

Documentation Patterns on Communicating Prognosis to Patients with Terminal Illness

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Introduction: Prognosis is an issue which most doctors and patients find difficult to discuss. Both patients and physicians find this process distressing as they can be unprepared to receive and give life-altering news. Although clinicians report that they are discussing prognosis, patients and caregivers frequently do not corroborate these reports, creating communication gaps especially in end-of-life situations.

Objective: This study determined how attending physicians documented the communication of prognosis on the patients' records in terms of content, timing, and frequency during the course of hospitalization.

Methods: This is a retrospective chart review of 234 terminally-ill patients admitted from January 2020 to March 2020 in five (5) clinical departments of a public tertiary hospital. Discharge summaries and physicians' daily chart notes were reviewed to identify the major events of each case.

Results: Two-thirds of the patients' records had no documentation of any discussion with patient/family/significant others relating to patients' worsening condition. The quantitative and qualitative forms of contextual information regarding patient prognosis were infrequently recorded. Notes on conversations of survival rate, probability of treatment response and failure were likewise lacking. However, for the occasional documentation observed, the timing of the communications was appropriate across the disease trajectory and was significantly correlated with all major points of illness deterioration ($p < .001$). Physician and patient characteristics had no association with the practice of documenting communication prognosis.

Conclusion: Communication prognosis is not a common practice for most physicians. Prognosis was poorly documented on the patients' charts, which could suggest that either such a communication process did not take place at all or physician education on documentation should be reinforced by an institutional protocol, especially in the care of terminally ill patients.

Key words: Terminal illness, hospitalization, prognosis, end-of-life situation

INTRODUCTION

Prognosis is an important consideration in the care of advanced illnesses and heterogeneous health trajectories because overall life expectancy critically influences several clinical decisions that could benefit or harm patients. Conversations about prognosis are necessary to engage patients and families in shared decision making about treatment choices concordant with their preferences. Moreover, end-of-life conversations result in improved quality of life as these could

prompt advance directives and settle any unresolved personal and family issues¹. (Cartwright, 2014)

Effective communication is critical to the successful delivery of health care services and the satisfaction of stakeholders. It encompasses individual expectations and understanding, and socio-cultural norms. Communication is an essential part of patient-centered and family-focused care.² The written form of communication certainly has its advantages - it can be used for future reference and can be easily and simultaneously disseminated to the care providers, and relatives involved in the care process. The documentation also has medico-legal value.³

Communication about prognosis is vital yet such discussions tend to be infrequent or imbalanced, often overly optimistic in routine care of seriously ill patients.² Patients and families report that health providers

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seldom disclose straightforward negative projections. These sensitive exchanges may be due to patient and physician factors, but these have not been explored fully in the local setting.¹ Considering the usefulness of prognosis communication as a transitional milestone in the care of seriously ill patients, it is prudent to determine if the highly challenging conversations during these critical points are properly documented events in the hospital stay.⁴ Thus, this study assessed the patterns of communicating prognosis among physicians attending to patients with terminal illness and the factors associated with certain patterns.

METHODS

Study Design and Population

This is a retrospective study conducted via medical chart review of patients with advanced or terminal stage of illness under the service of Internal Medicine, Pediatrics, Otorhinolaryngology/Head and Neck, Gynecology and Surgery admitted from January 2020 to March 2020 in Rizal Medical Center.

Sample Size

Selection of patients was based on the documented diagnoses on the chart and the clinical states such as sepsis, multi-organ failure, among others. Admitting and Census logbooks from the Medical Records Section were used as a basis for identification of patients. The sample size was computed at 148 with 95% confidence level using the Sloven's formula.

Data Collection

Data on patients' baseline demographics, diagnosis and date of death or discharge were collected. Similarly, demographics of the attendings were also obtained. Discharge summaries or clinical abstracts were reviewed to recognize the major events in the timeline of each case. Prognosis communication entries were noted in qualitative and quantitative forms. Qualitative statements reflecting the shift in care were identified such as "from curative to comfort," "goals of care," "advance care planning," "family meetings held," and "limited/exhausted or non-response to treatment options". The following contextual terms were also searched relating to communicating prognosis such as but not limited to: "discussed," "primed," "informed," and "aware."

Moreover, quantitative forms of stating prognosis were looked up in the charts using contextual terms such as: "poor prognosis," "unlikely / poor response," "low percentage". The timing and frequency of family meeting/s and chart entries in relation to significant changes in the trajectory of illness were also recorded against treatment failure, organ failure, refractory symptoms, and onset of catastrophic events.

Statistical Analysis

The data gathered were encoded in Microsoft excel sheets. Descriptive statistics were presented as percentages and frequencies.

Tests of associations between physician/patient demographics and the patterns of prognosis communication were employed utilizing Pearson's correlation coefficient r (rho) for variables on continuous scale and the chi-square test for association (contingency) between two categorical variables. All collected data were transferred and stored in a separate hard disk and the researcher kept the files for the duration of the study. All gathered data and information will be kept for five (5) years.

Ethical Considerations

This study was approved for implementation by the Hospital's Ethics Review Board. Permission to perform chart review of selected patients were signed by the Chief Training Office, Chief of Medical Professional Staff and the concerned Department heads.

RESULTS

A total of 234 patients were included in the study. The sources of the charts were from Internal Medicine ($n=182$, 79%), Surgery ($n=25$, 11%), Pediatrics ($n=15$, 6%), OB-Gyne ($n=7$, 3%) and ENT ($n=5$, 1%). Only 24 (10%) charts had more than 2 family meetings documented while the remaining 210 (90%) patients had 0-1 documented discussion of prognosis. About two-thirds ($n=153$, 65.4%) had no documented discussion at all and the remaining quarter held one (1) discussion during the entire hospital stay.

The profiles of the patients who were engaged in at least 2 documented discussions were between mostly 19-59 years old, males, married, completed primary school and Catholics. Cases of cerebrovascular disease were found to have more frequent family conferences noted in the charts (Table 2). There was no association between the occurrence of family conferences and the patient's age, gender, educational attainment, and religion. (Table 5)

On the other hand, there were only fifty (50) physicians out of 91 resident physicians in the five (5) departments involved, who conducted at least one family meeting with their patients, and only one (1) had more than 2 family meetings. The doctors who had at least one family meeting were mostly females ($n=32$, 64%), aged 26-29 years old ($n=34$, 68%), junior residents ($n=16$, 32.0%), single ($n=47$, 98%) and Catholics ($n=49$, 98%). (Table 3). The conduct of the family meeting was not influenced by the physician's age, gender, civil status, religion, and year level of training (Table 4)

Qualitative measures showed that the phrase "goals of care" were present in all the chart entries. Discussions on shifting care from curative to comfort were documented by the hospital's advance directive form. "Advance care planning" was also noted in some of the charts particularly those referred for palliative care services. The writing of "prime patients or relatives about condition" was a common practice observed. There were no chart inputs that stated disclosing the patient's survival rate, odds of treatment or failure and the like. Quantitative and qualitative statements are summarized (Table 7).

The timing of the communications was noted to be appropriate across the disease trajectory and was significantly correlated with all major points of illness deterioration ($p < .001$). (Table 1)

Two thirds of charts had no documentation of any discussion, 12.4% had conversations recorded during the first 24 hours of admission, 2.1% had discussions within 48 hours and 18.8% within 72 hours. Infrequent family meetings were also observed. More than half of patients had no family meeting/discussion (n=153, 65.4%) from the day of admission up to the patient's death or discharge. Only a quarter had only 1 discussion (n=57) during their entire hospital stay. (Table 2)

DISCUSSION

Documentation in medical records serves many purposes such as the main communication platform among healthcare professionals, evidence of patient care and justification of health providers' management and claims.³ Effective communication improves family satisfactions, trust in physicians, provides clinical decision making and

Table 1. Timing of family meeting from the illness of trajectory and , p value.

| Patients Events | Occurrence | Timing of Family Meeting | | | | Total | Likelihood Ratio | Phi/Cramer's V | p-value | Significance |
|-----------------------|------------|--------------------------|-------|-------|------|-------|------------------|----------------|---------|--------------|
| | | 24hrs | 48hrs | 72hrs | none | | | | | |
| Failure to Response | no | 1 | 0 | 5 | 86 | 92 | 57.555 | 0.441 | <0.001 | Significant |
| | yes | 43 | 6 | 18 | 75 | 142 | | | | |
| sign of organ failure | no | 3 | 1 | 0 | 90 | 94 | 49.640 | 0.408 | <0.001 | Significant |
| | yes | 34 | 2 | 20 | 84 | 140 | | | | |
| Refractory Symptoms | no | 1 | 0 | 0 | 94 | 95 | 66.219 | 0.466 | <0.001 | Significant |
| | yes | 48 | 3 | 8 | 80 | 139 | | | | |
| Onset of catastrophic | no | 0 | 0 | 1 | 86 | 87 | 43.833 | 0.361 | <0.001 | Significant |
| | yes | 37 | 2 | 6 | 102 | 147 | | | | |

Table 2 . Patient demographics and frequency of documentation.

| Characteristic | Frequency | % | With Documentation of family meeting (Frequency >2 documentatiosn) N 24 (10.2%) | Without Document of family meeting (Frequency of 0-1 documentation) N 210 | |
|------------------------|-----------|-------|--|---|------------------|
| | | | | 0 N- 153(65.4%) | 1 N 57(24.4%) |
| Age | | | | | |
| 1-18 yo | 15 | 6.4% | 1 (4%) | 8 (5.2%) | 4 (7%) |
| 19- 59 yo | 125 | 53.4% | 13 (54%) | 104 (67.%) | 36 (63.1%) |
| >60 yo | 94 | 40.2% | 10 (42%) | 41 (27.8%) | 17 (29.9%) |
| Gender | | | | | |
| Male | 129 | 55.1% | 16 (67%) | 99 (64.7%) | 17 (29.8%) |
| Female | 105 | 44.9% | 8 (3.42%) | 54 (35.3%) | 40 (70.2%) |
| Civil status | | | | | |
| Child | 14 | 6.0% | 1 (0.43%) | 8 (5.2%) | 4 (7.0%) |
| Single | 62 | 26.5% | 7 (2.99%) | 53 (34.6%) | 4 (7.0%) |
| Married | 124 | 53.0% | 12 (5.13%) | 66 (43.1%) | 19 (80.7%) |
| Widowed | 32 | 13.7% | 4 (1.70%) | 25 (16,31%) | 2 (3.51%) |
| Separated | 2 | 0.9% | 0 (0%) | 1 (0.65%) | 1 (1.8%) |
| Educational attainment | | | | | |
| Grade School | 81 | 34.6% | 10 (41.7%) | 56 (36.6%) | 11 (19.3%) |
| High School | 101 | 43.2% | 7 (29.2%) | 81 (53%) | 14 (24.6%) |
| College | 46 | 19.7% | 7 (29.1%) | 16 (10.4%) | 32 (56.1%) |
| Post Graduate | 0 | 0% | 0 (0%) | 0 (0%) | 0 (0%) |
| Religion | | | | | |
| Catholic | 210 | 89.7% | 22 (91.6%) | 137 (89.5%) | 52 (91.3%) |
| Christian | 12 | 5.1% | 1 (4.6%) | 10 (6.5%) | 1 (1.7%) |
| INC | 7 | 3.0% | 0 (0%) | 6 (4%) | 2 (3.5%) |
| Islam | 3 | 1.3% | 1 (4.6%) | 0 (0%) | 2 (3.5%) |

| | | | | | |
|----------------------------|----|--------|-----------|------------|------------|
| Diagnosis | | | | | |
| Brain Cancer | 3 | 1.3% | 1 (4.2%) | 2 (1.3%) | 0 (0%) |
| Brain Breast | 3 | 1.3% | 0 (0%) | 1 (0.6%) | 1 (1.8%) |
| Hepatobiliary | 13 | 5.6% | 1 (4.2%) | 10 (6.5%) | 2 (3.5%) |
| Colorectal | 12 | 5.1% | 0 (0%) | 12 (7.8%) | 0 (0%) |
| Gastric | 7 | 3.0% | 0 (0%) | 7 (4.6%) | 0 (0%) |
| Kidney | 8 | 3.4% | 1 (4.2%) | 7 (4.6%) | 14 (9.1%) |
| Lung | 9 | 3.8% | 1 (4.2%) | 9 (5.9%) | 3 (5.3%) |
| Pancreatic | 8 | 3.4% | 2 (8.3%) | 4 (2.6%) | 0 (0%) |
| Endometrial/OvarianDisease | 4 | 1.7% | 0 (0%) | 0 (0%) | 0 (0%) |
| Sepsis | 30 | 12.8% | 2 (8.3%) | 21 (13.7%) | 4 (7.0%) |
| Pneumonia | 44 | 18.8% | 2 (8.3%) | 27 (17.6%) | 11 (24.6%) |
| CVD | 24 | 10.3% | 5 (20.8%) | 15 (9.8%) | 3 (5.3%) |
| MI | 21 | 9.0% | 0 (0%) | 12 (7.8%) | 13 (22.9%) |
| Hematologic | 7 | 3.0% | 1 (4.2%) | 6 (4%) | 1 (1.6%) |
| ENT | 14 | 6.0% | 3 (12.5%) | 10 (6.6%) | 2 (3.5%) |
| Others : | | | | | |
| chronic | | | | | |
| Terminal Illness: | 27 | 11.54% | 5 (20.5%) | 10 (6.6%) | 3 (5.3%) |

Table 3. Physician demographics and frequency of chart documentation.

| Characteristic | Frequency | % | With documentation of family meeting (Frequency >2 documentatiosn) N = 1 | Without document of family meeting (Frequency of 0-1 documentation) N = 29 |
|-------------------|-----------|-------|---|--|
| Age | | | | |
| 26-29yo | 34 | 68% | 1 (2.0%) | 33 (67.3%) |
| >30-33 yo | 15 | 30% | 0 (0%) | 15 (30.6%) |
| >33 | 1 | 2.0% | 0 (0%) | 1 (2.0%) |
| Gender | | | | |
| Male | 18 | 36.0% | 1 (2.0%) | 17 (34.7%) |
| Female | 32 | 64.0% | 0 (0%) | 32 (65.3%) |
| Civil Status | | | | |
| Single | 47 | 98% | 1 (2.0%) | 49 (100%) |
| Married | 3 | 0% | 0 (0%) | 0 (0%) |
| Widowed | 0 | 0% | 0 (0%) | 0 (0%) |
| Separated | 0 | 2.0% | 0 (0%) | 0 (0%) |
| Year Level | | | | |
| 1st | 16 | 32% | 1 (2.0%) | 15 (30.6%) |
| 2nd | 10 | 20% | 0 (0%) | 10 (20.4%) |
| 3rd | 11 | 22% | 0 (0%) | 11 (22.4%) |
| 4th | 10 | 20% | 0 (0%) | 10 (20.4%) |
| 5th | 3 | 6.0% | 0 (0%) | 3 (6.2%) |
| Religion | | | | |
| Catholic | 49 | 98% | 1 (2.0%) | 48 (98%) |
| Christian | 0 | 0 | 0 (0%) | 1 (2%) |
| Muslim | 0 | 0 | 0 (0%) | 0 (0%) |
| Iglesia ni kristo | 0 | 0 | 0 (0%) | 0 (0%) |
| Others : specify | 1 | 2% | 0 (0%) | 0 (0%) |

Table 4. Association of physician demographic characteristics with patterns of documentation.

| Age Range | Freq | | Percent | | Freq | | Percent | | Test Statistics | |
|-------------------|------|-------|---------|------|------|--------|---------|---|--|--|
| | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 | | |
| 26-29 | 33 | 66.00 | 1 | 2.00 | 34 | 68.00 | | | *** Chi-square = 0.791, PhiCramer's V = 0.038, p = 0.673, "Not Significant" | |
| 30-33 | 15 | 30.00 | 0 | 0.00 | 15 | 30.00 | | | | |
| >33 | 1 | 2.00 | 0 | 0.00 | 1 | 2.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |
| CIVIL STATUS | | | | | | | | | | |
| Married | | | | | | | | | | |
| Married | 3 | 6.00 | 0 | 0.00 | 3 | 6.00 | | | *** Chi-square = 0.068, PhiCramer's V = 0.026, p = 0.798, "Not Significant" | |
| Single | 46 | 92.00 | 1 | 2.00 | 47 | 94.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |
| Religion | | | | | | | | | | |
| Buddhist | | | | | | | | | | |
| Buddhist | 1 | 2.00 | 0 | 0.00 | 1 | 2.00 | | | *** Chi-square = 0.021, PhiCramer's V = 0.020, p = 0.688, "Not Significant" | |
| Catholic | 48 | 96.00 | 1 | 2.00 | 49 | 98.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |
| Year Level | | | | | | | | | | |
| 1 | | | | | | | | | | |
| 1 | 15 | 30.00 | 1 | 2.00 | 16 | 32.00 | | | *** Chi-square = 2.163, PhiCramer's V = 0.208, p = 0.708, "Not Significant" | |
| 2 | | | | | | | | | | |
| 2 | 10 | 20.00 | 0 | 0.00 | 10 | 20.00 | | | | |
| 3 | | | | | | | | | | |
| 3 | 11 | 22.00 | 0 | 0.00 | 11 | 22.00 | | | | |
| 4 | | | | | | | | | | |
| 4 | 10 | 20.00 | 0 | 0.00 | 10 | 20.00 | | | | |
| 5 | | | | | | | | | | |
| 5 | 3 | 6.00 | 0 | 0.00 | 3 | 6.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |
| GENDER | | | | | | | | | | |
| Female | | | | | | | | | | |
| Female | 32 | 64.00 | 0 | 0.00 | 32 | 64.00 | | | *** Chi-square = 1.814, PhiCramer's V = 0.180, p = 0.178, "Not Significant" | |
| Male | | | | | | | | | | |
| Male | 17 | 34.00 | 1 | 2.00 | 18 | 36.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |
| DEPARTMENT | | | | | | | | | | |
| ENT | | | | | | | | | | |
| ENT | 3 | 6.00 | 1 | 2.00 | 4 | 8.00 | | | *** Chi-square = 5.3205, PhiCramer's V = 0.484, p = 0.267, "Not Significant" | |
| INTERNAL MEDICINE | | | | | | | | | | |
| INTERNAL MEDICINE | 21 | 42.00 | 0 | 0.00 | 21 | 42.00 | | | | |
| OB-GYNE | | | | | | | | | | |
| OB-GYNE | 5 | 10.00 | 0 | 0.00 | 5 | 10.00 | | | | |
| Pedia | | | | | | | | | | |
| Pedia | 9 | 18.00 | 0 | 0.00 | 9 | 18.00 | | | | |
| SURGERY | | | | | | | | | | |
| SURGERY | 11 | 22.00 | 0 | 0.00 | 11 | 22.00 | | | | |
| Total | 49 | 98.00 | 1 | 2.00 | 50 | 100.00 | | | | |

Table 5. Association of patient demographic characteristics with patterns of documentation.

| Demographics | Scaled_Documentation | | | | Total | | Test Statistics |
|------------------------|---------------------------|---------|---------------------|---------|-------|---------|---|
| | Without Document (0 to 1) | | With Document (> 1) | | Freq | Percent | |
| Age Range | Freq | Percent | Freq | Percent | Freq | Percent | *** Chi-square = 0.228, PhiCramer's V = 0.031, p = 0.632, "Not Significant" |
| 1 | 14 | 5.98 | 1 | 0.43 | 15 | 6.41 | |
| 2 | 112 | 47.86 | 13 | 5.56 | 125 | 53.42 | |
| 3 | 84 | 35.90 | 10 | 4.27 | 94 | 40.17 | |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 | |
| Gender | Freq | Percent | Freq | Percent | Freq | Percent | *** Chi-square = 1.433, PhiCramer's V = 0.078, p = 0.230, "Not Significant" |
| FEMALE | 97 | 41.45 | 8 | 3.42 | 105 | 44.87 | |
| MALE | 113 | 48.29 | 16 | 6.84 | 129 | 55.13 | |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 | |
| CIVIL STATUS | Freq | Percent | Freq | Percent | Freq | Percent | *** Chi-square = 0.668, PhiCramer's V = 0.053, p = 0.955, "Not Significant" |
| Child | 13 | 5.56 | 1 | 0.43 | 14 | 5.98 | |
| Married | 112 | 47.86 | 12 | 5.13 | 124 | 52.99 | |
| Separated | 2 | 0.85 | 0 | 0.00 | 2 | 0.85 | |
| Single | 55 | 23.50 | 7 | 2.99 | 62 | 26.50 | |
| Widow | 28 | 11.97 | 4 | 1.71 | 32 | 13.68 | |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 | |
| Educational Attainment | Freq | Percent | Freq | Percent | Freq | Percent | *** Chi-square = 2.776, PhiCramer's V = 0.109, p = 0.428, "Not Significant" |
| CHILD | 5 | 2.14 | 1 | 0.43 | 6 | 2.56 | |
| Colle | 39 | 16.67 | 7 | 2.99 | 46 | 19.66 | |
| Elem | 72 | 30.77 | 9 | 3.85 | 81 | 34.62 | |
| High | 94 | 40.17 | 7 | 2.99 | 101 | 43.16 | |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 | |
| Religion | Freq | Percent | Freq | Percent | Freq | Percent | *** Chi-square = 0.107, PhiCramer's V = 0.021, p = 0.743, "Not Significant" |
| CATHOLIC | 188 | 80.34 | 22 | 9.40 | 210 | 89.74 | |
| Non_Catho | 22 | 9.40 | 2 | 0.85 | 24 | 10.26 | |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 | |

| Diagnosis | Freq | Percent | Freq | Percent | Freq | Percent |
|--------------|------|---------|------|---------|------|---------|
| brain cancer | 2 | 0.85 | 1 | 0.43 | 3 | 1.28 |
| breast | 2 | 0.85 | 0 | 0.00 | 2 | 0.85 |
| chronic | 17 | 7.26 | 2 | 0.85 | 19 | 8.12 |
| colon | 12 | 5.13 | 0 | 0.00 | 12 | 5.13 |
| cvd | 20 | 8.55 | 5 | 2.14 | 25 | 10.68 |
| endometrial | 4 | 1.71 | 0 | 0.00 | 4 | 1.71 |
| ent | 13 | 5.56 | 1 | 0.43 | 14 | 5.98 |
| gastric | 7 | 2.99 | 0 | 0.00 | 7 | 2.99 |
| heart | 21 | 8.97 | 0 | 0.00 | 21 | 8.97 |
| hema | 6 | 2.56 | 1 | 0.43 | 7 | 2.99 |
| hepato | 12 | 5.13 | 1 | 0.43 | 13 | 5.56 |
| kidney | 7 | 2.99 | 1 | 0.43 | 8 | 3.42 |
| lung | 8 | 3.42 | 1 | 0.43 | 9 | 3.85 |
| pancreatic | 6 | 2.56 | 2 | 0.85 | 8 | 3.42 |
| pneumonia | 38 | 16.24 | 6 | 2.56 | 44 | 18.80 |
| sepsis | 28 | 11.97 | 2 | 0.85 | 30 | 12.82 |
| terminal | 7 | 2.99 | 1 | 0.43 | 8 | 3.42 |
| Total | 210 | 89.74 | 24 | 10.26 | 234 | 100.00 |

*** Chi - square = 16.055, Phi/Cramer's V = 0.235, p = 0.681, "Not Significant"

Table 6. Frequency of timing of family meetings based on major illness events.

| Patients Event | 24hrs | | 48hrs | | 72hours | | none | | Total | | Median Time of family Meting | Averagen Time of family Meting |
|-----------------------------|--------------|---------|-----------------|---------|----------------|---------|-------------|---------|-------|---------|------------------------------|--------------------------------|
| | within 24hrs | Percent | within 48 hours | Percent | within 72hours | Percent | No Meetings | Percent | Total | Percent | | |
| 1. Date of Detection | 29 | 12.4 | 5 | 2.1 | 44 | 18.8 | 156 | 66.7 | 234 | 100.0 | 72 hours | 52.62 |
| 2. Date of failure Response | 44 | 18.8 | 6 | 2.6 | 23 | 9.8 | 161 | 68.8 | 234 | 100.0 | 24 hours | 41.10 |
| 3. sign of organ failure | 37 | 15.8 | 3 | 1.3 | 20 | 8.5 | 174 | 74.4 | 234 | 100.0 | 24 hours | 41.20 |
| 4. refractory Symptoms | 49 | 20.9 | 3 | 1.3 | 8 | 3.4 | 174 | 74.4 | 234 | 100.0 | 24 hours | 31.60 |
| 5. Onset of catastrophic | 37 | 15.8 | 2 | 0.9 | 7 | 3.0 | 188 | 80.3 | 234 | 100.0 | 24 hours | 32.35 |

Table 7. Word/Phrase list used to document prognosis communication in charts.

| Quantitative | Qualitative |
|--------------------------|---|
| Poor prognosis discussed | Prime patient regarding condition Primed relatives about the condition Discussed the prognosis risk well explained |

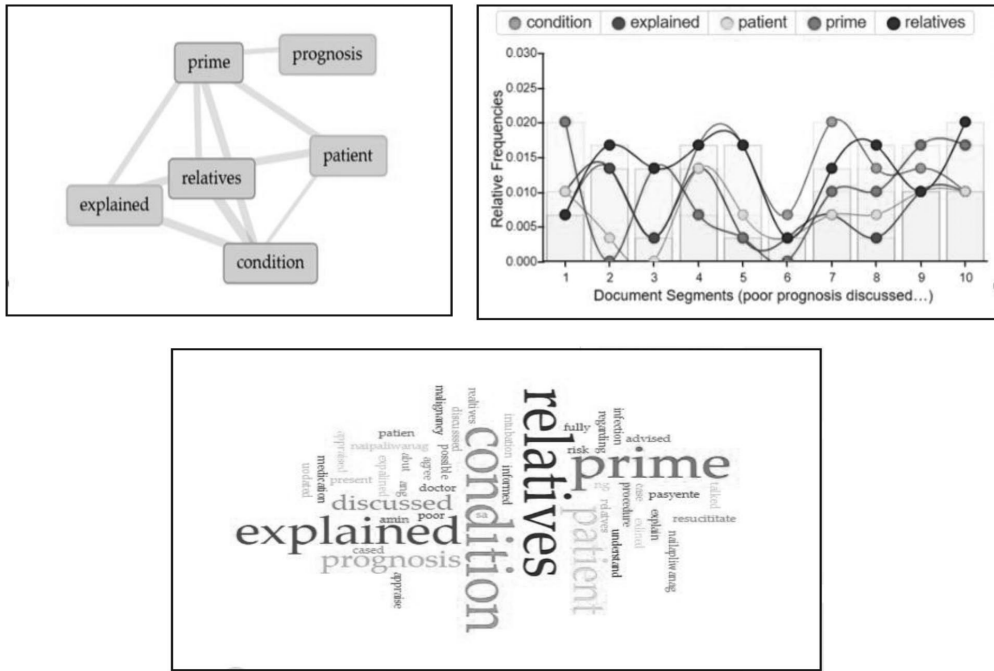


Figure 1. Word/Phrase list patterns used to document prognosis communication in charts

psychological well-being of patients and family members. According to some studies, the open disclosure of prognosis to patients and to other health care providers is essential to allow appropriate treatment for concurrent and perhaps emergent issues.⁶ This also aids the team members in how to counsel patients and families faced with an incurable, poor prognosis disease.

The quantitative and qualitative information about patient prognosis was infrequently documented on the charts. The adage stating “whatever is not written, did not take place” could be applied. The act of omission could impact not only on the delivery of patient-centered and family-oriented care but on legal and ethical grounds as well. Arguably, provision of this documentation may avoid issues concerning over-estimating prognosis by other health care providers in discordance to that of the admitting physician, and adopting inappropriate life-extending and aggressive treatment that may be given by other uninformed health care providers.⁸

The difficulties doctors face when discussing prognosis with their patients include deciding whether to provide estimates and survival statistics, discussing life expectancy with patients with ‘poor’ prognosis, conveying prognostic information with sensitivity and honesty, deciding on whether to encourage hope, and meeting the needs of patients from various cultural backgrounds whose prognostic information needs may differ.

Based on previous studies, various factors contribute to the “poor documentation” including compliance concerns and time constraints in clinical practice.⁹ Provider education is also one of the factors that is a problem with a fairly straightforward solution. Siegel believes that the major focus of documentation is to provide effective patient care.¹² Failure to properly document can have severe consequences, resulting in incorrect treatment decisions; expensive, painful, and/or unnecessary diagnostic studies; and unclear communication between consultants and referring physicians and departments, resulting in a lack of follow through with evaluation and treatment plan.¹ Insufficient provider education is one of the factors that cause poor documentation in the chart. Providers typically do not understand all facets of the health care process. It needs to be understood that physicians are adult learners; therefore, a modified approach needs to be taken when it comes to educating them.² They are also extremely busy, so it is very difficult to provide thorough education. They spend their limited amount of time providing the patient care, and the documentation becomes the secondary priority.⁷

Understanding which type of illness trajectory a patient has will help provide answers for two important and common questions many patients have: “How long do I have?” and “What will happen?”⁸ The physician should include in the family meeting agenda the understanding of the usual course of illness - both the expected time frame until death and also what the patient can expect with the illness progression.⁹ Although not everyone will fit into a specific illness trajectory prognosis, trajectories help both patient and health care provider plan for the care needs of the patient. It is far better for the patient to know about and be prepared for what might happen. Appraising one’s current state of disease provides the foundational knowledge necessary to discuss other elements of prognostic understanding, such as life expectancy and treatment options.

Timing of family meetings were observed mostly within their 72nd hour of admission. Studies showed that this duration gives clinicians sufficient time to complete a patient evaluation to discuss with the patient surrogates. A recent randomized controlled study employing structured family communication within 48 hours proved effective in ICU setting. Family meetings are important in a patient’s trajectory of illness because patients and families may want to know every detail about what to expect, including how their death might actually happen.³ Others might prefer to know this information in smaller doses, as they begin to exhibit signs and symptoms that would require patient care teaching. It is very important to ascertain the patient’s desire for this information including level of details so that constant communication through family meetings is ensured.⁵ When meetings do occur, they often are held in very close proximity to the patient’s death/discharge, suggesting those meetings maybe used primarily to negotiate the withdrawal of life support or not to sustain aggressive treatment rather than to learn the patient’s values and preferences and provide psychosocial support to families.

There is no association between physician / patient demographic profile in holding a timely family meeting, but based on the data, more than half of physicians are not regularly conducting or documenting family meetings or discussion of prognosis which may result in poor communication with patients and families.¹ Indirectly, this could be suggestive of physicians being unprepared for such sensitive conversations; thus, supplemental training may be needed to address this gap. Lack of standardized physician education on how best to hold family meetings, inadequate physician knowledge on the known advantages of family meetings, and lack of institutional protocols on family meetings in the ward likely contribute to present findings.² These results provide basis for expanding communication skills training for physicians. The limitation of this study is that 1) it focused only on written forms of communication and it is uncertain whether any verbal discussion or other unaudited form of communication took place; 2) Some patients/relatives completed advance/ medical directives without written proof that a family meeting actually happened; 3) Phone calls and telemedicine conversations were not explored.

CONCLUSION

Communication prognosis using quantitative and qualitative information was infrequently documented in the patients’ charts; hence, not a common practice. Prognosis was poorly documented on the patients’ charts, which could suggest that either such a communication process did not take place at all or physician education on documentation should be reinforced by an institutional protocol, especially in the care of terminally ill patients. The findings pose implications on delivering patient-centered and family-focused care as the act of omission could result in miscommunication between referred physicians/consultants and other health care providers. However, for the intermittent conduct of prognosis communication, the occasion of conversation was found to be well-timed according to the patient’s trajectory of illness. Patient and physician demographic profiles had no relation in the practice of documenting prognosis.

RECOMMENDATION

Physicians should disclose prognosis using sensible strategies. The combination of effective multiple communication and consistent family meetings with positive collaborative behaviors likely benefit most patients and families. The paper's findings suggest that standardization and quality improvement in documentation skills for physicians is warranted. Similarly, it is worth supporting to expand communication skills training for physicians in addition to instituting a standard protocol for holding family meetings and the like. Efforts to enhance prognosis communication for patients with terminal cases, may improve patients' illness understanding and thereby provide a more solid foundation for patients' medical decision making in terms of advance care planning and end of life care. Training programs may also explore helping healthcare professionals to sensitively consider a patient's readiness for prognostic discussion, in the context of their cultural background and desire for family members' involvement in the discussion process. These training programs will allow clinicians to increase their competence and confidence when engaging in these challenging conversations.

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