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Resident Discomfort in Advance Care Planning: Insights from a Multicenter Survey

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Abstract

Objectives: Despite growing mindfulness regarding the importance of advance care planning with terminally ill patients and families, many resident physicians remain uncomfortable and poorly trained for these discussions. To guide the development of future curricula, we assessed trainee attitudes, knowledge, perceived proficiency, and needs in providing quality end of life care.

Methods: A cross-sectional, self-administered survey-based study of internal medicine residents in the state of New Jersey. The survey was administered in February so that all participants had a minimum of 6 months of formal training.

Result: 83 residents participated in the study. The majority reported never caring for a dying patient as a medical student. 71.1% felt uncomfortable discussing advance care directives and a similar percentage felt uncomfortable leading a family meeting without attending supervision. Very few residents received any feedback regarding their competency in goal setting with ill patients.

Discussion: Young physicians are poorly trained to address the needs of an aging population with advanced comorbidities. Curricular changes are certainly needed to prepare physicians for the changing landscape of medicine, especially considering the growing shortage of geriatric and palliative care providers.

Introduction

Most physicians training in internal medicine will lead emotionally challenging conversations focused on advance care planning, advance directives, and decisions regarding End of Life (EOL) care with their patients and families both during training through the course of their own independent careers. Although internal medicine residency programs are expected to include EOL training in their curriculum, many physicians still feel unprepared and uncomfortable leading these difficult discussions [1].

Good communication at EOL is important; both patients and families rely heavily on health care providers for direction regarding care provided for their loved ones [2]. Although good quality EOL discussions have been associated with less aggressive care, decreased frequency of post-traumatic stress, and greater use of hospice, prior studies indicate that many patients have not discussed advance directives with a health-care provider within 6 months of a terminal diagnosis [3]. Instead, many of these difficult discussions occur during acute hospital care and are often led by house staff. Despite the vast majority of U.S. medical schools now reporting teaching EOL care, many residents report feeling uncomfortable leading these discussions [4]. In addition, few studies have examined the long-term effects of educational changes in end of life training to see if reformed curricular efforts have been successful. The goal of this study was to investigate resident comfort, perceptions, and experience providing end of life care and the barriers to quality care among a cohort of internal medicine residents across the state of New Jersey.

Methods

All internal medicine house staff (PGY1-3) across the state of New Jersey were invited to participate in an anonymous online survey. Two tertiary university hospitals and six community health systems participated in the study. House staffs, categorical residents only, were invited by coordination with chief residents at each site. Survey

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questions assessed personal experiences and comfort providing care to patients with a terminal diagnosis or during a terminal hospitalization. The survey was administered in February so that all participants had a minimum of 6 months of formal training. The survey was open for three months in the year 2015. The survey assessed the following resident characteristics: experience defining goals of care and advance care planning, discussion of code status, subjective emotions regarding Cardiopulmonary Resuscitation (CPR), prior experience caring for dying patients, mentorship when communicating with patients and surrogates, and perceived barriers to achieving quality EOL care. Nominal variables were used and combined when reporting barriers to effective EOL care communication. Demographics were obtained, including year of training, race, age, gender, and career interests. Participation was voluntary without any incentives offered. Those who chose not to participate were not penalized in any way. Baseline characteristics of the participating residents was collected and examined via descriptive analysis. Chi-squared analysis was used for dichotomous variables and a student *t*-test was used for continuous variables. SAS 9.2 with significance of $p < 0.05$ was used for all statistical comparisons.

Results

Demographic information

83 residents of the invited 213 residents (39%) completed the survey. Fifty one percent (51% of the respondents were female; mean age was 28.3 years; and 46% were Caucasian. Future career plans included cardiology (20%), gastroenterology (22%), and pulmonary/critical care (14%), while 22% were interested in either hospitalist medicine or primary care (Table 1).

Survey responses

The majority felt uncomfortable discussing advanced care directives (71%) and felt uncomfortable leading a family meeting without attending supervision (69%). Most denied sharing the likely outcome of CPR when discussing code status with patients and families (94%) and felt it was unethical for a provider to tell a patient and/or family member that CPR was not in the best interest of a patient (60%). Despite this, almost all of the residents surveyed reported feeling frustrated when terminally ill patients elected to remain full code (94%) and have felt guilt coding a patient whose prognosis they felt was very poor (98%) (Table 2). There was no statistically significant difference among PGY year, gender, age, or future career plans for each of the questions listed in Table 2.

Total number	83 **(100%)**
Sex and age Male,	41(49%)
Mean age, years	28.3
Race	
Caucasian (%)	38 (46%)
Asian	12 (14%)
Black/African American	5(6%)
Multiracial	20(24%)
Hispanic	8(10%)
Specialty of interest	
Allergy/immunology	1 (1%)
Cardiology	17 (20%)
Gastroenterology	18 (22%)
General internal medicine/primary care	6 (7%)
Hematology/oncology	8 (10%)
Hospitalist medicine	16 (19%)
Infectious diseases	1(1%)
Nephrology	2 (2%)
Pulmonary/critical care	12 (14%)
Rheumatology	2 (2%)
Year of training	
PGY-1	30 (36%)
PGY-2	28 (34%)
PGY-3	25 (30%)

Table 1: Baseline Characteristics of Residents.

I feel comfortable discussing advance care directives with patients or family members	
Yes	29%
No	71%
I feel comfortable leading a family meeting without attending supervision	
Yes	32%
No	69%
When discussing code status, I share the likely outcome of CPR for hospitalized patients	
Yes	6%
No	94%
Physician input that CPR is not in the best interest of a patient is paternalistic and unethical	
Yes	60%
No	40%
I have felt frustrated when terminally ill patients elect to remain full code	
Yes	94%
No	6%
I have felt guilty coding a patient whose prognosis I felt was very poor	
Yes	98%
No	3%

Table 2: Resident Responses Regarding Goals of Care Discussions.

With regard to educational experiences in EOL care, about half of the residents reported having lectures on communicating EOL care (48%) and of those who had these lectures, 53% reported they were not helpful. Many reported learning by watching a senior resident or attending physician have an EOL care discussion (72%) and of these, only 52% found it to be somewhat helpful. Few reported having a senior resident (29%) or attending physician (30%) observe them lead a conversation. Despite their attendance, few of them provided constructive criticism and/or suggestive feedback, i.e., senior residents, 39%, and attending physicians, 10% (Table 3). When asked about experiences in end of life care in medical school, most residents (84%) reported never caring for a dying patient on any of their inpatient clerkships and only about half of them (54%) rotated through palliative care or hospice prior to residency.

Barriers

Respondents were asked to comment on perceived barriers to quality EOL care. The majority of residents felt that personal lack of knowledge regarding patient prognosis (78%) and absence of a therapeutic relationship with the patient or family (73%) were major barriers. They often felt that the patient or family's limited knowledge about medical illness (70%) or projected disease

1. I have rotated in palliative and/or hospice medicine as a medical student.	
Yes	54%
No	46%
2. I have cared for a dying patient during my medical school training	
Yes	16%
No	84%
3. In residency, I have had lectures on how to communicate goals of care with patients/family.	
Yes	48%
No	52%
3b. If yes, were these lectures helpful?	
Yes	47%
No	53%
4. I have watched a senior resident or attending physician lead a family meeting during my residency training.	
Yes	72%
No	29%
4b. If yes, was this helpful?	
Yes	52%
No	48%
5. A senior resident observed me lead a family meeting during my residency training.	
Yes	29%
No	71%
5b. If yes, did he/she provide feedback about your performance?	
Yes	40%
No	61%
6. An attending physician observed me lead a family meeting during my residency training.	
Yes	30%
No	70%
6b. If yes, did he/she provide feedback about your performance?	
Yes	10%

Table 3: Educational Experiences in End of Life Care.

trajectory (69%) were also barriers to effective communication about EOL care. A smaller minority reported cultural beliefs (25%) or religion (22%) as difficulties (Table 4).

Discussion

Patient–physician communication about advance directives, goal setting, and EOL care is arguably one of the most challenging aspects of patient care. Unfortunately, due to poor communication outside of the hospital, difficult conversations often occur in the acute care setting with nearly 83% of deaths due to chronic illness occurring during inpatient hospitalization [5].

Across the country, most residents receive the majority of their medicine training in the inpatient setting; this includes the general medicine ward, the emergency department, and the intensive care unit. During training, resident physicians lead conversations regarding goals of care, code status, and end of life preferences with patients, surrogates, and loved ones. Research suggests that many physicians experience discomfort leading EOL care discussions [6]. Our study further explored these difficulties from vantage point of internal medicine residents across a variety of training institutions across the state of New Jersey.

Our results indicate that house staff feels unprepared prognosticating several chronic disease states which inevitably

Barriers	**N = 83 (%)**
Unsure of the patient's prognosis	
Never	2 (2.6)
Rarely	16 (19.2)
Sometimes	31 (37.3)
Often	34 (40.9)
Unsure of the patient's diagnosis	
Never	7 (8.4)
Rarely	44 (53)
Sometimes	26 (31.3)
Often	6 (7.3)
Lack of a therapeutic relationship with the patient/family	
Never	2 (2.4)
Rarely	20 (24.1)
Sometimes	21 (25.3)
Often	40 (48.2)
The patient's/family's religious beliefs	
Never	3 (3.6)
Rarely	62 (74.7)
Sometimes	14 (16.9)
Often	4 (4.8)
The patient's/family's cultural beliefs	
Never	2 (2.4)
Rarely	60 (55.3)
Sometimes	17 (20.5)
Often	4 (4.8)
Time Restraints / Competing Priorities	
Never	25 (30.1)
Rarely	22 (26.5)
Sometimes	21 (25.3)
Often	15 (18.1)
The patient's/family's limited knowledge about the patient's illness	
Never	1 (1.2)
Rarely	24 (28,3)
Sometimes	28 (33.7)
Often	30 (36.8)
The patient's/family's limited knowledge about expected disease trajectory	
Never	3 (3.6)
Rarely	23 (27.8)
Sometimes	30 (36.1)
Often	27 (32.5)

Table 4: Reported Barriers to Effective Communication at End of Life.

makes goal setting difficult. Surprisingly, few trainees reported supervised guidance during EOL discussions. It is challenging to postulate why. Perhaps, the growth of palliative care has made end of life care more specialized, limiting resident exposure to dying patients and shifting the expectations on who is responsible for addressing an individual's mortality. Our findings suggest that attending physicians, especially academic hospitalists, should actively seek to involve trainees in advance care planning. This is especially pertinent today as the number of older adults with chronic diseases is rising and the number of geriatricians and palliative care physicians is dramatically decreasing. Given the changing landscape in medicine, all subspecialists and internists will be expected to have some proficiency in handling these difficult and important conversations.

Many residents reported feeling frustrated when patients and families had limited knowledge regarding the severity of illness and it was cited as a significant barrier to quality EOL care. This is paralleled with existing literature indicating that patients often do not understand the severity of their respective illnesses. We project that this is likely a reflection of poor communication training from both house staff in training and seasoned attending physicians. Prior research in oncology revealed that many patients receiving palliative chemotherapy for incurable cancers did not understand treatment was unlikely to be curative [7]. These misunderstandings between patients and providers about treatment goals complicate future discussions when they become more ill, especially if they are under the care of an unfamiliar provider [8]. Our survey research, in the context of prior literature, reinforces the need to examine barriers to EOL care communication, to expand resident education and training, and to enhance physician–patient communication at earlier stages in the disease trajectory [9]. It is sobering to note that even after decades of curricular reform, many students report their experiences with death and dying to be inadequate. An online module may serve as a realistic intervention, especially here in New Jersey, to improve resident proficiency and comfort as demonstrated by colleagues at the University of Chicago [10].

Our study has several limitations. First, although the study was conducted at several different training programs, it was geographically limited to the northeast and more specifically, the state of New Jersey. Practice culture may differ around the country. In addition, of the available 213 residents to whom the survey was sent, there was a response rate of thirty nine percent. This may not be representative of the overall residents' view. The residents surveyed, however, came from various medical schools and are likely training in a similar cultural environment as their colleagues across the country. In addition, the population in which they train exposes them to a diverse patient population. Second, our findings are based on resident self-report, subjecting it to recall bias. The available curricula for EOL training at each site were not collected and thus unclear. Future studies may consider targeting the perceptions of patients and families, which would help determine if there was congruence or discordance in resident perceptions regarding EOL care. Despite these limitations, our findings add to the scarce literature on resident preparedness to address advance care planning and provide quality EOL care.

Disclosure Statement

The authors have nothing to disclose.

Contributorship

All authors contributed equally in the writing of this manuscript.

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