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# What do Doctors Know about Patients End-of-Life Care?

## ¿Qué saben los médicos acerca de la atención de los pacientes al final de la vida?

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**ABSTRACT**

The San Ignacio University Hospital and the Ethic Clinic Service have carried out continuous education for the hospital´s staff regarding the necessary care for patients at the end of life. Efforts have been made to train the health team on the end-of-life plan strategy and the concept of reorientation of therapeutic effort, to provide the necessary care in this final stage. This study´s objective was to identify the physician´s knowledge about these concepts and to assess whether their implementation was adequate in the clinical practice. The results showed that even though the workers do possess knowledge there are external barriers that prevent its implementation.

**Keywords**
education-clinical ethics; withholding-withdrawing; care end life; terminally ill.

**RESUMEN**

El Hospital Universitario San Ignacio y el Servicio de Ética Clínica han realizado una educación continua al personal del hospital frente al cuidado necesario para los pacientes al final de la vida. Se han hecho esfuerzos para capacitar al equipo de salud sobre la estrategia de plan de atención para el paciente en condición de fin de vida y el concepto de reorientación del esfuerzo terapéutico, con el fin de brindar los cuidados necesarios en esta etapa final. El objetivo de este estudio fue identificar el conocimiento de los médicos acerca de estos conceptos y evaluar si su implementación era adecuada en la práctica clínica. Los resultados mostraron que, a pesar de que los trabajadores cuentan con el conocimiento, existen barreras externas que impiden su aplicación.

**Palabras clave**
educación; ética clínica; retención-retirar; cuidado al final de la vida; enfermo terminal.

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## Introduction

Therapeutic obstinacy, defined as "adoption of disproportionate or useless measures with the aim of prolonging life in agony" (1), also known as therapeutic *overkill or dysthanasia*, occurs frequently in daily clinical practice since it is not easy to establish the boundary between beneficial and non-beneficial interventions, especially in patients at the end of life.

According to Spinello (2), some of the reasons why health personnel fall into such management are the fear that the patient's death will result in medical-legal problems, the lack of knowledge and education regarding the adequacy of therapeutic objectives in patients who cannot be cured, and the avoidance of difficult conversations about death.

Arenas Alejo et al. (3) set out three objective criteria for defining therapeutic stubbornness or obstinacy. The first refers to uselessness or futility, when an attempt is made to cure a patient, even knowing that the treatment will be ineffective. The second is severity, where the measure will lead to greater suffering, whether physical or moral. And lastly, exceptionality, which refers to therapeutic interventions with means that are disproportionate to the patient's context. When these three criteria are present, therapeutic overkill could be identified, which should lead to a rethinking of management objectives.

When faced with a patient with an incurable and irreversible diagnosis with a poor short-term vital prognosis, it is necessary to reflect on the best management option by analyzing the global context of that patient. When the curative management alternatives are exhausted and there is no response to the established treatments, the best option is to initiate the reorientation of the therapeutic effort, or also called *adequacy or proportionalization of the therapeutic effort*.

This measure is aimed at palliative management, providing adequate symptom control, guaranteeing basic care, offering the greatest possible comfort, and suspending unnecessary and futile interventions that do not bring any benefit to the patient but rather deterioration of the quality of life and prolongation of suffering (4,5).

Given the above, the need arose at the Hospital Universitario San Ignacio (HUSI) to establish a *Care Plan for end-of-life (EOL) patients*, with the aim of providing patients at this stage with the appropriate management to improve their quality of life. The plan has specific care that encompasses various aspects of care, ranging from comfort measures and symptom relief including for the patient and family as part of the comprehensive approach. The pathway, as well as the EOL care plan, can be found in the hospital repository (Almera), to which all the hospital's physicians have access.

## Recommended special care for the end-of-life patient

- Transfer the patient to a single room in hospitalization.
- Allow family company 24 hours a day. Receive support from the palliative care service for adequate symptom control.
- Offer spiritual and psychological support. Avoid dietary restrictions; the patient can eat what he/she wants.
- Discontinue medications and interventions that in the patient's clinical context are futile.
- Discontinue taking vital signs.

Said care plan has been socialized periodically since its implementation in 2016, with the majority of HUSI physicians and nurses, through regular conferences and direct counseling in the care of EOL patients.

The aim of this study was to describe and analyze physicians' knowledge of the concepts of reorientation of therapeutic effort and the EOL care plan to assess the need to intensify staff education for the correct approach to these issues.

## Materials and methodology

A cross-sectional observational study was designed through a voluntary and anonymous face-to-face survey. The population surveyed were HUSI physicians of various specialties, with prior authorization from the Ethics and Research Committee of the HUSI/Pontificia Universidad Javeriana.

A meeting was arranged with each department or unit director where most of the members of the department or unit were present. The objective of the study was explained to them, and they were given the link to answer the survey. Participation was anonymous and voluntary.

To construct the survey, a focus group was held with physicians specializing in different areas to develop the different questions. The survey consisted of ten questions, of which the first three were aimed at the demographic characterization of the population. Additionally, two questions were structured to evaluate the concept of EOL care plan. The first question asked whether or not the patient was familiar with this term, and the second offered multiple options, some correct and some incorrect, to determine whether or not there was clarity in the actions that are part of the EOL care plan. Two other questions were posed in the same way, the goal of which was to evaluate the concept of reorientation in the therapeutic effort. Finally, the final questions asked about the possible reasons that limit its application. The survey was structured using Google Forms (see annex).

## Results

A total of 212 surveys were conducted, and the age ranges of the respondents are listed in Table 1.

**Table 1.**
*Age range of surveyed physicians*

| Years | Percentage |
|---|---|
| 18-29 | 40.3 |
| 30-44 | 44.5 |
| 45-59 | 12.4 |
| 60 or more | 2.8 |

55.7% were postgraduate students (residents and fellows), 40% were specialists and 4.3% were general practitioners. The specialty of the surveyed physicians can be seen in Table 2. In addition, more than 70% of the participants were aware of the EOL care plan (Figure 1).

**Table 2.**
*Specialties of the surveyed physicians*

| Specialty | Percentage |
|---|---|
| Internal Medicine | 24.5 |
| Pediatrics | 16.3 |
| Geriatrics | 12.0 |
| Orthopedics | 11.1 |
| Emergencies | 10.6 |
| Oncology | 7.2 |
| General surgery | 6.7 |
| Gynecology | 5.8 |
| Intensive Care Unit | 4.3 |
| Neurology | 1.5 |
| **Total** | 100 |

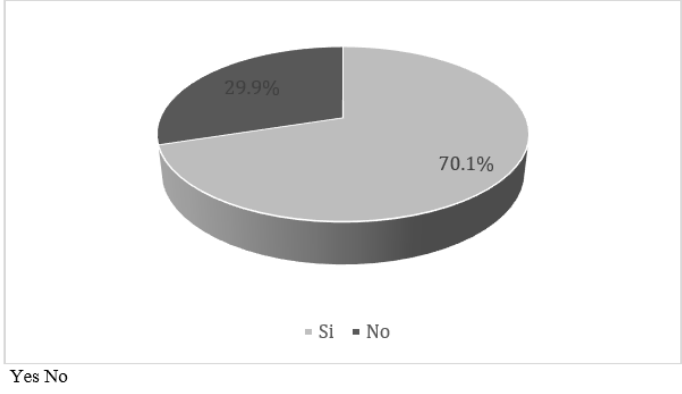


**Figure 1.**
*Knowledge of the end-of-life program*

The survey asked about some of the actions that make up the EOL care plan, and it was found that 83.3% were aware of the "anti-order" of suspending paraclinical tests and 53.2% were aware of the non-restriction of the diet, as can be seen in Figure 2.

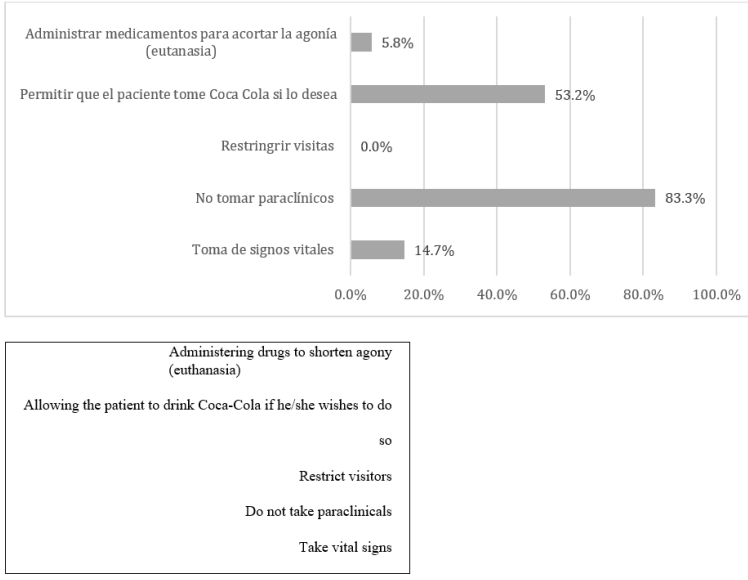


**Figure 2.**
*Knowledge of the actions within the end-of-life program*

Likewise, as can be seen in Figure 2, only 5.8% of the participants believe that reorientation of therapeutic effort is aimed at shortening agony through the administration of drugs (euthanasia), and 14.7% were unaware of the specific "antiorder" of not taking vital signs. Ninety-four percent of the participants reported knowing what reorientation of therapeutic effort is (Figure 3).

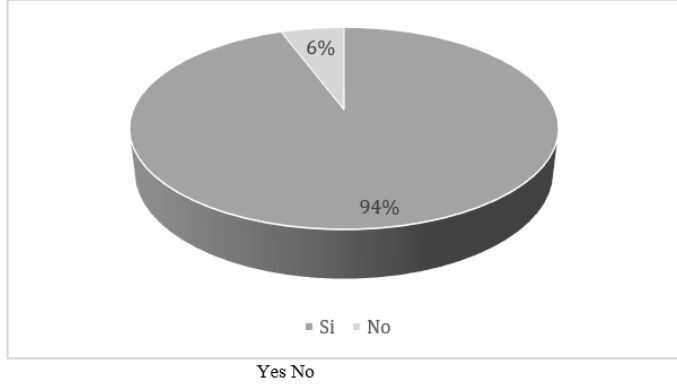


**Figure 3.**
*Knowledge of the reorientation of the therapeutic effort*

The participants who reported knowing what the reorientation of therapeutic effort is were

asked which actions are part of it. As can be seen in Figure 4, 93.9% of the participants know that reorientation of therapeutic effort includes the suspension or non-initiation of futile therapies in the patient's context and, 72.1%, the adequate management of symptoms. Only a low percentage of the participants (1.5%) considered that "all" drugs should be discontinued as part of the reorientation of the therapeutic effort, and only 0.5% and 3.0% considered that it included curing the patient and improving prognosis, respectively.

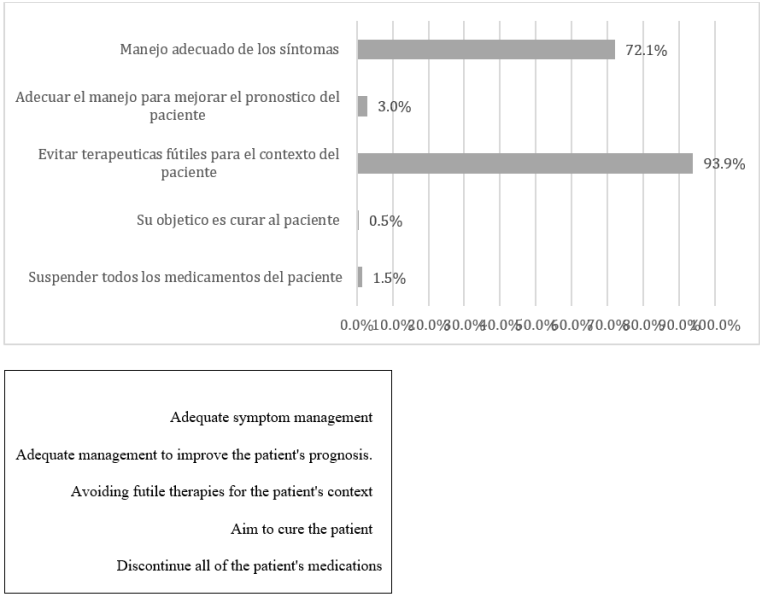


**Figure 4.**
*Knowledge of therapeutic effort redirection actions*

More than half of the participants (60.5%) reported having the necessary knowledge to make an initial approach to patients who are at the end of life or for whom a redirection of their therapeutic effort is needed (Figure 5).

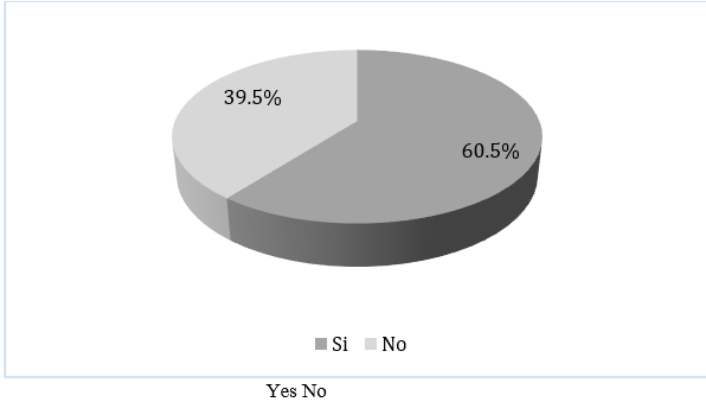


**Figure 5.**
*Do you have the knowledge to initiate redirection of the therapeutic effort?*

When asked if they had ever felt pressured to continue a therapy that they considered futile, 52.6% of the participants said they had. The most frequent causes were: feeling pressured by the patient or family, with 86 responses; 39 people reported feeling pressured for fear of legal proceedings; 27 people reported feeling moral distress about not doing everything possible to save the patient's life; 18 people reported discordance among the medical team; 7 people expressed not doing so to avoid difficult conversations; and 5 people indicated that they have not felt pressured (Table 3).

**Table 3.**
*Causes for which you have felt pressured to continue a futile therapy*

| Causes | Number of responses |
|---|---|
| Pressure from the patient or the family | 86 |
| Pressure from fear of legal proceedings | 39 |
| Moral anguish from not doing everything possible to save the patient's life | 27 |
| Disagreement among the medical team | 18 |
| Not doing so to avoid difficult conversations | 7 |
| Have not felt pressured | 5 |

Finally, the participants were asked whether they considered it easier not to initiate futile therapy or to discontinue it. Sixty-eight percent responded that it was easier not to initiate than to

withdraw a futile therapy already in place (Figure 6).

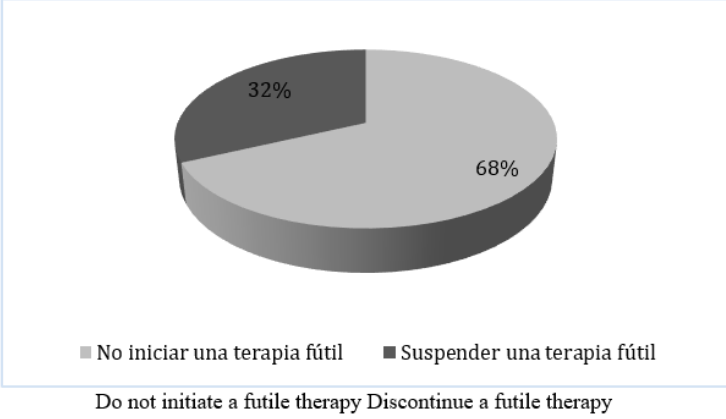


**Figure 6.**
*What do you consider easier: not to start futile therapy or to stop it?*

## Discussion

This study evaluated the knowledge of the concepts of reorientation of therapeutic effort and EOL care plan of physicians from different specialties at HUSI, in addition to evaluating the application of these concepts in clinical practice.

The results showed that most of the respondents reported having knowledge of the EOL care plan and the reorientation of therapeutic efforts. When evaluating the items that are part of these, it was corroborated that they do have adequate knowledge.

In addition to knowing the concept, it is important that physicians are clear about the characteristics of each strategy for its reasonable and appropriate implementation. Different authors have studied how to ensure that patients are provided with the necessary care at this stage of their lives. Zhang et al. (6) analyzed a group of terminally ill cancer patients and found that the factors that enhanced quality of life were: avoiding hospitalization, having fewer worries, having spiritual support counseling, and establishing an adequate doctor-patient relationship. They also found that unnecessary treatments, unmet needs, and family stress in caring for the patient were factors that negatively affected the patient's quality of life. Luna Meza et al. (7) reported in their study with terminal patients with oncologic pathologies that many patients and their families deny the proximity of death, which makes decision-making and shared conversations more difficult.

Patients rarely take the initiative in these types of conversations, and healthcare personnel rarely ask patients directly for their preferences. In addition, they reported that physicians' fear of confrontation with family members and patients leads them to perform futile interventions, such as artificial feeding tubes and cardiopulmonary resuscitation maneuvers, among others.

A study conducted in Medellin analyzed the knowledge of the adequacy of the therapeutic effort among health personnel (5). Approximately half of the participants understood the concept, and of these, the majority applied it correctly. However, differences emerged in definitions and associated practices similar to those reported previously.

The HUSI EOL care plan contains indications of all care needed to support appropriate care at this stage of life, including approaching and talking with end-of-life patients about what their preferences are for this stage and what is important to them, which aids in care planning and respects individual autonomy.

Unfortunately, as can be seen in the results of the present study, more than half of the respondents reported pressure from patients and family members to continue with a therapy that was considered futile for the patient's condition.

Some reported feeling pressured by fear of legal proceedings, as well as the moral anguish of not doing everything possible to save the patient's life, even if they were futile interventions, in addition to avoiding difficult and exhausting conversations, such as talking to the patient about the proximity of death.

These data show that there are reasons outside the theoretical knowledge of what "should be done" that lead physicians to not correctly apply the strategies of reorientation of the therapeutic effort and EOL care plan, which leads them to engage in futile practices.

As can be seen, the results are consistent with what is reported in the literature on the subject, which states the same reasons found in our study and concludes that suspending futile therapeutic interventions is often a difficult process for modern medicine, which is focused on curing disease and saving lives rather than on care, in addition to the popular belief that everything possible should be done to maintain life at all costs (2,6-9).

## Conclusions

It is evident that the theoretical training of hospital healthcare personnel on the EOL care plan and the reorientation of therapeutic efforts have been adequate. The results of this work encourage us to maintain the continuous education of physicians and nurses so that they have sufficient tools to reorient the therapeutic effort and implement the EOL care plan in the clinical situations that merit it.

However, it is disturbing that, despite healthcare professionals' familiarity with the theoretical knowledge of these strategies and their constituent elements, they sometimes fail to implement them due to the external influences already described. These obstacles could be mainly due to insufficient communication and ineffective relationships with the patient and family members. In addition, there is the influence of cultural beliefs that lead people to think that restricting therapeutic efforts is equivalent to abandoning the patient.

Therefore, we consider it necessary not only to maintain the educational efforts already implemented in the hospital but also to address the emotional aspect of the professionals. This implies providing them with the certainty of solid institutional support and motivating them to engage in open communication with their patients to face these issues in a more serene manner. Likewise, the option of incorporating these topics from the undergraduate stage of training is proposed so that the students of our institution acquire this knowledge and feel confident in dealing with patients at the end of life. This implies having a clear understanding of the medical-legal framework and receiving training to deal effectively with these issues with families.

The support of the Clinical Ethics Service will help to provide support in making complex decisions that arise in the medical routine, especially in cases of external pressures (patients, family, fear of legal proceedings, moral anguish when having conversations near the end of life, among others), and, thus, provide practical tools in the resolution of ethical-moral conflicts in daily practice.

## Conflict of interests

The authors declare that they have no conflicts of interest, except for being part of the Clinical Ethics Service.

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## Annex. Research project survey

"Knowledge of physicians at Hospital Universitario San Ignacio regarding the concepts of care plan for patients in end-of-life condition and reorientation of the therapeutic effort."If you agree to answer this survey, you consent to the handling of the answers recorded therein. It is an anonymous survey in which only general data of age, gender and specialty will be requested.

Age:

◯ 18-29
◯ 30-44
◯ 45-59
◯ 60 or more

Level of training:

◯ Resident
◯ Specialist
◯ Fellow
◯ General Practitioner

Specialty:

◯ Emergency
◯ Gynecology
◯ General surgery
◯ Internal Medicine
◯ Intensive care unit
◯ Neurosurgery-neurology
◯ Oncology
◯ Orthopedics
◯ Pediatrics
◯ Geriatrics

1. Are you familiar with HUSI's end-of-life care plan?

◯ Yes
◯ No

If yes, which of the following actions are included in the end-of-care plan for end-of-life patients?

◯ Take vital signs
◯ Do not take paraclinicals
◯ Restrict visitors
◯ Allowing the patient to drink Coca-Cola if he/she wishes to do so
◯ Administer drugs to shorten the agony (euthanasia)

2. Do you know what a redirection of therapeutic effort is?

◯ Yes
◯ No

If yes, which of the following actions are part of the redirection of the therapeutic effort?

◯ Discontinue all of the patient's medications

- ◯ Aim to cure the patient
- ◯ Avoid futile therapeutics for the patient's context
- ◯ Adequate management to improve the patient's prognosis
- ◯ Adequate symptom management

3. When you are faced with a patient at the end of life or in need of redirecting your therapeutic effort, do you feel you have the knowledge to make an initial approach before requesting support?

- ◯ Yes
- ◯ No

4. In an end-of-life patient, have you felt pressured to continue therapies that you consider futile?

- ◯ Yes
- ◯ No

5. For what reason did you feel pressured?

- ◯ Pressure from patient or family
- ◯ Fear of legal proceedings
- ◯ Avoidance of difficult conversations about death
- ◯ Has felt moral anguish of not doing everything possible to save life
- ◯ Others (specify)

6. For you it is easier:

- ◯ Do not initiate futile therapy
- ◯ Discontinue futile therapy