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The physician as patient in palliative care: A retrospective case-note audit
Palliative Medicine, 2016; 30(9):889-892

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Published version available via DOI: http://dx.doi.org/10.1177/0269216316639774

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17 December 2020

http://hdl.handle.net/2440/129494

The physician-patient:

A retrospective case note audit of specialist palliative care referrals

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Keywords (4-6)

Abstract (250 words -structured)

Background:

Aim:

Design:

Setting/participants:

Results:

Conclusions:

This study adds to the growing body of literature that identifies the potential difficulties associated with caring for medical practitioners. By understanding some of the complexity of this particular doctor-patient relationship, clinicians can approach the management of physician-patients with a more sound understanding of their particular care needs.

Introduction

Caring for dying patients can be challenging, however a dying physician may present unique challenges to palliative care teams.[1-3] Compounding factors such as involvement of multiple specialists, lack of a coordinating clinician, prolongation of curative treatments, resistance to palliative care input, and barriers to discussing psychosocial needs may lead to suboptimal and late access to palliative care.[1, 2, 4] Furthermore, by providing greater access to after-hour services, palliative care teams may have difficulties maintaining professional boundaries.[2, 5] Physician-patients may challenge the authority of the treating team through their awareness of the clinical system or their knowledge of a particular illness.[1, 2] Confidentiality can be compromised through pressure to communicate with colleagues, or through unwanted clinical opinions.[2, 6]

Similarly, the dying physician must deal with personal and professional difficulties related to their role ambiguity as patients and as physicians.[1, 3, 4, 7, 8] Medical knowledge can be psychologically challenging: the rational understanding of the illness may be discordant with their emotions and behaviours.[3] Physician-patients may suffer from increased anxiety or fear[1, 4] due to their awareness of adverse effects, complications and limitations of the treatments provided,[1] or due to the likely avoidance of psychosocial wellbeing discussions.[2] Behaviourally, the need to remain in control can translate into self-doctoring behaviours by accessing own test results, overly directing consultations or bypassing referral systems.[1, 2] These behaviours can also be observed when patients have health professionals as relatives.[9]

Despite an academic interest in how medical practitioners access healthcare services,[10] studies of dying physicians are scarce. Findings are derived from studies focused on the lived-experience of doctors as patients or by interviewing treating medical specialists. No studies to date have examined the specific treatment provided to dying physicians.

This retrospective case-note audit aims to describe and examine the care provided to physician-patients referred to palliative care, and to identify issues faced by the physician-patient and by the treating team.

Methodology

Eligible cases included all medical practitioners' case notes who had been admitted for hospice care or who were private palliative care outpatients at an Adelaide hospital during January 2007 to April 2013 and had died. GBC searched electronically and manually the hospice and the private practice records of the selected period and identified all potential physician-patients. Thirty cases were identified but only 25 were included because one was a non-palliative admission, another patient was alive, and it was uncertain whether the other three were medical practitioners.

The researchers developed a data collection tool based on available literature[1-3] (Appendix 1). Questionnaire items recorded demographic data and information about practices of self-referral, self-management and prescribing, access to services, psychosocial wellbeing, patient outcomes, and professional interactions. The questionnaire was piloted with an initial set of notes and adjustments were made where necessary.

LMM performed the review of patient notes. GBC independently reviewed a subset of notes to assess inter-rater reliability. The initial calculated Cohen's Kappa value was 0.62 and the average agreement was 81%. All discrepancies were resolved and taken into account for all subsequent reviews.

Descriptive statistics were obtained. Mann-Whitney and Pearson Chi Square tests were employed, however the small number of cases precluded the identification of significant differences between the majority of variables.

The study received prospective ethical approval (Calvary Hospital Ethics Committee 13-CHREC-E010).

Results

The majority of physician-patients were male (84% n=21), and were general practitioners (GPs) (36% n=9) or psychiatrists (24% n=6). Prior to diagnosis 52% were retired and 40% worked full-time. The average age was 71 years (range: 42-89 years).

Eighty-eight per cent had a malignant illness (n=22), 62% were referred to palliative care by their oncologist (n=15), 25% by a GP (n=6), and 12% by a surgeon (n=3). Three patients were referred by non-treating doctors, and two by a medical relative. Nine patients had close relatives who were medical practitioners or nurses (36%). Reason for referral in 80% of the patients (n=20) was for general palliative support/assessment and for 20% of the patients there was an acute crisis requiring palliative care input.

Initial palliative care assessment occurred in the community (52% n=13) or while the patient was an inpatient (44%, n=11). The total period of palliative care input varied between 4 and 480 days (16 months) with an average of 117 days. Only seven patients were referred within 90 days of their illness being identified as advanced or metastatic. Women were more likely to be referred within less than 90 days of an advanced disease diagnosis than were men (X^2= 4.542, p=0.33).

The majority of patients were admitted to hospice at least once during their illness (76% n=19) and came from their usual accommodation (58% n=14). The shortest stay was of two days, and the longest was of 30 consecutive days. The average length of stay was 10 days. Four patients were admitted twice to hospice, and one patient was admitted four times for respite care.

Patients younger than 65 years tended to be admitted to hospice more than their older counterparts (X^2=5.714, p=0.017). Two patients had increased consultant level input whilst in the hospice and junior medical staff documented reticence to make any treatment decisions without senior support because of the physician-patients' demand for consultant-level direction. One patient had increased direct communication with the palliative care physician outside working hours.

Among the treatments provided while receiving palliative care input, 56% had blood tests assessments, 24% had diagnostic imaging, and 24% received antibiotics. Patients who received antibiotics were significantly younger than their counterparts (U=27.000 p=0.005). Eighty-eight per cent received community outreach services (n=22), 80% received domiciliary care services such as equipment and allied health assessments (n=20), 66% received nursing home care (n=19), and 56% engaged with psychosocial services (n=14). Four patients were noted to have no barrier to discussions about end of life care, disease progression and psychosocial wellbeing. In contrast, two patients were documented to be actively avoiding conversations about the terminal nature of their illness. Sixty-four per cent had personal after-hours contact with palliative care (n=16). Three physician-patients had evidence of medically qualified family members directing their treatment decisions (12%). No issues about confidentiality were reported in any of the case notes.

Forty-four per cent of the patients had their medications changed by non-palliative care doctors (n=11) and 16% had evidence of changing their medications by themselves. Patients who had their medications changed by doctors external to the team were significantly younger than patients whose medications were not changed (X^2=4.573, p=0.032). Two patients were noted to have unorthodox pain medication plans: one patient insisted on intravenous opioid medication and another initiated high levels of opioid medications himself. Another patient unduly directed their medical care whilst in hospice care, including the route of medication administration and the initiation of intravenous fluid therapy.

Ninety-two per cent of the patients had evidence of GP involvement in their care (n=23). The two patients without GP involvement were referred to palliative care less than a week before their deaths. Patients who had GP involvement significantly had more days of palliative care input (U= 46.000, p=0.007).

Fifty-two per cent of the physician-patients died in hospice (n=13), 20% in hospital (n=5), 20% at home (n=5) and eight per cent in nursing homes (n=2).

Discussion

This retrospective case note audit provides further information about the behaviours of physician-patients when facing the end of their lives. It supports the findings of others about the risk of self-prescribing, self-management, of undue control of medical and treatment decisions and difficulties of assuming the "patient role".[1, 2, 11] There was evidence of some physician-patients who wanted to direct their own care, of bypassing conventional referral systems and of prescribing for themselves. There also appeared to be some reluctance or fear by junior members of the medical team to make decisions because of the patient's desire for consultant-level advice only. There was evidence of medically qualified family members making decisions without professional advice or support.

It is not possible to determine whether the duration, the quality of patient care and patient outcomes were different for this cohort of patients. Younger physician-patients appeared to have a hospice admission more frequently than older patients.

Within the limitations of a retrospective case note audit, this work supports previous anecdotal and single case reports about physician-patients.[1, 2, 11] A prospective study of physician-patients who may be facing their own death, would allow further analysis to identify the real and potential difficulties for all physician-patients when accessing health care. This would also assist treating clinicians in their approach and understanding of their colleagues as patients. The development of evidence-based guidelines would support medical practitioners when caring for colleagues. This would be a useful outcome, particularly for more junior medical staff.

I am not sure whether the discussion should highlight issues of overtreatment or under-treatment of physician-patients (may be even looking at differences according to age). Also, there seem to be some differences when there is GP involvement.

Conflict of Interest Statement: The authors declare that they have no conflict of interest.

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