

End of Life Discussions in an Academic Family Health Team

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ABSTRACT

Death is still a taboo in our modern society and end of life discussion would not normally be part of a patient-doctor interaction until confronted by a terminal diagnosis. This evasive attitude may lead to dilemma and confusion regarding the extent of medical interventions to be provided to the dying patient. Awareness regarding this topic has been fueled by media reviews and national campaigns. We describe a clinical audit and survey in an Academic Family Health Team exploring the overall prevalence of end of life discussions in adult patients, the perceived barriers to such discussions and suggestions for improvement.

BACKGROUND

-Preferences regarding advance care planning cannot be inferred from patients' age, health or other demographic features¹. Discussion should be initiated while the patient is relatively well and continued over time^{2,3}.

-The majority of patients desire End of Life (EOL) discussion, and feel it improves the patient-physician relationship⁴, but are not willing to initiate the discussion⁵. Physicians feel patients should initiate the discussion³.

-25% of all Medicare costs are incurred by 5% of people in their last year of life⁶ but EOL discussion can cut EOL costs for cancer patients by 36%⁷.

-Limited guidelines available: Evidence-Based Geriatric Nursing Protocols for Best Practice suggest all patients, regardless of age, gender, religion, socioeconomic status, diagnosis or prognosis should be approached to discuss advance care planning⁸.

METHODS

Chart Review

- 1) Random sample (350) of all non-nursing home, rostered patients >18 years of age
16,282 total → 10,333 fit criteria → 350 random sample
- 2) Searched sample charts for list of key EOL terms (69 flagged)
- 3) Reviewed these charts for number of chronic diseases and extent of EOL discussion

Provider Survey

- 1) Created Google survey comprised of 7 questions regarding current practices around EOL discussion and willingness/barriers to change
- 2) Granted ethics approval (Health Sciences Research Ethics Board at Queen's University)
- 3) Distributed to 100 primary care providers in a single Academic Family Health Team (53 resident physicians, 43 attending physicians, 4 nurse practitioners)

RESULTS

Chart Review

-Of the charts reviewed only 1% had documented EOL discussions (Fig. 1).

Provider Survey

- Few resident physicians conduct EOL discussions (Fig. 2).
- Providers are more likely to conduct EOL discussions with older, unhealthy patients (Fig. 3).
- Barriers to EOL discussions were identified (Fig. 4).
- Strategies to increase the number of EOL discussions were identified.

RECOMMENDATIONS

-In the Academic Family Health Team studied, few primary care providers conduct EOL discussions in adult patients.

-Recommendations to facilitate increased frequency of EOL discussion:

- 1) Seminar training with provision of standardized discussion initiation phrases.
- 2) Electronic medical record reminders.
- 3) Worksheets to guide discussion amongst patients and families.
- 4) Wait room signage welcoming patients to initiate or entertain discussion.

-Further studies needed to compare patient and provider satisfaction with current state of EOL discussions versus satisfaction after initiation of the above recommendations.

-Limitations: lack of documentation of EOL discussions, spelling errors, small sample size, lack of guidelines.

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Fig. 1 Proportion of patients with documents EOL discussions.

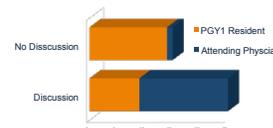


Fig. 2 EOL discussions amongst primary care providers.

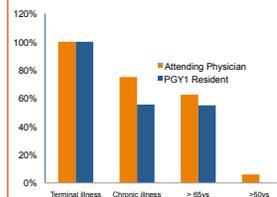


Fig. 3 Participants asked to identify the groups of patients they felt warranted EOL discussions.

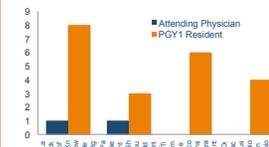


Fig. 4 Participants asked to identify perceived barriers to EOL discussions.



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