

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Advance Care Planning: A Learning Module

Louise Hanvey BN MHA

Paul Daeninck MD MSc FRCPC

S. Lawrence Librach MD CCFP FCFP

for the EFFPEC project team

Objectives

Define advance care planning & explain its importance

Describe the steps of ACP

Describe the role of patient, proxy, health care professionals

Identify pitfalls & limitations in advance care planning

LH

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Objectives

Discuss the process of development of the teaching module

Identify the challenges in development

Briefly review the content of module



Context for Developing the Module: EFPPEC

EFPPEC is a national project aimed at facilitating the development of palliative & end-of-life care curriculum at Canada's 17 medical schools.

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

EFPPEC Partners

Association of Faculties of Medicine Canada (AFMC) principal partner/CHPCA co-partner

Health Canada funding & close involvement of Canadian Strategy on Palliative/End of Life Care Working Group on Formal Caregiver Education

Office is located at CHPCA in Ottawa

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

How does EFPPEC Work?

Build on present state in medical schools by forming/facilitating local teams

Identify common competencies in EOLC & examine to those competencies

Assist in the development of curricula & clinical experiences

Evaluation is a key component



Case Description

Jennifer: 59 y o woman of Chinese descent

4 mo ago, developed lower thoracic back pain; Fam doc and orthopedic surgeon seen, but source of pain not apparent. Significant back pain using acetaminophen-oxycodone tablets 2 tabs qid without relief

1 wk ago, sudden severe thoracic back pain.

ER visit, x-ray showed T12 collapse.

Admitted, bone scan= bone mets at T 5, 6, 12, L 3, 4, & left acetabulum.

Abdominal MR= mass in head of pancreas, a 4 cm hepatic met and paraortic LNs.

Liver Bx= anaplastic adenoca

Dx: pancreatic adenocarcinoma

Surgeon feels she will need surgery to prevent duodenal obstruction

Medical Oncologist recommending chemotherapy with gemcitabine

LL

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Case Description

Jennifer immigrated to Canada.

First marriage to an abusive Chinese man lasted only 2 y.

Second marriage x 29 y to Harold (Caucasian). She is a product manager for a generic pharmaceutical company. Her husband, 61 y, is on disability pension from municipal transit post-MVA. He has a back injury and needs cane to walk.

3 children: a married son, a daughter finishing her MA in psychology and a 14 y o daughter with Down's Syndrome.

They attend church infrequently.

Jennifer's mother is alive with mild dementia, lives in a residential home. Her father died 10 y ago with lung cancer. She has 2 siblings that she speaks to infrequently.

Jennifer and Harold sit down with medical team to discuss options for treatment.



Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

ACP - Definition

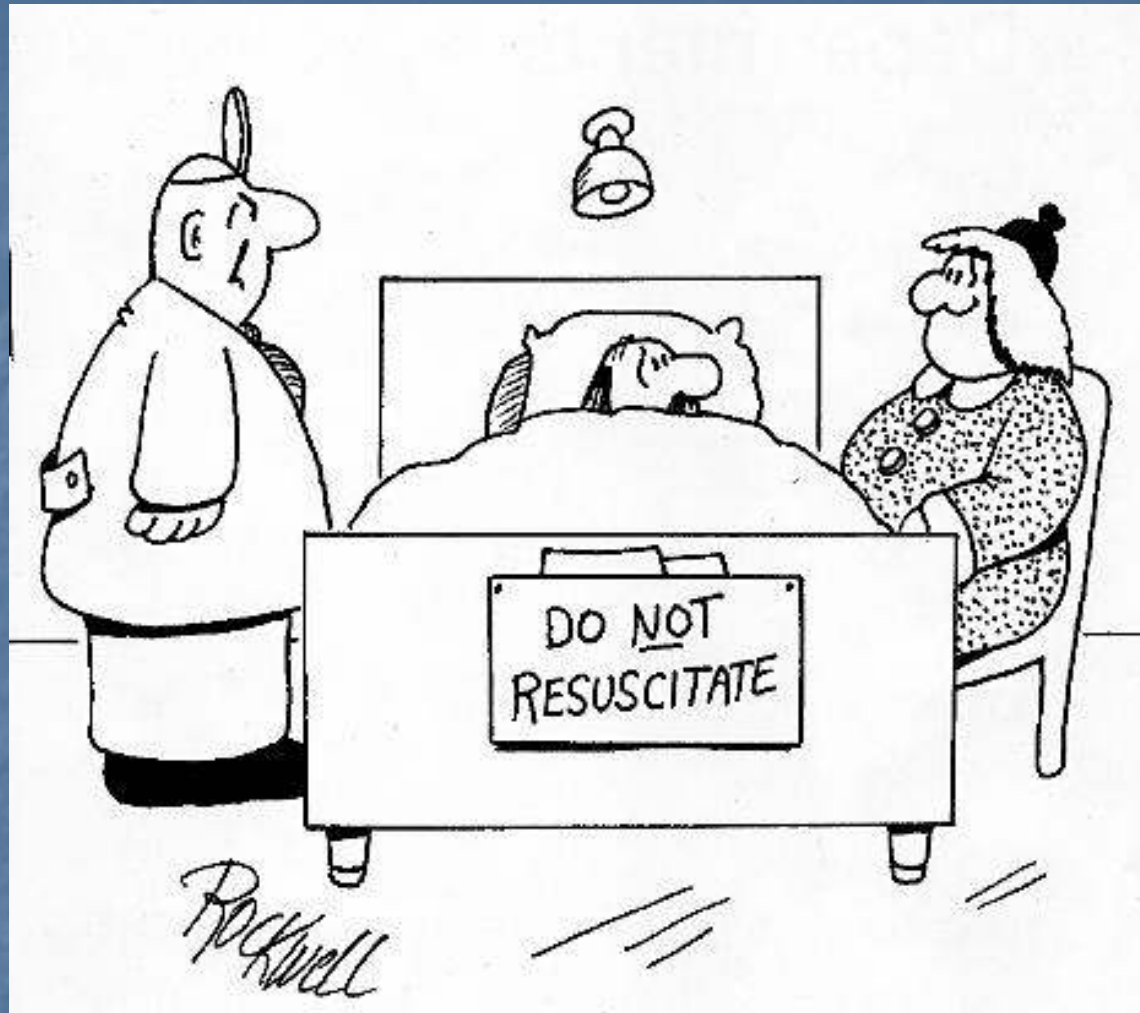
A process whereby a capable (mentally competent) adult engages in a plan for making personal health care decisions in the event that he/she becomes incapable of personally directing his/her own health care



ACP is a process

**It is not defined by a
written document only**





"You're not supposed to write on your husband's chart, Mrs. Johnson!"

ACP - What is it?

**Process of planning & making choices
for future medical care**

**Values, preferences, wishes & goals
are explored & documented**

**Determines who is substitute decision
maker (SDM)**

Professional & legal responsibility





*"And to my wife, Elizabeth, who hated my guts,
I leave my large intestine."*

ACP - What is it?

Trust building patient/family & HCP

Reducing uncertainty

Helps to avoid confusion & conflict

Permits peace of mind



Advance Directive (AD)

A legal written document that outlines choices when someone is incompetent

Many different formats dependent on jurisdiction

Living Will

Proxy directive (legal term to designate SDM)

Power of attorney for personal care



Advance Directive

Explains who makes health care decisions when the patient is unable incompetent & gives direction to that person

It is not a consent





“Ok, so you don't want CPR or tube feeds, but you'll take the fried rice & szechuan beef...”

Content – Initiating the Conversation

Conversations about ACP best conducted before the end of life is near

Best when individual has time & peace of mind to think about the goals of care, can talk openly about wishes & concerns with family or close friends & with HCPs who can provide information & support

PD

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

5 Steps for AC Planning

1. Introduce the topic
2. Engage in structured discussions
3. Document patient preferences
4. Review, update
5. Apply directives when need arises



Step 1: Introduce Topic

Be straightforward & routine

Determine patient familiarity

Explain the process

Determine comfort level

Determine SDM



Step 2: Engage in Structured Discussions

SDMs present

Pt may choose to have a conversation with you before speaking to SDM

Describe scenarios, options for care

Elicit patient's values, goals

Use a worksheet

Check for inconsistencies



Role of SDM

Entrusted to speak for the patient

Should make decisions based on direction from person & not their own choices

Involved in the discussions at some point

Must be willing & able to take role



Patient & SDM Education

Define key medical terms

Explain benefits, burdens of treatments

Life support may only be short-term

Any intervention can be refused

Recovery cannot always be predicted



Step 3: Document Preferences

In the health record

Note any AD & review with team

Sign the documentation

Ensure portability across setting & provinces if possible



Step 4: Review & Update

Follow up periodically especially as condition changes

Note major life/illness events

Discuss & document changes

Enter into the medical record

Ensure portability



Step 5: Apply the ACP

AD only applies if the person is not capable

Decisions about care must be discussed with the capable patient

Consent must be obtained



Step 5: Apply the ACP

Determine applicability

Read & interpret the AD if there is one

Consult with the SDM

Carry out the treatment plan

Expect disagreements & plan for resolution



Benefits of ACP

Symbol of HCPs commitment to patient empowerment

Reminds us to value pts/families as partners in planning EOL care

Encourages planning for death
concrete aid for overcoming aversions
face hard decisions about dying



Benefits of ACP

Reduces future difficulties; provides guidance for pt's wishes ("note in pocket")

May reduce/resolve conflict & disagreement

Can be completed at any time

Can be revised



Common Pitfalls

Failure to plan

Unclear patient preferences

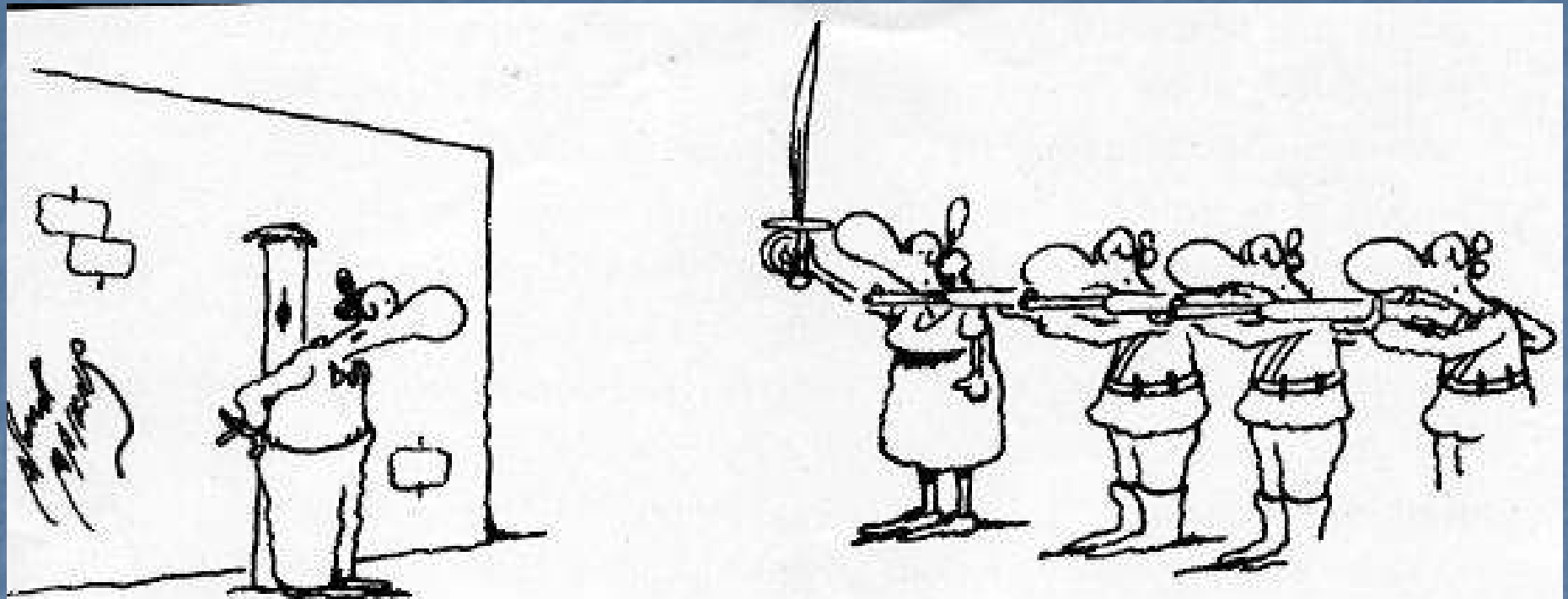
Complete (& sign!) AD

SDM absent for discussions

SDM unwilling to follow wishes

AD inaccessible





"I think you misinterpreted the terms of my living will, dear."

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Common Pitfalls

Focus too narrow

DNR does not encompass all of ACP

Poor understanding of medical interventions

Communicative patients are ignored

AD not read, not understood by HCPs



Preparation for the Final Days

Advance planning

personal choices, caregivers, setting

Loss, grief, coping strategies

Educating / training patients, families & caregivers

communication, tasks of caring

what to expect

physiologic changes, events

symptom management

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Advance Planning

Practical Issues

Financial, legal affairs

Organ donation

Autopsy

Burial / cremation

Funeral / memorial services

Guardianship



Developing the Module



LH

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

The Need for ACP Education



Health Canada's Secretariat on Palliative & EOLC hosted a meeting on ACP which highlighted the need for education for health professionals.

Working groups of the Canadian Strategy on Palliative & End-of-Life Care approached EFPPEC to develop a module for health professional education.

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Objectives

To produce a multifaceted, interprofessional education module on ACP for health professionals' undergraduate & postgraduate students.

Developed as an interprofessional approach to be used by physicians, nurses, social workers, spiritual advisors, & trained palliative care volunteers.



Objectives

Topics include:

importance of advance care planning

incapacity to give informed consent

decision making process for EOLC

communication of end of life conditions &
risks/benefits of possible treatment

appointment of a substitute decision-maker

models of advance directives

**Will not re-invent the wheel, but rather
draw on existing Canadian resources.**



Expert Working Group

Physicians – family medicine, palliative medicine, critical care

Social worker

Nurse

Lawyer

Health Canada representative

People with experience in developing ACP educational resources

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Editorial Review Group

Members of a broad Editorial Review Group were identified to review the module

Interprofessional with representation from across the country

More than 50 people participated in the review representing all provs / territories



Editorial Review Group

physicians, nurses

lawyers, social
workers

chaplains, volunteers

bioethicists,
educators

EFPPEC Local
Leaders/
Teams

Editorial Review
Group

participated in a
consensus
building exercise
to approve &
modify the
program

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Needs Assessment

Gathered & synthesized existing resources in Advanced Care Planning Education

Pallium, Ontario Government/Alzheimer's Strategy, Fraser Valley Health Authority Calgary Health Authority, Ian Anderson Program, Dalhousie University, Gunderson Lutheran Medical Foundation Inc.

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Needs Assessment

Searched provincial government websites to identify relevant material relating to advance care planning, health proxies, substitute decision makers; & advanced directives guidelines.

Searched the national professional association & provincial Colleges of Physicians & Surgeons & Colleges of Nurses websites for ACP guidelines.

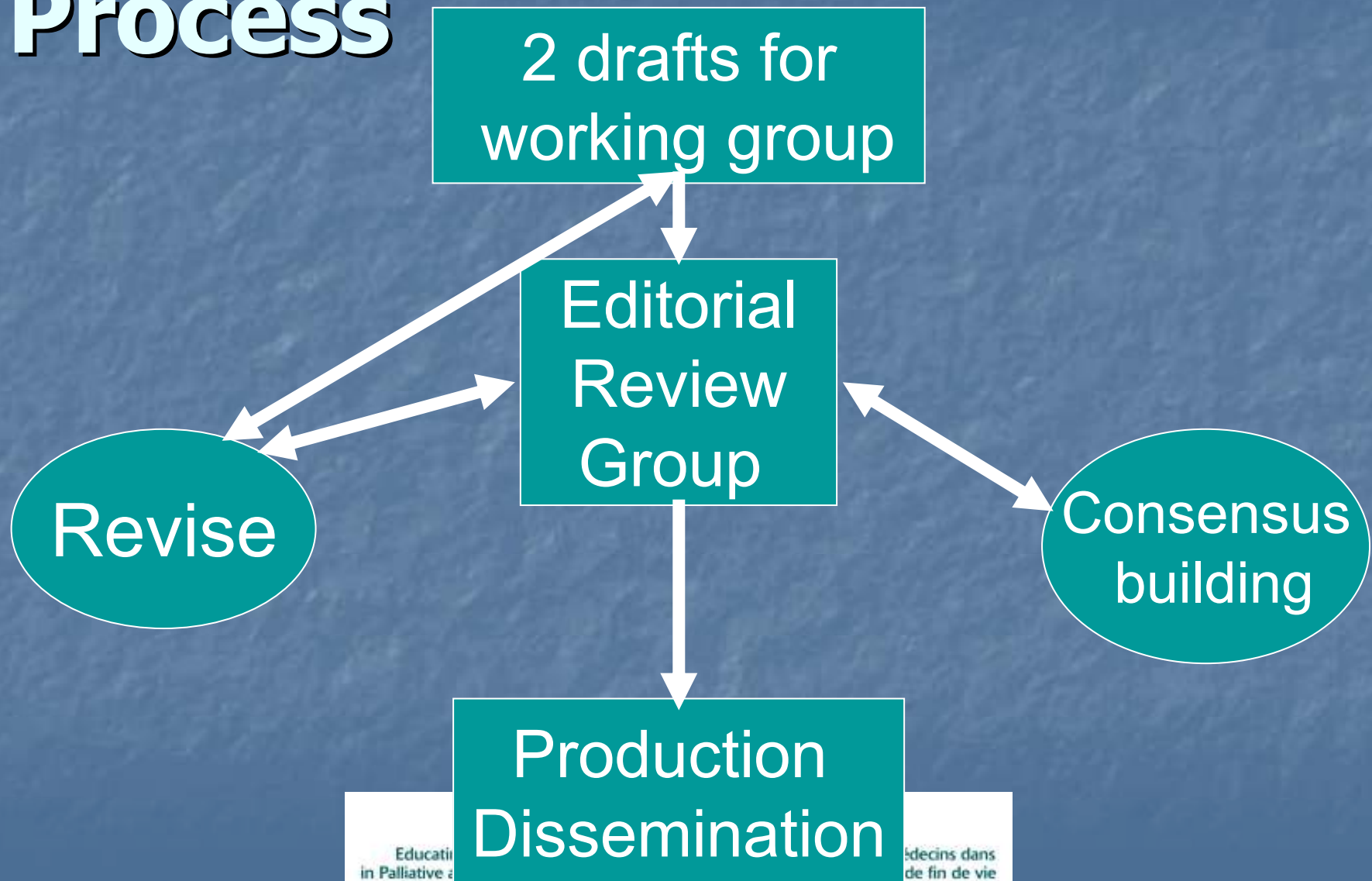


Needs Assessment

Advised the EFPPEC Local Leaders of the initiative, & ask them to identify learning resources that they have developed or would recommend.



Process



Process

Overwhelming support for the module.

All found content relevant – wanted to add content rather than remove.

Constructive recommendations for additions/modifications.



Challenges in Developing the Module



Educational Challenges for Physicians in Palliative Care and End-of-Life Care

Challenges

ACP laws across Canada are not harmonized, leading to different requirements under the various provincial statutes.

Laws include federal legislation (criminal law); provincial legislation (Advance Directive & Health Care Consent Legislation) & Common Law



Challenges

**Terminology is not consistently used
or understood**

**e.g., proxy, substitute decision-maker,
advanced directive, proxy directive,
living will**



Challenges

Understanding of the concepts of consent to treatment & their relationship to the process of advance care planning is not clear



Content of the Education Module



Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Content Overview

Overview

ACP & Consent & Capacity

How to Initiate the Conversation

Having the Conversation

Explaining Life-Sustaining Therapy



Content Overview

**Advance Care Planning & the Values
& Experiences of Health Care
Providers**

**Conflict: Prevention & Management
Building Organizational Capacity for
ACP**

Educational Resources

Teacher's Guide

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Content – Legal Framework

Over the past 15 to 20 years, legislation has been enacted in almost all provinces & territories across Canada to codify the right to make arrangements about personal choices for future health care. Provinces & territories provide legal recognition for different forms of advance directives. ACP laws across Canada are not harmonized, leading to different requirements under the various provincial statutes.



Content – Legal Framework

It is the health care provider's responsibility to know what the law says in their province/territory

What form of AD is recognized?

Is there a definition of capacity or competence? What is it?

Does the law specify an age below which one cannot make an AD? What is it?

Does the law enable a person to appoint a substitute decision-maker?

Does it allow you, as a HCP, to take instructions from an advance directive or must you speak with a substitute decision-maker before providing (or not providing) treatment?

If there is no substitute decision-maker appointed, to whom does the health care provider turn? Does the law specify a hierarchy of people who can make treatment decisions for an incapable person?



“In some respects, this century’s scientific & medical advances have made living easier & dying harder.”

Approaching Death: Improving Care at the End of Life

The Institute of Medicine, Washington,
D.C., 1997

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Summary

Advanced directives require open & direct communication

ADs ensure patient's wishes known & honoured

ADs can guide health professionals

EFPPEC module valuable teaching tool for advanced care planning





**“No, the advanced directive
doesn't allow you to forbid your
husband from marrying again!”**

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Questions? Comments?

Educating Future Physicians
in Palliative and End-of-Life Care



Former les futurs médecins dans
les soins palliatifs et de fin de vie

Content – The Role of Health Professionals

Health care providers can & should be a support & resource to individuals doing advance care planning. Health care providers should know how to assist an individual to complete an advance care plan.



Content – Ethical Obligations

While the provincial/territorial legal framework is not uniform across the country, there is a legal & professional ethic that crosses provincial/territorial lines. This ethical obligation is expressed by a number of Canadian professional bodies – obliges professionals to honour a person's advance care choices wherever possible.



Content – Role of Health Professionals

The CMA Code of Ethics advises:

Ascertain wherever possible & recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.

Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.



Content – Role of Health Professionals

The Code of Ethics for Registered Nurses (Canadian Nurses Association) states that:

Nurses must respect a person's advance directives about present & future health care choices that have been given or written by a person prior to loss of decisional capacity.

When a person lacks decisional capacity, nurses must obtain consent for nursing care from a substitute decision-maker, subject to the laws in their jurisdiction.



Content – Having the Conversation

The module focuses on the human side of advance care planning – the conversations health care professionals have with the person & his or her family, how to prepare, what to talk about & what to look out for.

Provides many examples of how to initiate & have the conversation.

