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Caring for the terminally ill: what do the doctors think?

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Summary
Patients' perception of end-of-life events varies with cultural norms and values, and expectations may differ from clinicians practice and actions. In contemporary practice, conflict of ideas often results in patients discharging themselves against medical advice. Clinicians (67) that have been in medical practice for at least five years at the main tertiary hospital in Benin City were interviewed with a semi-structured questionnaire. The main outcome measured was clinicians' attitude towards caring for the terminally ill patients and physician assisted suicide (PAS). The mean age of the clinicians was 36.89 ± 7.57, 11 females and 56 males. Twenty-six clinicians (40%) do not routinely record in the case notes details of their discussion on prognosis with their patients. Forty one (62.1%) clinicians will not support life while patients are on palliative care, while 49/66 (74.2%) will transfuse their patients with blood. Thirteen (31.7%) will not support life, and will not transfuse blood. Fifty seven (85.1%) clinicians will not support euthanasia, 8 of the 9 physicians who will support PAS are males, while 6 of the 9 clinicians that will grant patient's request for PAS are gynaecologists. All (17) clinicians in Internal Medicine specialty will not support PAS, while 51/67 (77.3%) clinicians are of the opinion that patients should be routinely informed of the prognosis of their disease. Documentation of physician-patients interactions is poor amongst clinicians. Most will not support life and physician-assisted suicide for the terminally ill patients. However, in clinical practice most will transfuse their patients on palliative care with blood and give other life support treatment; an apparent dissociation between what clinicians think and what is practised.

Keywords: *Terminally ill, palliative care, euthanasia, will to die, physician assisted suicide*

Résumé
La perception des maladies de la fin d'actvites de vie varie en function des normes culturelles et les valeurs et l'esperance de vie peuvent differer des actions et practiques des médecins. En pratique contemporaire suivant le conflict des idees resulte des décharges des patients eux –meme contre la volonté médicale. Les médecins (67) praticiens d'au moins 6 ans au Centre Hospitalier Universitaire de la ville de Bénin, Nigéria étaient intervivés a l'aide d'un questionnaire sémi-structuré. Le résultat principal était l'attitude des médecins de donner les soins aux maladies gravement malade et le suicide assisté par un médecin. L'age moyenne des médecins était de 36.89+_ 7.57 ans, 11 femmes et 56 males. Vingt six médecins(40%) n'enregistraient pas régulièrement les discussions sur le prognotie avec leurs patients. Quarante un (62.1%) des médecins ne supportent pas quand leurs patients sont en soins médiocre, 74.2% transfuseront du sang a leurs patients. Treize (31.7%) nbe supporteront pas vivre et ne seront pas transfuser. Fifty-seven (85.1%) des médecins n'encourageront pas l'euthanasie, 8 sur 9 médecins males qui supporteront le PAS alorsque 6/9 médecins qui permetront ausx patients de faire le PAS sont des géniclogues. Tous les médecins généralistes ne supporteront pas le PAS, alorsque 5/17(77.3%) des médecins sont de l'option que les patients soient informés des prognotie de leur maladie. La documentation des interactions entre le médecin et les patients est faible parmi les médecins. Plusieurs ne supportent pas la vie et le suicide assisté par un médecin pour la terminalité des patients gravement malade. En pratique clinique, plusieurs transfusions de sang aux patients et l'emploi d'autres médicaments de support, apparait une dissociation entre entre ce que les médecins pensent et ce qu'ils pratiquent.

Introduction

The will in the terminally ill patient to live shows substantial fluctuation as death approaches [1]. Depression often features prominently amongst the older patients, which is poorly recognized and managed by Physicians involved in end-of-life care [2,3]. In the developed world, physician-assisted suicide (PAS) and euthanasia are topical social and medical issues. These contrast sharply with the African culture where life adverse events and personal mistakes, which are poorly understood, are blamed on witchcrafts and superstition beliefs. Cross-cultural studies have shown that healthcare providers and patients often differ in their views on health related matters [2-5]. The willingness to consider future illness and the end-of-life events for example, is not universal; patients in some communities are reluctant to consider or speak about such matters [6,7]. In this community the writing on this subject is scanty; however there are glaring gaps in our current state of knowledge about life events generally.

Caring for the dying requires competence in all aspects of end-of-life care and the ability to build trusting relationships between patients and physicians. In a recent review of the deaths in the gynaecological ward at the University of Benin Teaching Hospital (UBTH), the authors noted the need for patients and relations to use discharge against medical advice (DMA) as an option of care for the terminally ill patients [8]. The emergence of palliative care as a new specialised field of medicine requires an interdisciplinary approach. There have been tremendous advances in the last two decades in palliative care medicine with a frightening reality that life could be supported and or prolonged indefinitely.

The desire to improve the quality of care for the dying (palliative medical practice) in our hospital wards informed this research. The study was designed to examine the attitude of clinicians involved in care to the terminally ill patients in our hospital and community generally.

Materials and methods

Sixty-seven (67) senior clinicians that have been in medical practice for at least five years at the UBTH in the specialty of Obstetrics and Gynaecology, Internal Medicine, Surgery including Anaesthesia and General Practice were interviewed with a semi-structured questionnaire. Information obtained from the physicians included personal data on age, sex, year of qualification and specialisation, and marital status. Also, information on practice status (consultant or senior registrar) in the hospital was obtained. Data was collected on the number of terminally ill patients cared for in the preceding six month to the date of inter-

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view, details of discussion with patients including prognosis disclosure practice and documentations in the case notes, the use of analgesics, basic life support interventions including oxygen therapy, intravenous fluid administration and blood transfusion. The physicians were then requested to respond to an open ended question on support for PAS and euthanasia.

The study was conducted between June and September 2002. Information obtained was subjected to computer analysis using Epi Info 2000 statistical software for mean, Anova test, odd ratios, 95 % Confidence Interval, Chi square, *P* values (Yates corrected or Fishers exact) as appropriate. Chart and figures were generated using appropriate computer software.

Results

A total of 67 interviews were conducted during the study period, all questionnaires were adequately filled and analysed. The mean age of the clinicians was 36.89 ± 7.57 years. There were 11 females and 56 males. Table 1 shows some selected statistic for the age of the respondents. The mean ages of the two groups are 34.7 ± 6.65 and 37.33 ± 7.79 years (female and male respectively). The difference was not statistically significant (ANOVA T Statistic = 1.03, *P* value = 0.305; Bartlett's chi square = 0.378, df =1, *P* value = 0.54).

Table 1: Selected statistics figures for the Age distribution of the caregivers

Age	No. (%)	Mean	Range	Median	Variance	Std
Female	11 (16.7)	34.72	29-50	33.00	44.22	6.65
Male	55 (83.3)	37.33	28-65	35.00	60.63	7.79

The most frequent medical conditions listed by clinicians amongst the terminally ill patients during this study were advanced carcinomas 41 (61.19%), chronic medical diseases 11 (16.42%), HIV/AIDS 10(14.93%), head injury 2 (2.99%). Twenty-six clinicians (40%) do not routinely record in the case notes details of their discussion on prognosis with their patients. Table 2 is a summary of patients' awareness of the diagnosis of their illness stratified by documentation of discussion details in the case notes by clinicians. Nine patients (34.6%) of the 26 clinicians who do not keep details of their discussion in the case notes will be unaware of the prognosis associated with the diagnosis of the illness. The chance of this happening is 1.3500, (95% C.I = 0.636 - 2.862, Chi square, Yates corrected = 0.25, Fisher exact *P* value = 0.3064) not significant.

Table 2: Prognosis awareness by patients stratified by documentation of details of discussion in case notes by clinicians

	Not Aware No (%)	Aware No. (%)	Total No.(%)
No details in case notes	9 (34.6)	17(65.4)	26 (100.0)
Details in case notes	10 (25.6)	29 (74.4)	39 (100.0)
Total - clinicians	19 (29.2)	46 (70.8)	65 (100.0)

The majority of clinicians 41/67 (62.1%) will not support life while patients are on palliative care. Table 3 illustrates clinicians' attitude towards life support for patients on palliation and blood transfusion. The majority of caregivers 49 (74.2%) will transfuse their patients while on palliative care, while a minority 13 (31.7%) will not support life, and will not transfuse patients on palliation with blood. The odds of patients not being transfused with blood while on palliative care and having no life support is 2.4375, [95% CI, = 0.6946 - 8.5538, Risk Ratio (RR) = 1.9817 (95% CI = 0.7259 - 5.4099), Chi square - Yates corrected = 1.2665, Mid-p exact = 0.0851, Fisher exact = 0.129], not significant. The majority 21/25 (84.0%) of the clinicians who will support life while patients are on palliative care will transfuse their patients with blood.

Table 3: Clinicians' Attitude towards life support and blood transfusion for patients on palliation

	No Transfusion No (%)	Transfusion No. (%)	Total No. (%)
No Life support	13 (31.7)	28(68.3)	41 (100.0)
Life Support	4 (16.0)	21 (84.0)	25 (100.0)
Total - Clinicians	17 (25.8)	49 (74.2)	66 (100.0)

Table 4: Blood Transfusion given to patients on palliation stratified by Clinicians specialty

	No Transfusion No (%)	Transfusion No. (%)	Total No. (%)
Obstetrics and Gynaecology	5 (17.9)	23 (82.1)	28 (100.0)
Internal Medicine	8 (47.1)	9 (52.9)	17 (100.0)
Surgery	5 (35.7)	9 (64.3)	14 (100.0)
Anaesthesia	0 (0.0)	7(100.0)	7 (100.0)
General Practice	0 (0.0)	1(100.0)	1 (100.0)
Total - Clinicians	18 (26.9)	49 (73.1)	67 (100.0)

Fig. 1. Blood transfusion given to patients on palliation stratified by Clinicians specialty

Table 4 (depicted in Figure 1) is a cross tabulation of the attitudes of clinicians towards blood transfusion to patients on palliative care by specialty. All the anaesthetists (100.0%) who responded will transfuse their patients, while 23/25 (82.1%) of obstetricians and gynaecologists will transfuse their terminally ill patients. Most (64 out of 67) physicians prescribed analgesics to the terminally ill patients under their care, 3 clini-

clans did not because it was not necessary as patients were in deep coma and or with head injuries.

Table 5: Support for Euthanasia stratified by Gender

	Indifferent No. (%)	No Euthanasia No. (%)	Yes Euthanasia No. (%)	Total No. (%)
Female	0 (0.0)	10 (90.9)	1(9.1)	11 (100.0)
Male	1 (1.8)	47 (83.9)	8 (14.3)	56 (100.0)
Total Clinicians	1 (1.5)	57 (85.1)	9 (13.4)	67 (100.0)

Table 6: Response to Euthanasia stratified by Specialty

	Indifferent No (%)	No Euthanasia No (%)	Euthanasia No (%)	Total No (%)
General Practice	0 (0.0)	1 (100.0)	0 (0.0)	1 (100.0)
Anaesthesia	0 (0.0)	7 (87.0)	1(12.5)	8 (100.0)
Surgery	0 (0.0)	12 (85.7)	2 (14.3)	14 (100.0)
Internal Medicine	0 (0.0)	17 (100.0)	0 (0.0)	17 (100.0)
Obstetrics and Gynaecology	1 (3.7)	20 (74.1)	6 (22.2)	27 (100.0)
Total - Clinicians	1 (1.5)	57 (85.1)	9 (13.4)	67 (100.0)

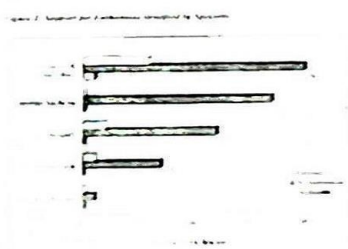

Fig. 2. Support for Euthanasia stratified by Specialty

The majority 57/67 (85.1%) of the clinicians interviewed will not support physician-assisted suicide or euthanasia. Table 5 is a summary of clinicians' attitude towards physician-assisted suicide stratified by gender. The majority 8/9 (88.9%) of the 9/67 (13.4%) physicians who will support physician-assisted suicide are males. One (1.5%) male was indifferent to granting patients request for assisted suicide. Six of the 9 clinicians that will grant patient's request for assisted suicide are obstetricians and gynaecologist (table 6). Figure 2 depicts clinicians' support for euthanasia by specialty. All the clinicians (17) in the Internal Medicine specialty interviewed will not support physician-assisted suicide.

Table 7 is a summary of physicians' attitude to prognosis information management stratified by support for euthanasia. A large proportion, 51/67 (77.3%) of the interviewed clinicians are of the opinion that patients should be routinely informed of the prognosis of the disease, while 7 (77.8%) of the 9 clinicians who will support euthanasia will discuss details with their patients.

Table 7: Clinicians attitude to prognosis information management stratified by support for Euthanasia

	No Information No (%)	Information No. (%)	Total No. (%)
Indifferent to Euthanasia	1 (100.0)	0 (100.0)	1 (100.0)
No to Euthanasia	12 (21.4)	44 (78.6)	56 (100.0)
Yes to Euthanasia	2 (22.2)	7 (77.8)	9 (100.0)
Total - Clinicians	15 (22.7)	51 (77.3)	66 (100.0)

Discussion

The number of terminally ill patients occupying hospital beds is likely to increase as the quality of care improves in our hospitals. In this study and similar work [3,8], the majority of the patients are likely to die from advance malignancies or chronic infections including HIV/AIDS, and the need for quality care will involve a multidisciplinary approach and improvement in communication skill. The art of history taking and documentation of physician-patients interactions is a time tested primarily skill and requirement of modern orthodox medical practice. In this study a large proportion of physicians (40%) document poorly their interactions with patients. The average age (36 years) of clinicians and the minimum duration of five practice-years in the study, should guarantee that physicians should know the importance of history taking and documentation. The skill seems to be on the decline or have suffered greatly from lack of in-depth practice at various level of patients' care. Out of the 26 physicians who will not document their discussion with patients, 9 will also not inform their patients about the prognosis associated with their disease. Caring for the terminally ill patient (palliative medicine) is all encompassing, it should be inclusive of respect for patients' goals, preferences and choices, which requires a new approach, specialization and is multidisciplinary in nature [13-19].

The majority of the clinicians responded that they would not support life while patients are on palliative care; this finding seems to be dissociated from the fact that a larger majority (74.2%) will transfuse their patients with blood. Only a small minority expressed clearly their opinion of not supporting life and giving blood transfusion to their patients while on palliative care. The chance of this happening was slim, P value 0.085 (mid-p exact). The physicians who will support life will transfuse their patients with blood. There is no coherent or clear clinical practice guideline, which is confusing to the patients and their family. The family members and relations witness their patients being transfused with blood, and are requested to purchase life saving drugs giving the expectation of a possible cure. This clinical response was strongest amongst the anaesthetists and gynaecologist. The Internal medicine clinicians are equally divided about transfusing terminally ill patients. A clear-cut opinion in the study was that nearly all clinicians would prescribe analgesics to their terminally ill patients. This practice of routinely giving analgesics is equally contentious in modern day practice [10,11,12].

Generally clinician in Benin will not support physician-assisted suicide (PAS), however of the few that will grant patients request majority are males and are gynaecologists. The Internal medicine clinicians will not support PAS. Physicians will routinely discuss prognosis with their patients but not PAS. Responding effectively to a patient request for physician-assisted suicide is an important clinical skill. It involves openness to discussions about PAS, clinician expertise in overseeing the dying process and the maintenance of a strong physician-patient relationship [7-9]. These attributes are clearly not in the present day practice of care for the dying in our hospitals and community.

Conclusion

Physician-patients interactions documentation is poor amongst clinicians; most will not support life during palliative care or offer physician-assisted suicide for the terminally ill patients. This attitude towards caring for the dying is not replicated in clinical practice, as most will transfuse their patients on palliative care with blood and give other life support interventions. An apparent dissociation between what clinicians think and what is practised.

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