How Do Doctors Make Decisions About Surgery In Frail Patients

And What Factors Influence These Decisions?

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Background

Frailty is a concept that describes decreased physiological reserve[1]. Evidence shows that frailty is a risk factor for post-operative complications[2-4]. It is also a risk factor for increased mortality in the setting of cardiac surgery[2]. Little is known about how decisions are made about surgery in frail patients.

Aims

1. To explore how surgeons and anaesthetists make decisions about surgery in patients who are frail.
2. To identify what training surgeons and anaesthetists would find useful in helping them to make decisions about surgery in patients who are frail.

Data Collection

Individual interviews were conducted with three surgical consultants, three anaesthetic consultants, three surgical trainees and three anaesthetic trainees. A paired interview was also carried out with a surgeon and an anaesthetist.

Data Analysis

Interview transcripts were analysed using framework analysis. Transcripts were coded and codes collapsed progressively using a constant comparative approach to develop an analytical framework. Using the framework, transcripts were charted and analysed.

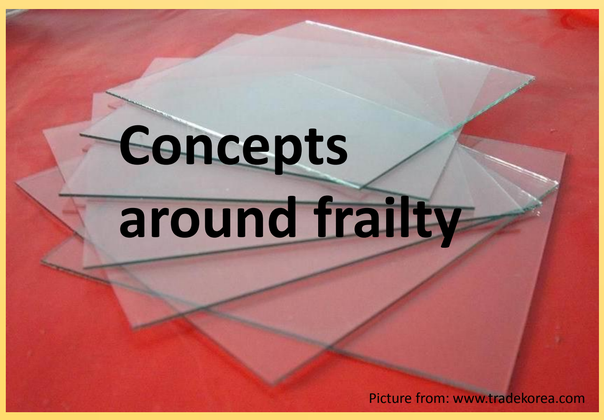
Results

Four categories were identified during analysis: (1) concepts around frailty, (2) shared decision-making, (3) learning and (4) factors in decision-making.

Perceived to be a subjective concept

Physical, psychological and social components

Associated with a poorer outcome at surgery



Surgeons' greatest challenge was decision-making

Anaesthetists' greatest challenge was post-operative care

"I very much believe in the concept of shared decision-making"

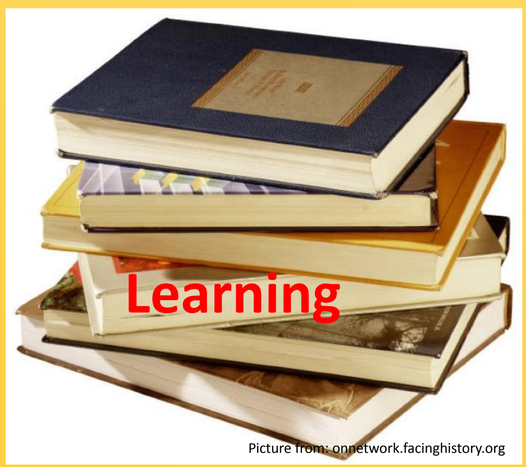
"The whole paternalistic approach is completely finished"

Few were aware of the term 'advance care planning'

Both surgeons and anaesthetists ideally involved in decision-making (but not always)

Minimal training in working with frail patients

Case-based courses and communication skills training requested



Reflection an important part of learning for trainees; "you learn from every case don't you"

Reflection perceived as less important by consultants; "it's irrelevant what I think of the consultation"

Default approach often that surgery is required; "It's win or bust"

Multiple clinical factors impact on decision-making including pre-morbid state and the aims of surgery

Consultants didn't find breaking bad news challenging, whereas trainees often did

Greatest challenges to decision-making included lack of time and the challenges of informed consent

Conclusions

1. Frailty was perceived as a multifactorial concept that has a negative impact on surgical outcomes.
2. Sharing decisions with patients was seen as the optimal approach for surgical decisions.
3. Anaesthetists and surgeons shared some perspectives but often had differing views on decision-making.
4. Reflection was seen as an important learning experience for trainees but less so for consultants.
5. The commonest approach was to aim for surgery and then consider the reasons for not offering this.

Future Work

1. A theoretical decision-making model about surgery in frail patients will be developed.
2. A tailored learning intervention will be designed for core surgical and anaesthetic trainees.

References

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