

Facilitating Advance Care Planning: An Interprofessional Educational Program

Teacher's Guide



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

Funding for the Educating Future Physicians in Palliative and End-of-Life Care and the Advance Care Planning project is provided by Health Canada.

The views presented in this document are not endorsed by and do not necessarily reflect the views held by Health Canada.

Introduction

The “Facilitating Advance Care Planning: An Interprofessional Educational Program” has been designed as an education program for all health care providers at all levels. This Teacher’s Guide will provide suggestions for effective teaching, some teaching materials such as case materials so that teachers can use the curriculum materials most effectively.

Some Basic Concepts of Adult Learning and Behavioural Change

Adults are more likely to learn if:

1. They see “What is in it for me?” (learning needs/gaps)
2. They can articulate “What do I want?” (realistic goals)
3. They are actively engaged in the learning process.
4. The experience is intense and enjoyable.
5. Materials are adjusted to their level.
6. They can see results. (evaluation)

Active learning that involves discussion, problem solving, and analysis has been demonstrated to enhance retention of information.

Learning also is a social experience. Without the support within one’s peer group and within the organization or institution for knowledge transfer into clinical practice, education will not produce behavioural change and improve patient care and policies in the area of ACP.

Other forces that will drive clinical change (Davis and Taylor-Vaisey) include:

- a) External forces:
 - e.g., societal, political, financial, regulatory
- b) Factors integral to the practice:
 - e.g., patient needs, characteristics, demands, practice location
- c) Internal or personal forces:
 - e.g., motivation, professionalism, desire for competence, opinion leaders

So, education alone may not produce behavioural change and thus a change in patient outcomes for ACP unless the educational methods are effective.

Teaching Methods

1. *The Interactive Lecture*

The lecture is probably the most common way of teaching in the health care professions. Although the efficacy of this teaching method is questionable, there are some advantages as well as disadvantages, to this learning method. It is likely that considerable teaching will continue to be done in this fashion. Making the lecture more interactive and making sure that the style of delivery is effective will enhance learning.

The material in the ACP Education Program can be presented in an interactive lecture format. However, there is too much material for it all to be crammed into one lecture. Resist the temptation to try and cover all the information in one lecture. The suggestion is that the material can be divided into a series of 40-minute lectures that can build on knowledge transfer from session to session. Leave time for interactivity such as case discussion and allow adequate discussion as some of the issues in ACP can be quite challenging and sometimes emotionally-charged.

Participants in the lectures should be told how to access the full document.

Delivering an effective lecture is a learned skill and is beyond the scope of this teacher's manual. However, we will review how to make a lecture more interactive:

1. **Use cases to illustrate.**

Mostly you will be seeing clinical audiences but all audiences often will benefit from the introduction of case examples. Cases should be illustrative of the main objectives of the lecture and should not be too complex unless that complexity is the message you want to convey. The cases should be real but respect patient and family confidentiality by hiding identifiers on charts or imaging, using initials or names that are fictitious, and be careful about revealing too many sensitive and potentially damaging issues. At the end of the lecture, audiences often are keen to hear the outcome of the case. Spend a few minutes going back to the case. This can be part of your summary. For your convenience, we have provided you with a number of cases in this manual.

Cases may also be presented using trigger tapes or other video resources. See the resource section.

2. **Break up the amount of direct lecturing time.**

Provide a change of pace. Pause to ask for questions. Allow questions during your presentation or make sure you leave enough time for end of lecture discussion. Ask for feedback from the audience. Question or poll the audience on certain issues. Introduce another illustrative brief case or reflect on an experience you had recently and ask for similar experiences or stories from the audience. Show a video vignette.

3. Ask questions of the audience and in smaller groups ask for questions during the presentation.

Take time to ask for questions. Make sure you repeat the gist of a question. If you do not know the answer, say so. Do not make up answers. You can ask someone in the audience to answer if they know the answer, but you can ask the questioner to come to you after the lecture so you can contact that person with an answer in the near future. Keep your answers as brief as possible. Answering a question should not turn into a mini-lecture.

4. Use a variety of audience participative interaction and discussion techniques.

You can ask multiple-choice questions of the audience and have them respond with the answers by a show of hands or by using technology such as touchpads. You can use dyadic discussion or table discussion. For example, say “If this was your patient, what issues do you think confront the patient and family in making this decision? Please turn to your neighbour and have a five-minute conversation and list the issues you think are important”. Then spend a few minutes discussing the issues with the audience, bringing them back to important issues in your lecture.

2. *Small Group, Case-Based Teaching*

Small group (6-12 participants) case-based teaching (SGT) plays a major role now in educating students at all levels and in continuing professional development. Whether it is used in a problem-based learning format or in more traditional small group teaching in seminars and tutorials or workshops at conferences, it is popular because it can be a very effective adult learning technique. Physicians and other health care professionals learn from their cases every day that they practice in the clinical setting. When small group teaching works well, using cases to focus learning has clear benefits for students including:

- Allows the deeper exploration of issues in patient and family care,
- Encourages better listening skills,
- Builds problem-solving skills,
- Develops teamwork skills,
- Focuses on enhanced self-directed learning, and
- Offers more opportunities for self-evaluation.

SGT is **not** a lecture to a small group or an open-ended, unplanned process.

Key Skills in SGT

1. *Setting the Stage*

a) **Plan ahead.**

Although teaching groups may occur spontaneously and be effective, for example, at a team meeting or on ward sit-down rounds, the best small group teaching requires careful planning. You will need to:

- Review the topic and session learning objectives,
- Read the case and prepare discussion questions,
- Identify the composition of the group as related to functions and experience,
- Review and/or organize the suggested time frame of each content segment.

b) **Convene the group.**

If the group is new, introduce yourself as the facilitator and then have the members introduce themselves. State the purpose and objectives of the group session.

c) **Develop a mutually acceptable agenda.**

Announce the timing of the session and discuss the framework of the session.

d) **Create a non-threatening environment.**

Discuss the ground rules for the small group session and the expectations that all members must participate. Also, define the role of the facilitator.

2. *Accomplish the task*

a) **Provide limited and relevant information.**

Avoid getting involved too early. Let the group problem solve. Intervene only if the group is not moving forward.

b) **Actively involve all group members.**

Let no one dominate the discussion or completely avoid participation.

c) **Question effectively to promote critical thinking.**

Look for controversy and explore differences.

d) **Use these value-added techniques to add to the interactivity and discussion:**

- Role plays, patient interviews,
- Trigger tapes, videos,
- Student facilitators,
- Point/counterpoint debates,
- Written materials,
- Newspaper articles, patient letters, and
- Editorials.

e) **Listen and reinforce the points made by group members.**

Draw conclusions, identify learning gaps, and correct misinformation.

f) **Focus the group.**

Follow the agenda and objectives but avoid intervening if an interesting and important discussion develops. Refocus the group if they are too off track. Create a “parking lot”—a flipchart list of issues that are not totally on topic but that can be dealt with at the end of the session or assigned as tasks.

g) **Observe and identify group behaviour.**

Remind group members of the ground rules and deal with conflict effectively.

Role of the facilitator

- a) Establish informality
- b) Openly admit what you don't know. Saying "I don't know." is OK.
- c) Encourage speculation, but identify it as such.
- d) Refrain from criticizing any ideas put forward by group members.
- e) Guidance of the discussion.
- f) Keep on track.

Questioning techniques

Skilful questioning is the key to effective facilitation. Through questioning, the facilitator can achieve many objectives. Some of these objectives and examples of questions are listed below:

To open a discussion	"What is advance care planning helpful for?"
To make a point	"Why do you think that the patient's mother was upset?"
To check understanding	"What is the legal standard in this case?"
To surface new ideas	"How else could he have communicated this issue?"
To keep on track	"Can we go back to John's problem with making a decision?"
To bring out feelings/ attitudes	"How would you feel if you were confronted by this SDM?"
To bring out reactions to a point	"How do the rest of you feel about Carol's point?"
To suggest an approach/ idea	"What do you think would have happened if...?"
To broaden a discussion	"What other factors might be important here?"
To explore different approaches	"What approach would the ethics committee take?"
To advance a discussion	"What is the next step in the assessment process?"
To summarize	"What are the key points that we can take away?"
To move toward agreement	"Does this represent the thinking of all of us?"
To test ideas	"What would happen if we increased the dosage?"

Case writing and development

In SGT and in using cases in teaching in general, there are a number of basic steps to follow in writing a case:

1. Identify the specific learning objective(s) to be achieved. The list should number three to four objectives per case.
2. Select a case in which the learning objectives can be illustrated. Use real cases as the foundation for the written case study. This adds realism and will help participants easily identify with the subject. Sometimes, blending different cases into one will be effective.
3. The case should demonstrate the knowledge, attitudes, and skills needed in clinical practice.
4. Protect patient and family confidentiality at all times but especially when the case contains sensitive information. Change details such as name or initials, age, profession, number of children, etc., so that the patient or family cannot be identified.
5. Avoid choosing a case that is highly complex. Otherwise, you may overwhelm or confuse learners who are trying to distinguish pertinent from extraneous information.
6. Be concise. Give just enough information to provide the context. When there are too many variables, participants may get sidetracked and engage in debate about approaches or issues that are unrelated to the intended goal.
7. Develop a list of the key questions that need to be asked at each step in the case.
8. Ask peers to review the case description to be certain that the key teaching points are clear.

Medium Groups

Medium groups of up to 15-20 can also be managed similar to smaller groups but the interactivity and balancing participation become even more challenging.

Cases for Teaching

Case 1 – Jennifer Parsons

Case Description

Jennifer is a 59-year-old woman with metastatic pancreatic adenocarcinoma. Four months ago, she developed lower thoracic back pain. She saw her family doctor and then an orthopedic surgeon but the source of her pain was not initially apparent. She continued to have significant back pain for which she was taking acetaminophen-oxycodone tablets two tablets four times a day without much relief. One week ago, she developed sudden severe thoracic back pain. An x-ray in the emergency department showed a collapse of T12. She was admitted. Investigations with a bone scan was compatible with multiple bone metastases at T5, T6 and T12, L3, L4, and the left acetabulum. Abdominal MR scan showed a mass in the head of her pancreas, one 4 cm. hepatic metastasis and paraortic lymph node enlargement. Liver biopsy showed an anaplastic adenocarcinoma. The diagnosis of pancreatic carcinoma was made.

The surgeon feels she will need surgery to prevent duodenal obstruction and the medical oncologist is recommending chemotherapy with gemcitabine.

Jennifer was born in China and immigrated to Canada. Her first marriage to an abusive Chinese man was brief and lasted only two years. Her second marriage for 29 years was to Harold who is Caucasian. She works as product manager for a generic pharmaceutical company. Her husband is on a disability pension from the municipal transit company following a serious accident. He has a back injury and requires a cane to walk—he is 61 years old. They have three children: a married son, a daughter just finishing her masters degree in psychology and a 14-year-old daughter with Down’s syndrome. They attend church infrequently. Jennifer’s mother is alive and lives in a residential home—mild dementia. Her father died ten years ago with lung cancer. She has two siblings that she speaks to infrequently.

Jennifer and her husband, Harold, sit down with the medical team to discuss options for treatment.

Detailed Case Information

Area*	Details
1. Illness/treatment summary	The disease is inoperable but because of the size of the mass and the worry of potential obstruction, the surgeon may want to do a preventive bypass operation.
2. Physical	<ul style="list-style-type: none">▪ Steady pain over lower thoracic area, 7/10. Increased by movement▪ Constipation▪ Nausea after meals

* formatted according to the components of care in the CHPCA Model of Palliative Care (www.chpca.net)

Area*	Details
	<ul style="list-style-type: none"> ▪ Anorexia ▪ Weight loss 15 lbs. which she assumed was due to her dieting
3. Psychological	<ul style="list-style-type: none"> ▪ No serious problems in the past ▪ Now feels very anxious and very sad about her fate ▪ Feels hopeless and helpless ▪ Anxiety over youngest daughter's future ▪ Somewhat concerned and angry over the delay in diagnosis
4. Decision making	<ul style="list-style-type: none"> ▪ Her husband has been very helpful so far but she is confused because she does not understand fully what her disease is, how extensive it is and what treatment options exist
5. Communication	<ul style="list-style-type: none"> ▪ She feels she is a good communicator ▪ She shares a lot with her husband ▪ Known for her communication skills at work
6. Social	<ul style="list-style-type: none"> ▪ Born in China and raised there until age six when her parents fled to the USA because of religious persecution ▪ First marriage to an abusive Chinese man was brief and lasted only two years ▪ Second marriage for 29 years to Harold who is Caucasian ▪ She works as product manager for a generic pharmaceutical company ▪ Husband is on a disability pension from the municipal transit company following a serious accident—he has a back injury and requires a cane to walk—he is 61 years old ▪ Three children: <ul style="list-style-type: none"> ▪ Jeff, age 28, lives in town—married, no children ▪ Cynthia, age 24, has just finished her masters degree in psychology—lives nearby ▪ Anna, age 14, has Down's syndrome but is reasonably functional and is attending school ▪ No history of drug or alcohol problems in family ▪ Her mother is alive and lives in a residential home—mild dementia ▪ Her father died ten years ago with lung cancer ▪ Two sisters who live out of town—they get together only twice a year but e-mail and phone often ▪ Has health benefits through work ▪ Lives in two-storey home ▪ No major debts but does not have disability coverage ▪ Husband's pension is relatively small ▪ Watercolour artist—has a show coming up
7. Spiritual	<ul style="list-style-type: none"> ▪ Roman Catholic—husband Episcopalian ▪ Attend church irregularly ▪ Feels confused about her beliefs

Area*	Details
8. Practical	<ul style="list-style-type: none"> ▪ Difficulty climbing stairs and with ADL because of pain
9. Anticipatory planning for death	<ul style="list-style-type: none"> ▪ No planning at all yet ▪ Has discussed with her husband that she does not want to be kept alive on “machines”

Exercise on Goals of Care

This is an exercise to put a “personal” face on suffering, to see the world as it occurs for others.

You are Jennifer. You are lying in your hospital bed thinking about your future. Your pain is better now that the doctors have started the new pain medication. You have a lot of decisions to make and you are concerned about being a burden to your husband, Harold.

Take a minute or two to contemplate quietly what you think the goals of care are for Jennifer? For her health care team? Write down these hypotheses on the goals of care form.

Exercise on ACP

Now that you are aware of the goals of care for Jennifer and her family:

- a) What are the elements of an advance care plan for her?
- b) How will this be negotiated, confirmed, communicated and monitored?

Goals of Care Record Form

Area	Issues	Goals
1. Illness/treatment summary		
2. Physical		
3. Psychological		

Area	Issues	Goals
4. Decision making		
5. Communication		
6. Social		

Area	Issues	Goals
7. Spiritual		
8. Practical		
9. Anticipatory planning for death		

Case 2 – Harvey McGregor

Case Description

Harvey McGregor is a 73-year-old man. He has been having problems with his memory for the last two years. He saw his family doctor and then a neurologist. The diagnosis is early Alzheimer’s disease. Harvey is married to Eleanor.

Questions:

1. How will you begin the process of advance care planning with Harvey?
2. Who else needs to be involved?
3. What are the components of the ACP discussion?

Case 3 – Frances Hammond

Case Description

Frances is 48 years old. She has recently been diagnosed with ischemic heart disease and is awaiting a stenting procedure of her coronary arteries. She has a history of diabetes, hypercholesterolemia and obesity.

Questions:

1. Does she need an advance care plan?
2. Who else needs to be involved?
3. What are the components of the ACP discussion?

Case 4 – Farah Mohammed

Case Description

Farah is a 78-year-old Muslim woman who resides in a nursing home. She has had several strokes. She is confused and disoriented and has difficulty speaking. Recently she had an aspiration pneumonia and she has had increasing difficulty swallowing. Her son Faisal is the family spokesperson here in Canada. There are three other children, one son who lives in the US and the two daughters living in Pakistan. The family members are devout Muslims. The doctor in the hospital where she had her pneumonia treated suggested the family considered a feeding tube. Faisal is her eldest child and is the family spokesperson. He is not sure what to do and has asked his Imam for advice.

Questions:

1. What are the possible cultural issues that will impact ACP? How will you find out?
2. How can you help this family in making a decision?
3. If a decision is made to institute a feeding G-tube, should there also be a discussion of when it might have to be stopped?

Case 5 – Jonathan Somers**Case Description**

Jon is a 67-year-old university professor with esophageal cancer. He has advanced disease that could be treated with radiation only. He does not want chemotherapy. He has no formal advance directive but has told his physicians that he does not want a feeding tube or any “heroic measures” to keep him alive. His disease is progressing. He is weak and drowsy. His wife wants him to accept the feeding tube and states that when he is no longer able to make decisions, she will insist upon the feeding tube. No formal SDM has been designated. You feel Jon is still capable to make decisions for himself.

Questions:

1. How can you approach this issue with Jon and his family?

Case 6 – Myrna Beckwith**Case Description**

Myrna is a 43-year-old woman who has had metastatic breast cancer for six years. She has bone, liver and now brain metastases. Her disease is progressing rapidly. She has been told she has only a few weeks to live. Recently she has become quite withdrawn and talks about her death constantly. Her husband Fred and her two teenage children want her to “keep fighting”. She is admitted to an acute care hospital because of a pathological fracture of her femur which has been repaired with an intramedullary nail. She is approached by the medical team to agree to a DNR order. There is no formal advance directive. Her family feel she is giving up.

Questions:

1. How can the team help Myrna and family in this situation?

Case 7 – Lisa Marie Smith

Case Description

Lisa is age 18 months and has a progressive degenerative disease of her central nervous system. Children with this problem rarely live past the age of two years. She was diagnosed at about three months of age when she had delayed development and seemed to be deaf. She is blind as well. She does not seem to have much response to anyone but her parents. She has grown very little but is still taking some oral feeds, although she aspirates frequently. Her parents, James and Annette, have one other child age eight. They have been approached in the past about a feeding tube for Lisa and they have decided not to start one. They are looked after by a home palliative care team. One night, Lisa aspirates quite a bit and develops respiratory distress. She is taken to the emergency department where the pediatrician on call says they will have to intubate her and give her a feeding tube. The parents want to take her home and allow her to die at home. The pediatrician and a social worker threaten the parents with legal action to make them accept the recommended hospital treatment.

Questions:

1. What steps could have been taken to avoid this confrontation?
2. How can you help this family now?

Case 8 – Linda Scott*

Case Description

Linda Scott is a 70-year-old widowed woman with Alzheimer's disease. She worked as a bookkeeper so when she started having problems balancing her cheque book four years ago she became concerned and came to visit you. You eventually diagnosed her with Alzheimer's disease. In the last year and a half, her health has continued to deteriorate and while she still lives at home, she requires 24-hour care to help her with her activities of daily living. This care is provided by her long time friend Martha, a 65-year-old woman. Linda's only family are two cousins who live in the United States who she has not seen for seven years.

At the time of her diagnosis, Linda told you and Martha that she would "never want to go on a respirator" and, furthermore, did not want "any artificial feeding contraptions inserted" should she come to need them. You have not discussed these decisions with her since.

In the last few days, Martha noticed that Linda seems to be having more trouble with her speech and seems to choke when she swallows. When Martha brings her to the hospital, a CT scan is done which shows evidence of a new stroke. After a few days, it becomes evident that Linda's swallowing difficulties are not improving. Furthermore, since the stroke, Linda has not been able to communicate or to understand any information. Martha discusses Linda's previously

* from the Ian Anderson Program

expressed wishes with the medical team and they agree to make her DNR. In view of her difficulties swallowing, the medical team wants to insert a NG tube but Martha objects.

Feeling strongly that feeding is a necessity, the medical team asks for a bioethics consult. The bioethicist tells them that since Linda expressed these wishes regarding feeding four years ago, they may not reflect her current wishes. These, he feels, are not known since a lot can happen in four years. The bioethicist therefore recommends that her family in the United States be contacted and feeding discussed with them. The cousins say that while they have not seen or talked to Linda for seven years, they do not think she “would want to starve to death”.

Questions:

1. What steps could have been taken to avoid this situation?
2. How can you help this patient and family now?