Certificate in Physician Leadership for Hospital Medicine
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Final Capstone Project

What is the effect of a multimodal faculty development curriculum on new hospitalists' confidence and skill level in addressing primary palliative care needs of inpatients?

Project Definition and Scope:

Background

With advances in care and the aging of the population hospitalized patients have become increasingly frail and complex. Patients generally have multiple chronic progressive medical problems which are challenging to manage. Frequently hospitalists find themselves having complicated end-of-life decision-making and goals of care discussions with patients and their families. The decisions reached in these meetings have far-reaching impact financially, clinically and personally. Suboptimal or absent discussion can result in potentially unwanted interventions at the end-of-life, dissatisfaction with care, caregiver distress, prolonged hospitalizations, fruitless ICU utilization, wasted resources and increased suffering.

A 2015 in JAMA titled Barriers to Goals of Care Discussions with Seriously Ill Hospitalized Patients and Their Families was published in April of 2016. [1] The findings support what those of us working in this environment feel every day – hospitalists report that patient and families often find it difficult to accept a poor prognosis. According to this study, more and better training in having end of life discussions is needed for all clinicians.

Additionally, there are nowhere near enough palliative care specialists locally or nationally to meet the current needs of patients. A perspective piece in the New England Journal in 2013 suggests a care model that distinguishes between primary palliative care (skills all clinicians should have) from specialist palliative care (skills for managing more complex and difficult cases)[2]. A study on 2013 titled Dancing Around Death: Hospitalist-Patient Communication About Serious Illness illustrated that fact that there are specific examples of how physicians can communicate about death and dying.[3] They felt that the young age of many hospitalists in their study lead to infrequent acknowledgement of end of life issues.

A more recent study titled Confidence with and Barriers to Serious Illness Conversation: A National Survey of Hospitalists [4] was published in 2016 in the Journal of Palliative Medicine working in conjunction with SHM (Society of Hospital Medicine) to more deeply look at why hospitalists struggle with goals of care and serious illness conversations, and what is the most difficult aspect. This study revealed the most discomfort amongst those surveyed was discussing religious or spiritual preferences, managing conflict among patients or families and healthcare givers, and counseling families who request inappropriate treatments, to name a few.

To be able to successfully navigate these conversations physicians need to be emotionally available, responsive and skilled. Residency training and faculty development are not standardized nationally, and frequently physicians avoid having these conversations due to their lack of confidence. Most patients prefer to avoid aggressive end-of-life care, wish to know what their futures hold and would rather die at home. Open conversations about prognostic and realistic choices decrease the suffering of those who survive the loss of a loved one. However, as a profession, the default is often to continue burdensome care leading to patient dissatisfaction, unwanted interventions, physician burnout, difficult deaths and

increased costs. The goal of this project is to develop, implement and evaluate an individualized, blended learning curriculum to teach and mentor new hospitals in difficult conversations.

Literature suggests a peer coaching model has been attempted to teach primary palliative care skills. [5] This intervention took place in an academic medical center and was a voluntary program where palliative care providers provided coaching to hospitalists. The coach assessed what the learner wished to improve, gave them teaching and offered to observe patient interactions. While this appeared to have some success, the voluntary nature of the program would not meet our current known knowledge and skill deficit in our young hospitalists.

Patient's goals and values must remain paramount but should be informed by the medical and therapeutic realities. We will provide triggers to identify which patient's need goals of care conversations and a roadmap to navigate through those meetings. This will include training in how to prepare for these conversations, probe for current understanding, determine patients /family decisional style and respond empathetically to strong emotions.

Additionally, this curriculum will provide an overall framework for implementing palliative care conversations including successful/unsuccessful communication techniques, lowering physician discomfort level, avoiding pitfalls and providing practice opportunities. It will also address timing of an inpatient conversation at certain trigger points – admission, failed interventions, before escalation of care – in order to try and prevent care that is not in the patient's best interests in accordance with their wishes and hopefully avoid invasive

Below is the initial proposed curriculum description
The longitudinal curriculum will roll out stages. This is a complex skill which requires multiple modalities reinforcement over time.

Initially, the physicians will be provided pre-reading on having difficult conversations. Additionally hospitalists will complete online communication training modules available through CAPC (Center to Advance Palliative Care) and have a one hour didactic lecture highlighting the literature about best practices in having these conversations and some "how to" tips, including opening/closing and content to include in family meetings, as well as which health care team and family members to include. Lastly we will discuss time barriers, limitations and strategies to enhance the best environment possible (interruption free). The importance of self-care and wellness will also be stressed, and tips on coping with these high intensity meetings.

They will also be asked to fill out anonymous pre and post surveys assessing experience, knowledge, comfort and confidence in the skills we hope to be enhancing.

After their initial training as outlined above they will then participate in a simulated family meeting with a chronically ill mock patient's family facing end-of-life decisions. Faculty mentors and volunteers will provide qualitative feedback immediately and an objective structured score sheet will document quantitative results. Lastly we hope to observe the hospitals in real-time leading family meetings after this training is completed. We would hope to also solicit real family feedback about the communication for our hospitalists to continue to grow and refine their skills.

Methodology:

Taking our lead from a real case in our hospital, I wrote a case about a patient who is clearly at end of life but a family who is not ready to hear that. I wrote a case for the hospitalist which was very clear both about her medical condition (dementia, inoperable aortic stenosis, multi-organ failure and respiratory distress) and that the hospitalist felt that a comfort care approach was for the best.

I then wrote a case for both the patient's sister (with a rich social background which offered insight into why she feels so strongly that all measures must be taken) and her husband/daughter depending on who was doing the role play.

I brought all the cases to our Palliative Care Interdisciplinary Committee for feedback from that team, which was provided.

The volunteers were then trained in the simulation, which took over 8 – 10 hours. Initially I gave them a talk about end of life care as it stands in 2018 in the United States in the hospital, and then we began rehearsing for the sim. As all of the volunteers believe strongly in both this work and end of life planning it was difficult at first for them to simulate the combative, aggressive and angry demeanor I was looking for to challenge the hospitalists.

Once the volunteers were trained, I had to schedule the doctors, actors, simulation lab time and myself in order to get the simulations done.

The simulation was intentionally broken into two parts, first the introduction followed by another meeting after the family had "seen" the patient. The hospitalists were told up front if they got stuck they could ask for help, and we would be "re-doing" some of the meeting with certain language and phrases to help. Feedback was provided both by me as to the structural content of the meeting as well as the volunteers from a patient perspective.

Post surveys are being sent as well, and will be analyzed.

Results

The curriculum as outlined was able to be mostly carried out. All of the new hospitalists were required to attend the first offsite all day orientation we had ever created, a large piece of which was a didactic talk by the Medical Director of Palliative Care at our institution about difficult family meetings, followed by group role playing by the hospitalists after the talk. They were all also given the log in information for CAPC. During this time they were given a brochure I created with some helpful language/sayings in these situations based off of best practices from CAPC and Vital Talk.

Pre-surveys were anonymous and showed a wide range of comfort in primary palliative care skills, though many rated their comfort level as a "5" very comfortable with many complex and difficult skills, which in observation I feel is likely an overconfidence of their skills. I am still having the data analyzed.

Many of the physicians shared stories of real life situations they had been through either as residents or as new attendings. I was struck by the level of detail many remembered, and the clear toll it had taken on them. Many expressed feelings of isolation and self doubt about their decisions in these cases. They

also expressed frustration and even resentment towards patients when an impasse is reached in regard to shared decision making and goals of care.

To date, all of the physicians undergoing the simulation portion of this experience grew up in another culture with a language other than English as their primary language. They all shared their own cultures' mores about end of life, which ranged from a supportive environment for hospice and palliative care to "that idea doesn't exist in my country". We discussed how difficult it can be to learn the both the medical intricacies of end of life care and understanding the United States' complex relationship with death and dying.

Feedback from the volunteers centered mainly on body language, "working the room" i.e. paying attention to all parties in the meeting and attending to emotion, acknowledging the patient as a person, and soliciting information about who the patient was.

The most common difficulty I noted was that of physicians acknowledging patient emotion and articulating that they were aware. So far almost all of the physicians acknowledged in debriefing that they were aware the simulated family was angry, frightened and combative, but did not actually address it. We discussed ways to bring this into the meeting such as "I can see you are angry, can we talk about that?" Many attempted to repeatedly explain the medical situation in the hopes the patient's family would understand why they were suggesting comfort care. Much of our debrief discussions revolved around meeting the families where they were, i.e. on an emotional plane rather than trying to bring them to our factual plane of explanation.

All of the physicians involved came in on a day off for this training, and verbal feedback from them was not only positive but also articulated the need for more. Anonymous surveys have been sent out and I am awaiting feedback, which should be available by the time of the slide presentation in July.

Additional articles were sent to each physician after our simulations with additional suggestions as well as individualized feedback with suggestions next time they are running a meeting.

<u>Discussion/Impact</u>

I continue to believe simulation training offers an ability for physicians to take time to consider their approach to these problems. Of the simulations I was able to accomplish this spring, all were felt to be valuable by the participants. None of the participants to this time ever spent time in a simulation lab during training for the purposes of improving their communication skills.

However, there were many challenges in this experience that are worth reflecting upon.

Leadership Challenges: Because this project was of my own creation and there were no other staff with the clinical expertise and time to devote to this project I found it was very difficult to get it up and running in a timely fashion. I was not given extra time for this in the setting of my other duties and as such a very large project (running the second year of an AP residency program in hospital medicine) ended up occupying a great deal of my time, delaying the onset of the simulations.

It was also challenging to convince doctors to come in on their days off for this training. Because both the Division Chief and Vice President of Hospital Medicine felt strongly about this training they were very supportive in letting the hospitalists know this was required. I sent them an email with additional resources/reading material both before and after the simulations and though there was some general resistance at first once we started it was minimal.

Logistical Challenges: Despite my soliciting for "patient" volunteers from numerous venues I only was able to get three people trained. Therefore, we were limited by their time and availability and also my desire to not overtax them. I do believe that with either funding or payment to standardized patients I would have a larger pool to draw from.

Simulation and training is a small piece of skills around communication which can take years to hone in terms of these situations. Given the apparent lack of standardization amongst residencies across the country in training for these skills, the ABIM, ACP, SHM and other physician groups as well as individual hospital medicine programs will need to find a way to continue faculty development after completion of residency. Palliative care across the country does not have enough providers to have the millions of conversations which must be had on a yearly basis, and as I discussed with every hospitalist doing this training, we can and should be leading the way in assisting our patients in complex decision making at end of life.

What struck me the most in our debriefings so far was the emotional toll negative patient encounters had on our providers. Some had social support at work or a spouse at home who may or may not have been a physician. One provider told us a long story about a patient who clearly should not be a DNR but the daughter would not change his status. Ethics and palliative care both weighed in to support him, but he discussed multiple sleepless nights worrying about whether he was doing the right thing. Though months had gone by he was able to articulate the story to the smallest details, which he had never shared with anyone. Clearly this situation had both shaped him as a physician and made a very large impact on his wellbeing at the time.

Along with teaching young career physicians the technical and communication skills needed to successfully navigate conflict, angry and litigious patients, end of life dilemmas and patient care in general, we as a community also need to ensure we are taking care of our own and their emotional well-being. I am well aware physician wellness is a very hot topic and this is certainly the case at my institution. However, my next step with this project is to go back to my leadership team in hospital medicine and think through what resources we could provide that would be helpful for our physicians in this regard.

In summary, I remain firm in my belief that mandatory ongoing post graduate faculty development for primary palliative care skills is essential for hospitalists. Operationally this can be very challenging, for the reasons as outlined above. I hope to continue my work in this regard and share my experiences with others in the hopes of refining best practices that can help both our patients and our community.