

The development of an evidence based palliative medicine teaching programme for hospital junior medical staff

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Rationale

- * Most deaths occur in acute hospitals
- * EOL Care is provided by non-specialist doctors
- * Vocational colleges require PC skills (RACP, RACS, RACGP, RANZOG)
- * 87-98% of Australian & European doctors want further education in palliative medicine (Lofmark 2006)
- * Complexities of PC difficult to appreciate without clinical experience.

Aim....

- * To develop an evidence-based , targeted educational program in palliative medicine for junior resident medical officers.

Project method

* **Phase 1**

- * Survey of needs: cross sectional survey of junior resident medical officers (JRMO).

* **Phase 2**

- * Development of learning objectives matched to modules.
- * Informed by college requirements and survey results.
- * Mixed media.
- * 6 modules: with learning objectives, facilitator guides, evaluations.

Phase 1...Survey results

* 52/133 (39%) response rate

* 24 female

* Post grad year	2	21
	3	11
	4	12
	≥ 5	2

* 24 medical, 15 surgical, 4 general

<i>BREAKING QUESTIONS</i>	<i>BAD NEWS</i>	Strongly Disagree	Disa gree	Undec ided	Agre e	Strongly Agree
Comfortable discussing death and dying		0	3	3	36	10
Consultants positive role models to guide my own practice.		1	4	5	30	12
Because of past reactions, I now avoid discussions about the end of life.		24	26	2	0	0
My undergraduate education in palliative medicine has adequately prepared me for my current needs.		0	15	20	14	2
I would benefit from clinically relevant communication skills teaching		0	8	11	25	7

<i>GOALS OF CARE QUESTIONS</i>	Stro ngly Disa gree	Dis agr ee	Un dec ide d	Agre e	Stron gly Agree
Confident discussing 'not for resuscitation' orders	2	3	7	31	9
Confident discussing prognosis with patients and their families	2	14	15	20	1
Patients should direct their own discussions, the medical role should be passive.	7	36	7	1	0
I find it difficult to balance 'giving in' to requests for futile treatments versus confronting the patient and/or their family.	1	24	13	13	1

<i>GENERAL QUESTIONS</i>	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Principles of palliative care are relevant to my everyday practice.	0	2	3	33	9
I feel well equipped and supported when managing complex patients with terminal illnesses	1	7	6	31	2
I have a clear understanding of the palliative care services within the hospital and local community	2	15	6	20	3
Caring for the dying is an essential part of all medical practice, regardless of specialty.	0	0	0	26	21
Postgraduate education in palliative care is not necessary.	19	24	3	0	1

Results continued

“It would be excellent to have further training in this area...although I feel comfortable discussing end of life decisions, it does not seem to be part of the culture at this hospital”

“NFR training is regrettably absent!”

Phase 2....6 Modules

1. Communication 1: “Do you want the good news or the bad news?”
2. Communication 2: Assessing and communicating goals of care
3. Symptoms 1: Pain – the essentials
4. Symptoms 2: Other symptoms and emergencies in palliative care
5. End of life care: Principles and practice
6. Ethics: Shades of grey in everyday life

Each module consists of....

- * Powerpoint presentation
 - * Slides with evidence cited
 - * References cited at conclusion
- * Facilitator's guide
- * Evaluation
- * Essential reading references
- * Communication 1 & 2, and EOL care have film components.

Communication 1



“DO YOU WANT THE GOOD NEWS OR THE BAD NEWS?”

MODULE 1

What is “bad news” ?

- *Obvious - ‘life and death’
 - *Metastatic cancer
 - *Large stroke
 - *Sudden death of a loved one
- *Can be more subtle - examples
 - *Musculoskeletal injury in an athlete
 - *Delay of an anticipated discharge
 - *Need to take lifelong medication

When might I need to 'break bad news' ?

- *All with a life limiting illness
- *When there is (or perception of) a change
- *When a treatment decision is needed
- *If requests or expectations seem inconsistent
- *If disease specific treatments are not working
- *At the time of referral to specialist palliative care services

Patient and carer expectations about communication...

- * Different from physician expectations

- * Gold et al. found:

- * Patients and carers feel information should be automatically offered or provided when questioned.

- * Carers felt updates should be routine and automatic.

- * Doctors feel updates should be when a significant change or new development

Clarify information needs

“Some people like to know everything that is going on, others prefer not to know too many details. What would you like?”

- *Doctors are not good at predicting patients' information needs
- *These needs may vary over time, and between patient and caregivers
- *Families who want information withheld from the patient present a particular challenge

Facilitating Hope and Coping

- *Emphasise what **can** be done (even when disease specific treatments are not working)
- *Reassure that most symptoms can be relieved
- *Emphasise the available support
- *Explore and discuss realistic hopes and expectations (where appropriate)

“We can hope for the best, working together using all the available therapies, while also making preparations in case things don't work out as we hope”

DVD 1

- * Breaking Bad News

- * “How to do it better”

Red Flags & Practice Tips

- * It **does** matter
 - * Poor communication leads to job stress, dissatisfaction, burnout, complaints and litigation
- * Frequent, but time-limited meetings may provide better communication more efficiently and provide more support to the family and importantly the team
- * Avoid
 - * saying “*nothing can be done*”
 - * Giving too much (or too little) information
 - * Criticising the management of others
 - * Being defensive: its not personal

References

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- * Baile WF, Buckman R, Schapira L & Parker P **Breaking Bad news: more than just guidelines** (correspondence) *Journal of Clinical Oncology* 2006;24(19):3217
- * Baile WF, Kudelka AP, Beale EA, Gloger GA, Myers EG, Greisinger AJ, et al. **Communication skills training in oncology. Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness** *Cancer* 1999;86:887-897
- * Buckman R **Communications and emotions: Skills and effort are key** *British Medical Journal* 2002;325:672
- * Clayton JM, Hancock KM, Butow PN et al. **Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers** *Medical Journal of Australia* 2007;186(12):S76-108
- * Gold M, Philip J, McIver S, Komisaroff PA **Between a rock and a hard place: Exploring the conflict between respecting the privacy of patients and informing their carers** Manuscript submitted for publication.

Facilitators guide: PowerPoint Presentation - notes

* SLIDE 2

- * Communication with patients and their families, informally or more formally with a family meeting is a necessary, though frequently dreaded task in all fields of medicine.
- * There is no doubt that having a successful approach and not avoiding this task is enormously helpful in your everyday work, is of huge benefit to your patient and makes work imminently more pleasant!

Evaluation examples of questions

- * How much **new information** did you learn from the session?
 - * None at all
 - * A slight amount
 - * A fair amount
 - * A good amount
 - * A great amount

- * I have an approach to challenging communication, particularly the angry patient or relative.

1

2

3

4

5

Essential reading references

- * Clayton J et al. *Clinical practice guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their carers.* MJA 2007; 186(12): S77-108

Summary

- * Need for palliative medicine training for JRMOs
- * Acknowledged by JRMOs and Colleges
- * Package developed to allow delivery by non-PC specialists
 - * Slides + references +/- video
 - * Facilitators guides
 - * Evaluations
 - * Essential reading
- * Dissemination strategy under development