

Educational needs of foundation doctors caring for dying patients

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ABSTRACT The aim of this study was to identify the educational needs of year one North of Scotland foundation doctors caring for dying patients. A postal questionnaire approach was used. The results from the questionnaire (79/132 respondents) confirmed that year one foundation doctors are frequently exposed to patient death, with 61% finding their most memorable patient death to be emotionally distressing. A quarter (26%) of respondents had recent experience of significant personal bereavement. Communicating with patients and relatives at the end of life, concerns about overtreatment and lack of senior support were highlighted as particularly difficult issues. Educational needs of the foundation doctors were identified, emphasising the importance of emotional, analytical and personal competencies.

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More than 50% of all deaths in the UK happen in acute hospitals.^{1,2} At any one time it is estimated that at least 12% of all hospital inpatients have 'advanced disease' (prognosis less than three months) and that up to 86% of all deaths follow a period of illness and/or frailty.^{3,4} In other words, most deaths are to some extent predictable. Yet many junior doctors find caring for the dying to be stressful.^{5–8}

One of the most ill-starred meetings in modern medicine is that between a frail defenceless old man nearing the end of his life, and an agile young intern at the beginning of his career.⁹

Several aspects of caring for dying patients have been highlighted in the published literature as contributing to junior doctors' stress/distress. These doctors often feel unprepared for dealing with dying patients^{9–11} and find communicating with dying patients and their relatives particularly difficult.^{5,12,13} This can be heightened if the patient/relatives in some way remind the doctor of their own family^{12,14,15} or if the doctor has not had an opportunity to build up a relationship with them, e.g. when 'cross-covering'.^{7,16} Overtreatment (real or perceived),^{12,14,17,18} patient suffering^{15,19} and lack of support^{7,9,12,14} are all recognised as contributing to junior doctor distress, in particular causing feelings of guilt and self-blame.^{14,20}

Care of the dying has been recognised as important by the Scottish Government,¹ the General Medical Council²¹ and the Academy of Medical Royal Colleges (AMRC).^{22,23} The North of Scotland Deanery needed to respond to the requirements of the AMRC (2007) Foundation Programme curriculum document²³ for all the foundation trainees in the region. The existing North of Scotland Foundation teaching programme did not have any sessions specifically about end-of-life care.

The aim of this study was to explore the experiences of junior doctors looking after dying patients, with a view to developing an educational intervention that would address any identified educational needs.

TARGET POPULATION AND METHODS

Year one foundation (FY1) doctors (i.e. in their first year after obtaining their medical degrees) working within the North of Scotland Deanery (n=132) were chosen as the target population. It was felt that any educational intervention resulting from the needs assessment should be tailored for FY1s because such an intervention would be 'too early' in medical school, where learners would have difficulty putting their learning in context. Year two would be 'too late' to address issues of junior doctors being unprepared and unsupported for the care of the dying task.

A postal questionnaire was chosen as the most appropriate method for several reasons:^{24,25}

- It provided an opportunity for all FY1 doctors in the region that would be affected by the educational intervention to share their views.
- By including the entire target population, it was hoped that ownership of any resulting educational programme would be promoted.
- The target population was spread over a very large geographical area (Grampian, Moray, Highlands, Orkney, Shetland and the Western Isles). A postal questionnaire was the only cheap and efficient means of reaching them all.
- A questionnaire provided the means of answering the research questions.
- Coding and analysis of the data would be achievable by the researcher.

TABLE 1 Questionnaire on foundation year doctors' experiences of death and dying

<p>1. How old are you? <input type="checkbox"/> 20–24 <input type="checkbox"/> 25–29 <input type="checkbox"/> 30–34 <input type="checkbox"/> >35</p> <p>2. How long have you been working as a doctor? <input type="checkbox"/> <3 months <input type="checkbox"/> 3–6 months <input type="checkbox"/> 6–12 months <input type="checkbox"/> >12 months</p> <p>3. Where are you working at present? <input type="checkbox"/> General Medicine <input type="checkbox"/> Care of the Elderly <input type="checkbox"/> General Surgery <input type="checkbox"/> Paediatrics <input type="checkbox"/> Obstetrics and Gynaecology <input type="checkbox"/> General Practice <input type="checkbox"/> Other (please specify).....</p> <p>4. Have you had any close family or friend bereavements in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. How many patients have you been involved with at or around the time of death? <input type="checkbox"/> None – please go to Q.7 <input type="checkbox"/> One – please go to Q.6 <input type="checkbox"/> 2–5 – please go to Q.6 <input type="checkbox"/> 5–10 – please go to Q.6 <input type="checkbox"/> >10 – please go to Q.6</p> <p>6. Please consider the patient death you feel is the most memorable. a) How long had you known the patient? <input type="checkbox"/> <1 hour <input type="checkbox"/> 1–24 hours <input type="checkbox"/> 1–7 days <input type="checkbox"/> 1–4 weeks <input type="checkbox"/> Months b) Was the death expected? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know c) The patient had unrelieved suffering. <input type="checkbox"/> Strongly disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly agree d) The death had a strong emotional impact on you. <input type="checkbox"/> Strongly disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly agree e) You received adequate support following the death. <input type="checkbox"/> Strongly disagree <input type="checkbox"/> Disagree <input type="checkbox"/> Agree <input type="checkbox"/> Strongly agree</p>	<p>7. Please rank the following situations according to how difficult you find them. (Circle appropriate response)</p> <p>a) Talking to patients about death. Not at all Most difficult situation possible 0 1 2 3 4 5 6 7 8 9 10</p> <p>b) Talking to relatives about death. Not at all Most difficult situation possible 0 1 2 3 4 5 6 7 8 9 10</p> <p>c) Certifying death. Not at all Most difficult situation possible 0 1 2 3 4 5 6 7 8 9 10</p> <p>d) Viewing bodies in the mortuary. Not at all Most difficult situation possible 0 1 2 3 4 5 6 7 8 9 10</p> <p>e) Talking to recently bereaved relatives. Not at all Most difficult situation possible 0 1 2 3 4 5 6 7 8 9 10</p> <p>f) Please describe any other situations you find difficult.</p> <p>8. Have you ever been uncomfortable with your consultant's decision to... a) stop feeding/fluids <input type="checkbox"/> Yes <input type="checkbox"/> No b) continue or commence feeding/fluids <input type="checkbox"/> Yes <input type="checkbox"/> No c) sign a 'not for resuscitation' form <input type="checkbox"/> Yes <input type="checkbox"/> No d) refuse to sign a 'not for resuscitation' form <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever had to sign a 'not for resuscitation' form without consultant or SpR supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you received support from any of the following during or after a patient's terminal illness? (Tick as many boxes as appropriate) <input type="checkbox"/> Other foundation year doctors <input type="checkbox"/> Senior house officers/specialist registrars <input type="checkbox"/> Nurses <input type="checkbox"/> Consultant <input type="checkbox"/> Educational supervisor <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Other (please specify).....</p>
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Question development was informed by a literature review of junior doctors' experiences. The questionnaire (Table 1) provided the opportunity to confirm/further explore the themes from the literature in the local setting, with a particular focus on the following questions:

- Is recent personal bereavement common?
- Is exposure to patient death frequent?
- Are patient deaths seen as emotionally powerful? Which factors contribute to this experience (brief relationship with the patient, unexpectedness, unrelieved suffering, lack of support)?
- How difficult are common tasks when caring for dying patients?
- Is perceived overtreatment an issue? Is perceived undertreatment an issue?
- Who do FYI doctors look to for support? How frequently is support received from senior medical staff?

- Are FYI doctors signing 'not for resuscitation' forms without support/supervision? This question did not arise from the literature review. However, the author was aware of anecdotal reports of this practice happening locally.

The questionnaire was pilot-tested by junior doctors within the department of palliative medicine to ensure the questions were understood and considered relevant and acceptable. The questionnaires were posted to all 132 North of Scotland FYI doctors, with a covering letter assuring anonymity. A stamped, addressed envelope was enclosed.

Ethical review The North of Scotland Research Ethics Committee reviewed and approved the study.

RESULTS

Respondents

A total of 74/132 (56%) completed questionnaires were returned. Almost all the respondents were under 30 years old (71/74 [96%]) and had been working for between six and 12 months (72/74 [97%]). They were working in a wide range of specialties (general medicine n=19, care of the elderly n=10, general surgery n=23, paediatrics n=5, obstetrics and gynaecology n=5, other n=12). Just over a quarter (19/74 [26%]) of respondents had a close family or friend bereavement in the last year. The majority (55/74 [74%]) had been involved at least five times with patients at or around the time of death. Only one respondent stated that they had not been involved in the care of a patient at the end of life.

Most memorable patient death

The majority (53/74 [72%]) of 'most memorable' patient deaths were expected. The FYI had known the patient for less than one week in 44/74 (59%) cases; 5/74 (7%) had known the patient for less than one hour. Most (53/74 [72%]) did not feel their patient had unrelieved suffering (Figure 1), but more than half (45/74 [61%]) felt the death had a strong emotional impact on them (Figure 2). Approximately half (41/74 [55%]) reported having adequate support following the death (Figure 3).

How difficult are common tasks when caring for dying patients?

Talking to patients about death, talking to relatives about death and talking to bereaved families were felt to be difficult (score $\geq 5/10$) for the majority of respondents (88%, 82%, 84% respectively, median scores 7, 7, 7.5 respectively). Certifying death or viewing bodies in the mortuary were perceived as easier tasks (median scores 2 and 3.5 respectively).

Particular difficulties around communicating at the end of life were described by some respondents in free text responses. Six respondents emphasised that discussing not for resuscitation (NFR) forms and the withdrawal of active treatments were the aspects of speaking to relatives that they found most difficult. Other contributing factors that made communication difficult were not knowing the patient ('telling families that their relative had died when you are covering and don't properly know the patient'), and lack of senior support ('being left at a weekend to deal with palliative patients when my senior house officer is busy with other patients'). One respondent described a weekend when five patients died as 'the hardest 48 hours I've spent in medicine with no support from anyone'.

Other situations that were identified as difficult in the free text responses included getting all the necessary paperwork (death certificates, cremation forms) done ('after being shocked by patient's sudden death being

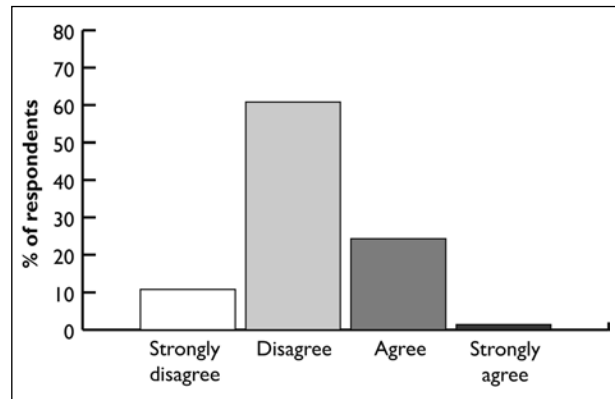


FIGURE 1 The patient had unrelieved suffering.

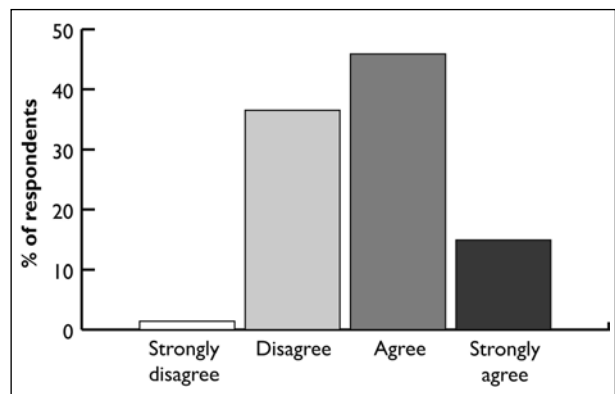


FIGURE 2 The death had a strong emotional impact on you.

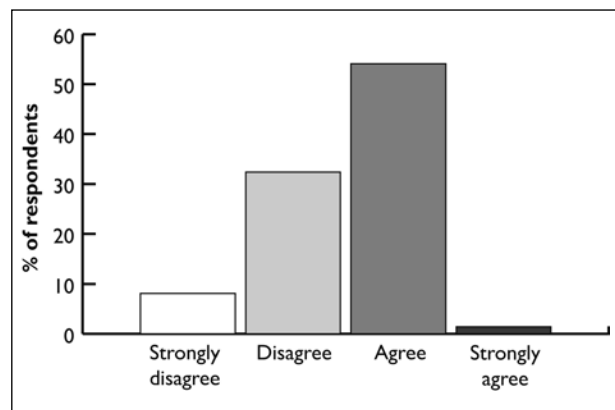


FIGURE 3 You received adequate support following the death.

harassed to get cremation papers done immediately), supporting colleagues and coming to terms with one's own emotions. One respondent described 'difficult[y] accepting that someone can die despite everyone's best efforts'. Another reflected 'how a death [that] doesn't seem to affect some other doctors makes you question your ability'.

Is perceived overtreatment an issue?

Two fifths of respondents had been uncomfortable with apparent 'overtreatment' decisions by consultants at the end of life – continuing fluids (30/74 [41%]) and refusing to sign an NFR form (30/74 [41%]). A smaller proportion

TABLE 2 Sources of support for junior doctors following patient death

Source of support	n	%
Other FYI	53	72
Nurse	36	49
Friend	28	38
Family	27	36
Senior house officer/Specialty registrar	24	32
Consultant	6	8
Educational supervisor	2	3
None	11	15

were concerned about perceived undertreatment – discontinuing fluids (16/74 [22%]) and signing an NFR form (8/74 [11%]).

Are FYIs signing NFR forms without support?

Almost one fifth (14/74 [19%]) had had to sign an NFR form without senior doctor supervision.

Who is accessed for support?

The most common sources of support for FYI doctors were their fellow FYIs (53/74 [72%]) and their nursing colleagues (36/74 [49%]). Only 8/74 (11%) respondents had received support from a consultant or educational supervisor. Some 11/74 (15%) respondents felt they had not received any support (Table 2).

DISCUSSION

The questionnaire confirmed that end-of-life care situations are experienced by North of Scotland FYI doctors. While 61% of respondents described their most memorable patient death as having a 'strong emotional impact', it is interesting to note that most of these deaths were not considered to be unexpected or associated with unrelieved suffering. This contrasts with previous research that identified strong emotions as being related to perceived suffering and the death being shocking or unexpected.^{14,15} If deaths are not shocking or accompanied by suffering then why do they still cause distress?

It is conceivable that these junior doctors are struggling with the realisation that death is inevitable, and that the biomedical fight against disease is often unsuccessful.²⁶ At least 12% of patients in an acute hospital are in the terminal phase of their illness.⁴ This proportion of the workload is not reflected in the emphasis given to palliative and end-of-life care in undergraduate medical curricula (e.g. Aberdeen's undergraduate curriculum has just six days' focus on palliative/end-of-life care).

The questionnaire did, however, highlight other issues that may contribute to the care of the dying task being difficult for junior doctors. Just over a quarter of respondents had experienced a close family or friend

bereavement in the previous year. The incidence of close family/friend bereavement for FYI doctors has not previously been published. There may have been response bias, with FYI doctors who had experienced recent bereavement being more likely to return their questionnaires. However, even if we assume that all non-respondents did not have a recent bereavement we are still left with an incidence of recent bereavement of 14%. Personal experience of loss and family illness have been described as qualitative themes important in emotionally powerful incidents.^{12,14}

Communicating with patients or families around the time of death is well recognised as difficult and stressful.^{5,12,16,27,28} This is confirmed by the survey, which also highlights that these communication scenarios are considered more difficult than other potentially distressing duties of a junior doctor (specifically, certifying death and identifying bodies in the mortuary).

The literature also suggests that perceived overtreatment at the end of life is a source of stress for junior doctors.^{12,14,17,18,29} Respondents to this survey more frequently identified being uncomfortable with a consultant's decision to continue treatment as opposed to a consultant's decision to withhold/withdraw treatment. This may reflect that such decisions may seem more 'real' to the junior doctor, who has to physically do something to a patient rather than omitting to do something. The apparent unnecessary continuation of treatment can have other consequences. Junior doctors perceive the overtreatment of the terminally ill as a mark of consultant fallibility.¹⁸ Those junior doctors who perceived their consultants as being fallible were the most likely to have poor job/career satisfaction.¹⁸

The effective care of dying patients requires a co-ordinated team approach. While many (72%) respondents had received support from their peers, and half had been supported by their nursing colleagues, perhaps the most concerning finding from the questionnaire was that only 11% of respondents had received support from a consultant (or educational supervisor) during or after a patient death. Previous studies have shown that junior doctor discussions with consultants about patient death may happen frequently (74–76% of patient deaths), but that these discussions are less often (24–35%) perceived as supportive.^{30,31} Lack of support has been identified as an important theme of emotionally powerful deaths.^{7,14} Another possible consequence of this apparent lack of support is the fact that 19% of respondents stated that they had had to sign an NFR form unsupervised. NHS Grampian resuscitation guidelines clearly state that NFR forms should (except in exceptional circumstances) be signed by the consultant or senior specialist registrar.

It has been noted in medicine that there is often a culture of not expressing emotions or seeking help, and

as a result there is a hidden curriculum of 'educational neglect', where faculty do not discuss death or the emotional sequelae of looking after dying patients and their families.^{11,15,31} Such negative role modelling will potentially have a number of knock-on effects. Stressed and overwhelmed junior staff will be given the impression that there is something wrong with them ('how a death [that] doesn't seem to affect some other doctors makes you question your ability') and that they are not allowed to (and possibly don't know how to) get appropriate help and support. Patient care will suffer as junior staff are left with inappropriate responsibilities, such as signing NFR forms, without adequate and constructive supervision. Finally, these unsupported junior staff are likely to become unsupportive senior staff.³²

Using a questionnaire to explore junior doctor experiences had a number of limitations. The format of a questionnaire lends itself to the gathering of quantitative data. Qualitative data about the range and depth of experiences will usually not be caught. Free text responses were sought, but unsurprisingly most respondents did not provide them. Obviously a semi-structured, tape-recorded interview could have overcome these problems, but this process is very time- and labour-intensive and dependent on the skills of the interviewer. A further potential limitation of this study is respondent bias. It is conceivable that only the junior doctors who had particular types of experience considered returning the questionnaire. The results would not then be generalisable and, while a 56% response rate is quite high for a postal survey, almost half of the potential respondents are not represented.

From the questionnaire and literature review several areas are highlighted as important for any educational/support intervention:

- Communication (end-of-life, including breaking bad news, NFR discussions and dealing with strong emotions):
 - o patients
 - o families (including bereaved)
 - o staff (in particular with consultants)
- Legal and ethical issues surrounding end-of-life care:
 - o NFR
 - o treatment withdrawal
- Understanding the impact of one's own emotions and stress on the ability to practice effectively
- Knowing how and when to seek help and support

It is interesting to note that these needs relate more to emotional, analytical and personal competencies than to cognitive or technical competencies. This accurately reflects the reality of end-of-life care, where the 'technical' interventional facets of medicine are of minimal importance.³³ Quality of life in advanced disease has repeatedly been shown to be independent of markers of disease severity.³⁴⁻³⁶ This reduces the

importance of the traditional medical history, examination, investigations and treatments – quality of life does not fit well into biomedical constructs of disease. More important appears to be the attitude of care, particularly promoting patient-centredness.^{9,37,38}

The AMRC (2007) Foundation Programme curriculum²³ focuses on acute care, particularly the management of the acutely ill patient. There is therefore a significant emphasis on technical and clinical competencies. This study has shown that junior doctors encounter end-of-life care situations frequently and that these situations are often distressing, requiring the development of emotional and personal competencies.

Careful thought will need to be given to the educational strategies used to address these needs. In the north of Scotland a small-group case-based teaching session has been developed for FYI doctors. This session addresses prognostication, illness trajectories and end-of-life care (symptom control, treatment withdrawal). More importantly, the facilitated small-group approach helps promote peer support and allows the junior doctors to explore ways of dealing with difficult situations in a safe environment. There remain concerns about how effectively this learning will transfer into the clinical environment.

Learning is context dependent and the influence (both positive and negative) of role modelling in these situations cannot be over-emphasised.¹⁹ It is therefore important that clinical and educational supervisors are aware of the issues highlighted by this study – particularly that patient death can be emotionally distressing for junior doctors, that consultants need to ensure that they explain their treatment intent to their junior staff, and that junior staff who are struggling may well have had a recent significant personal bereavement. To deal effectively with these issues consultants may themselves need access to training and support. Changing working patterns for junior doctors, particularly in response to the European Working Time Directive, provide further challenges to consultants trying to provide continuity of supervision and support.

Future research could focus on the education and support needs of consultants responsible for junior doctors looking after dying patients. The issues of lack of support and perceived under/overtreatment could be further analysed through interviews with both junior doctors and consultants. Finally, a similar questionnaire could be administered to newly qualified nursing staff. It would be interesting to compare their experiences with those of junior doctors and explore whether interdisciplinary support/education would be useful.

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