients and their families to express preferences and facilitates holistic and individualised care.[3]
- In the hospital setting, recognition of death sometimes occurs late with a tendency to pursue active treatment even in the last days of life.[4]
- Providing much of the medical care in public hospitals, doctors in training are central to the diagnosis and management of dying patients.

AIM

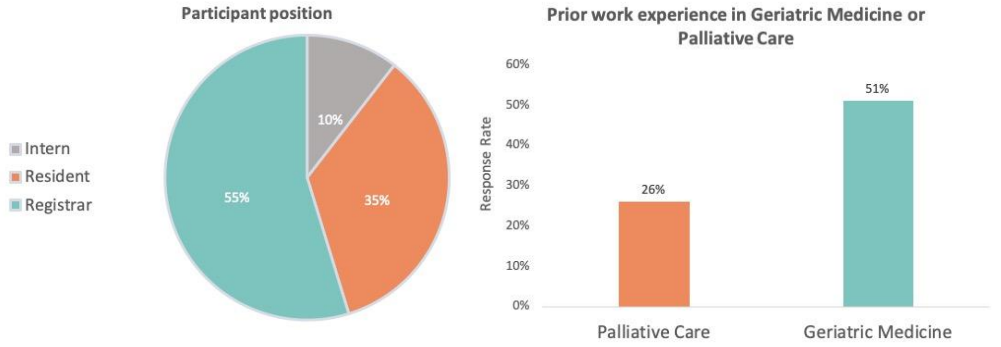
1. Explore perceptions of junior hospital doctors about the recognition of dying patients.
2. Identify facilitators and barriers to diagnosing and managing dying patients.

METHOD

- Exploratory mixed methods analysis.
- Participants - junior doctors across two metropolitan Melbourne Health services.
- Anonymous online survey – multiple choice and free text responses.

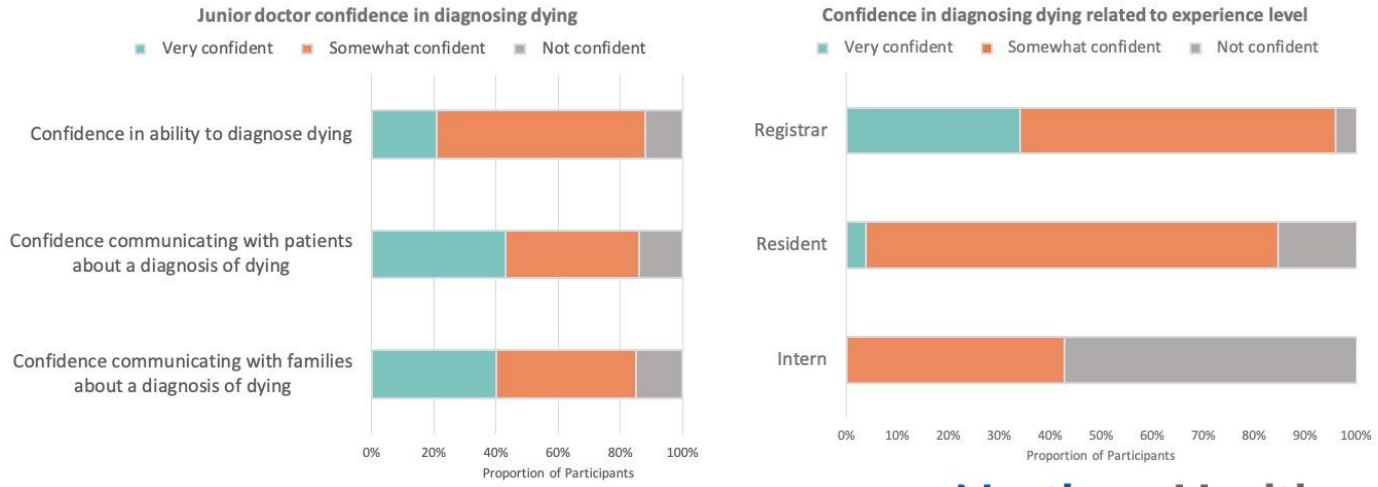
DEMOGRAPHICS

- 96 surveys were completed by interns, residents & registrars.



QUANTITATIVE RESULTS

- 67% of participants were somewhat confident, and 21% were very confident, in diagnosing dying.
- Confidence in diagnosing dying and communicating with patients / families increased with greater clinical experience. 57% of interns & 4% of registrars felt they were not confident in their ability to diagnose dying ($p<0.05$).



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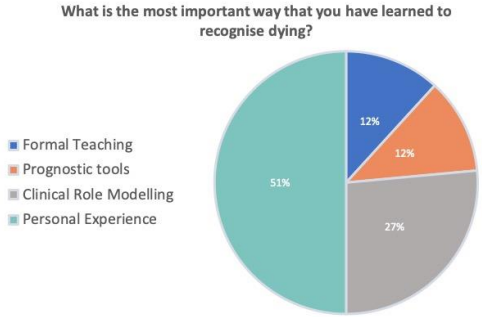
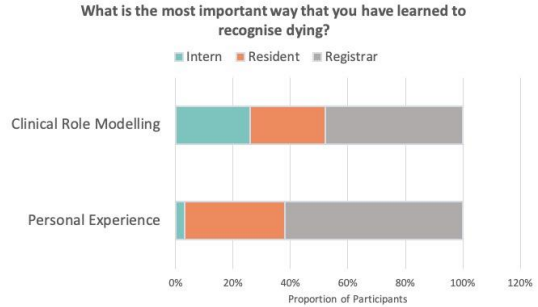
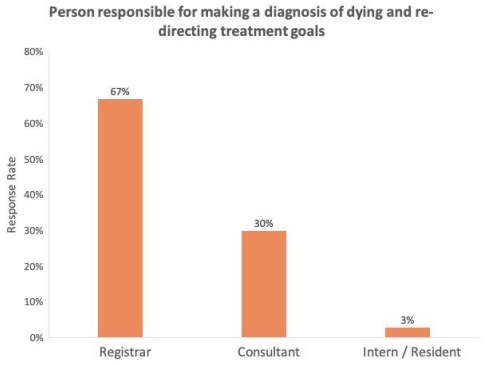
QUANTITATIVE RESULTS

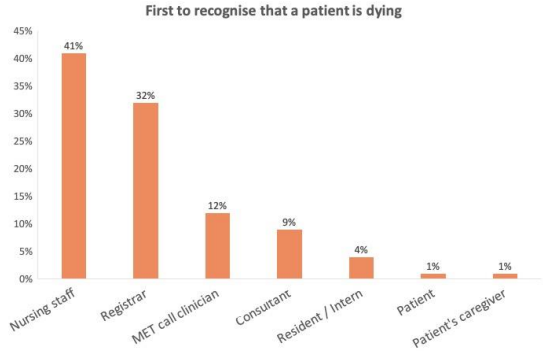
- Personal experience (51%) and clinical role modelling (27%) were ranked the most important in learning to recognise dying. Interns relied most on clinical role modelling (86%) and Registrars relied on personal experience (53%) for their learning. This difference was statistically significant ($p<0.05$).





- Nursing staff were most commonly identified as the first to identify dying (41% of respondents), followed by Registrars (32%) and ICU or MET call clinicians (12%).
- Diagnosing dying and re-direction of treatment goals was reported to be largely the responsibility of Registrars (67%) and Consultants (30%).





QUALITATIVE RESULTS

Free text responses described issues related to the recognition of dying. Five themes emerged from thematic analysis:

1. Clinical experience and learning at the bedside

- Observing clinical role models and experience managing dying patients was thought to positively enhance skills in diagnosing and managing dying.

> *"The best education is experience and seeing senior clinicians manage dying well" - (Resident)*

2. Formal education

- Participants requested education on death and dying, symptom management, prognostic tools and communication skills training.

> *"More simulated teaching, role plays, to practice family discussions and answering the tough questions." - (Registrar)*

3. Systems and culture

- Attitudes perceiving death as a failure were reported to prevent timely recognition of dying.

> *"There needs to be a cultural change. Death shouldn't be seen as failure." – (Registrar)*

- Poor continuity or unfamiliarity with patient's illness trajectory were described as barriers.

> *"…it seems clear to me that a patient is dying, but due to changeover of consultants, there may be a reluctance to recognise this as they are meeting the patient for the first time." - (Registrar)*

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QUALITATIVE RESULTS

4. Disagreement

- Disagreement between treating clinicians, or differing expectations between clinician and patient or family was identified as a barrier to diagnosing dying.

> *"In intensive care we often find that treatment goals of the home team, are not consistent with the clinical picture of a patient dying." - (Registrar)*

5. Emotional impacts on patient, family and clinician

- When diagnosis of dying is delayed, participants reported increased patient suffering, inadequate symptom management and loss of patient autonomy in decision making.

> *"The patient is often not able to make an autonomous decision, because the treating team keep offering treatments and investigations and the patient interprets these as potentially improving their situation, whereas if the patient was actually aware they were dying then they might not want those treatments." - (Registrar)*

- Participants reported this resulted in clinician distress; contrasting this with feelings of satisfaction and reward when dying was managed well. Families were said to be given false hope and to be ill prepared for death where recognition of dying was delayed.

CONCLUSIONS

Findings from this study show that junior doctors:

- Recognised the importance of timely recognition of dying and barriers to this, including culture.
- Identified clinical experience and clinical role-modelling as the most important factors in learning to diagnose dying.
- Reported delayed diagnosis of dying leads to patient, family and clinician suffering and distress.
- Wanted more communications skills training and education about caring for dying patients.

Recommendations from these findings:

- Increased communications skills training for junior doctors is needed.
- Bedside teaching and role modelling is a priority for teaching junior doctors to diagnose and manage dying.

REFERENCES

1. Australian Commission on Safety and Quality in Health Care (CSQHC). (2015). National consensus statement: Essential elements for safe and high-quality end-of-life care. Sydney, Australia: ACSQHC.
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4. Gunasekaran et al., (2019). Recognising and managing dying patients in the acute hospital setting: can we do better? Intern Med J., 49(1), 119-122.

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