

GT JAN-FEB 04 GET THE CODE 2883WORDS 0 PICS

“Get the Code Status:” Teaching Housestaff About End of Life Communication with Older Patients

Christopher Frank, MD, CCFP, Natalie Whiting, MD, CCFP

Abstract

Background

Discussions with older patients about their preferences for resuscitation can be time-consuming and challenging. There is little guidance in the literature to assist medical educators to teach students and residents to discuss extent of treatment wishes with older patients.

Methods

Medline was searched using MeSH headings; cardiopulmonary resuscitation, communication, decision-making, advance directives, residency and internship and teaching.

Results

There are few studies looking specifically at teaching about end of life communication (EOL) skills with elderly patients. Major themes identified included integration of EOL communication principles into existing pre-clinical and clinical courses, continuing formal teaching into the clinical years of training, the importance of supervised clinical experiences with observation and feedback, and role modelling with more senior staff. The differences between older patients and younger ones may not be well recognized by educators. The experiences of the author with EOL teaching and recommendations based on the literature and experience are summarized.

Conclusions

There is no “best way” to teach these communication skills, but it is important to consider exposure in pre-clinical years with practical and relevant teaching repeated in the clinical years. It is important to consider the skills of EOL communication with older patients as different from those required with a younger population. The use of role modelling and observation is very important but didactic or classroom-based strategies during clinical years can be helpful.

Key Words

Advance Directives
Communication
Medical Education
Teaching Methods

Background

Discussions with older patients about their wishes for resuscitation can be challenging and time-consuming. Although the nature of “getting the code status” has been the subject of many papers, there has been little focus on the older patient specifically. In a recent review of the literature, we found there was not enough research available to provide an evidence-based approach to extent of treatment discussions with the elderly hospitalized patient.¹ Similarly, there has been little written about strategies to teach medical trainees how to discuss end of life care wishes with older patients.

This concern is pertinent, based on an increased emphasis on a patient-centred approach to medical decision-making and given increased knowledge of poor outcomes of CPR and resuscitation of older patients. The common expectation of medical housestaff is that they discuss end of life treatment options with older patients whenever appropriate. However, medical trainees receive little training about how to optimally do so. Rates of CPR discussion are low in hospitalized elderly, and physician/resident discomfort with the process of discussion has been found to be a barrier to CPR decision-making.² The goal of this paper is to review the literature on teaching housestaff to talk about resuscitation preferences with older patients and to provide teaching strategies for medical educators and clinical preceptors.

Articles were identified from 1990-2003 on Medline using the MeSH headings cardiopulmonary resuscitation, communication, decision-making, advance directives, residency and internship, and teaching. Citations from identified articles were used.

Medical trainees experience with (EOL) discussions

Medical students and residents receive more exposure to end of life and palliative care than in the past.³ This may occur during the pre-clinical years in lecture format, or in a variety of formats during clinical clerkship and residency years. Despite this, medical trainees commonly report discomfort with their skill and experience in discussion of resuscitation preference with patients.^{4,5}

Reviews of medical school curricula have found that formal teaching about end of life (EOL) discussions often occurs in classroom settings during the pre-clinical years.^{4,6} An important study of medical students’ experience and approach to end of life care⁷ looked at 98 clinical clerks in an American medical school. Students were asked to provide narrative description of their exposure to end of life care throughout medical school. The results provide insight into strategies to effectively teach communication skills necessary for end of life care.

Students were asked to comment on their experiences with dying patients, and with obtaining DNR and end of life orders. They were asked about their own skills and attitudes and those of their attending physicians and residents. Students were also asked about their suggestions for teaching.

Four major themes emerged from the study: (1) students’ anxiety and uncertainty about EOL care, (2) guidance and role modeling, (3) preparation for EOL care, and (4) recommendations for curriculum development.

Most students were concerned about the emphasis of teaching EOL care in the pre-clinical years with little emphasis on attitudes, specific strategies and skills during clinical rotations. Although 100% of students reported working with dying patients, only 40% had observed a physician communicating EOL issues with patients. Clerks felt that

many of the responsibilities related to EOL discussions were delegated to students with a minimum of guidance or supervision. Students related experiences where they felt that a lack of role modelling and lack of backup to seek support or to “debrief” after a difficult clinical encounter was a significant educational and personal concern.

Most students felt the emphasis on early exposure in pre-clinical years was problematic and the topic was isolated in the curriculum and could be better integrated, especially during clinical years. Most emphasized that “experience can never be taught” but the lack of support and supervision when getting the clinical experience was a problem. Students had practical suggestions for non-didactic strategies to teach EOL communication in the classroom, including role playing exercises, case vignettes and the use of literary resources to gain understanding of the dying experience.

Several studies have looked at the quality of CPR/resuscitation discussions done by residents. Residents generally believe they are well versed in the pragmatics as well as the ethics of “code status” discussions.⁸ However, when residents are observed they often do not consistently provide accurate and relevant information needed for informed decision making.^{9,10} This may be particularly important with older patients where the quality of information sharing is crucial if consent is to be truly *informed* consent.¹¹ In one study, no residents suggested family involvement in decision-making, potentially a useful strategy with elderly patients. All residents expressed an interest in training in communication but most reported minimal supervision of EOL discussions and few had observed their attending physician with patients.⁹ There have been no observational studies of how the attending physicians perform CPR discussions, and observing senior physicians may not always be instructive.

Teaching strategies identified in the literature

Reviews of medical school and residency curricula have been done and national recommendations to improve EOL teaching have been made in the United States.¹² American geriatric medicine programs were identified as one of the specialties with the most comprehensive EOL teaching.¹³

One barrier to the use of older patients in teaching about communication is the difficulty of using frail elderly people for bedside teaching or as simulated patients (SP) in OSCE examinations. This may be because of the challenge of recruitment and because it may require training and make-up to increase the apparent “frailty” of an older volunteer or SP. CPR discussions with the frail elderly may be more time-consuming, especially if cognition is a concern and consideration of capacity is required. This time commitment can be a deterrent to experienced physicians providing role modelling or observing trainees conducting discussions.

Another reason older patients may not be a focus in the literature is because researchers may not consider their needs to be different from younger patients. In an article outlining the development of a program to use standardized patients to teach clinical ethics, educators from the Medical College of Ohio used SP’s almost exclusively in their 40’s to expose students to ethical aspects of CPR discussions and advanced directives.¹⁴ The ethical and pragmatic aspects of these discussions may be very different in a healthy or a frail 70 or 80-year old patient.

In an educational initiative in Oregon, first year internal medicine residents were observed by an instructor and by a second resident during a discussion of advance

directives with elderly volunteer simulated patients.¹⁵ The goal of the program was to provide individual feedback to improve residents' skills, increasing the comfort of residents involved. The majority of residents rated the program highly and felt their skills improved significantly. Specific areas of improvement noted were better knowledge of the legal and practical aspects of advanced directive, improved strategies for raising the topic of advanced directives and improved skills in providing clear and understandable information about resuscitation. Of note, all of the older volunteers agreed to participate in future sessions, having found the experience useful.

One article was found that described the use of an OSCE station for internal medicine residents on the use of advanced directives.¹⁶ The OSCE station was, however, a case discussion of a vignette and was not a conventional station with simulated patient. No other papers evaluating the role of OSCE examinations in the teaching of CPR discussions were found in the literature.

Other strategies were identified in the medical literature or by personal communications that have not been formally evaluated. These include the use of literary sources to alter attitudes and encourage reflection, the use of commercially available products such as the Robert Buckman series on communication skills (which has a vignette involving CPR discussion to provide role modelling), and the use of role plays in large group settings. A workshop involving interactive discussions and role-playing was reported using first-year residents at UBC.¹⁷

Recommendations for teaching CPR and EOL discussions

The major themes to take from the available literature include integration of EOL communication principles into existing pre-clinical and clinical courses, continuing formal teaching into the clinical years of training, the importance of supervised clinical experiences with observation and feedback, and role modelling with more senior staff. This section will review our experience with some of these approaches and provide considerations for other strategies.

At Queen's University, a student-run elective in first year medicine has been developed to provide exposure to patients receiving palliative care for a variety of conditions.¹⁸ In the "Living with an Incurable Illness" elective, students visit patient/mentors at their homes for a 10-week period. Patients with dementia and their caregivers have been mentors and have provided enlightening and positive experiences for students.

One of the educational focuses of faculty/student meetings is to review the options for breaking bad news and conducting EOL discussions. For many students this is a high priority for the course and they are very interested in improving their communication skills. No formal evaluation of the communication aspect of the course has been done. This model could be considered for undergraduate teaching of geriatric medicine and palliative care, as it opens students' eyes to the realities of the lives of frail older patients in the community.

Other opportunities for teaching in the pre-clinical years, such as the use of patient volunteers, role-playing and the use of humanities and literature, have not been developed or integrated with existing courses. We have developed an OSCE station for clinical clerks, based on "getting code status" for a lady in her mid-70's admitted to hospital for pneumonia. The station has not been formally evaluated, but has not posed major logistical issues to exam organizers and has been positively viewed as a challenging

station by students. The station uses checklist items based on the principles of consent to treatment with a global rating scale counting for a significant portion of the mark. This sort of station is feasible for clerks and residents, but would not be advisable as part of a pre-clerkship clinical skills exam.

Although medical students and housestaff emphasize the role of clinical and bedside teaching in resuscitation communication, we have found that classroom teaching of trainees in their clinical years can have an impact on the quality of communication. All family medicine and psychiatry residents doing geriatric medicine at Queen's receive a teaching session on Ethics and End of Life.

This session uses CPR discussion as a framework for clinical ethics in the elderly. Residents are asked to develop a policy related to CPR decision-making for a fictional nursing home as an interactive introduction to the practicalities and ethical issues of CPR discussions. Because CPR decision-making involves the principles of informed consent, capacity, decisional responsibility, conflict resolution and medical futility, it serves as an excellent framework for application of these issues to other clinical problems. The residents also appreciate time to discuss difficult end of life situations encountered in previous rotations.

Another strategy used is a pocket discussion aid developed by a Care of the Elderly Fellow. The card provides housestaff with a structure for organizing discussions and with practical information such as survival statistics to be included for different clinical situations. This pocket card has been evaluated informally using family medicine residents and plans are underway to evaluate its use on an Internal Medicine Clinical Teaching Unit.

The importance of role modelling in teaching communication skills with older patients has been recognized. At St. Mary's of the Lake Hospital's Geriatric Inpatient Unit, policy mandates that CPR discussions occur with all patients admitted for rehabilitation or assessment. This provides an excellent opportunity for role modelling in the practicalities and skills of CPR discussion. This is an area, however, where a more formal and standardized approach to attending physician role modelling would improve this teaching opportunity and is currently being reviewed. The workshop on ethics and EOL care is done early in the residents' two-month rotation to provide them a foundation that role modelling, observation and direct feedback can build on. Observing resident interactions with older patients or with volunteer patients has been used in the evaluation of care of the elderly residents.

Conclusions

CPR discussions with older patients are challenging, but there is little in the literature about strategies to teach students and residents how to conduct them. There is no "best way" to teach these communication skills, but it is important to consider exposure in pre-clinical years with practical and relevant teaching repeated in the clinical years. It is important to consider the skills of discussion with older patients as being distinct from those with a younger population. The use of role modelling and observation is very important but didactic or classroom-based strategies can be helpful.

References

1. Frank, C. Getting "Code Status" from the hospitalized elderly patient: a review of the literature. Heyland, D.K., Chen, B, Farquar, D, Myers, K. and Iwassa, K. CMAJ (in press).
2. Calam, B., Far, S. and Andrew, R. Discussions of 'code status' on a family practice teaching ward: what barriers do family physicians face? CMAJ 2000;173(10), 1255-1259.
3. Mullan, P.B., Weissman, D.E., Ambuel, B. and von Gunten, C. End-of-life care education in internal medicine residency programs; an interinstitutional study. J Palliat Med 2002;5(4), 487-496.
4. Buss, M.K., Marx, E.S., and Sulmasy, D.P. The preparedness of students to discuss end-of-life issues with patients. Acad Med 1998;73(4), 418-422.
5. Morgan, R. and Westmoreland, C. Survey of junior hospital doctors' attitudes to cardiopulmonary resuscitation. Postgrad Med J 2002; 78(921), 413-415.
6. Ury, W.A., Berkman, C.S., Weber, C.M., Pignotti, M.G. and Leipzig, R.M. Assessing medical students' training in end-of-life communication: a survey of interns at one urban teaching hospital. Acad Med 2003;78(5), 530-537.
7. Wear, D. 'Face-to-Face with It': medical students' narratives about their end-of-life education. Acad Med 2002;77(4), 271-277.
8. Tulskey, J.A., Chesny, M.A and Lo, B. See One, Do One, Teach One? Housestaff Experience Discussing Do-Not-Resuscitate Orders. Arch Intern Med 1996;156(12), 1285-1289.
9. Tulskey, J.A., Chesny, M.A and Lo, B. How Do Medical Residents Discuss Resuscitation With Patients? J.General Internal Medicine 1995;10(8), 436-442.
10. Miller, A., Lo, B. How Do Doctors Discuss Do-Not-Resuscitate Orders? West J.Med. 1985;143(2), 256-258.
11. Fitten, L.J., Waite, M.S. Impact Of Medical Hospitalization on Treatment Decision-making Capacity in the Elderly. Arch Intern Med 1990;150, 1717-1721.
12. Barnard, D., Quill, T., Hafferty, F.W., Arnold, R., Plumb, J., Bulger, R. and Field, M. Preparing the ground: contributions of the preclinical years to medical education for care near the end of life. Working group on the pre-clinical years of the National Consensus Conference on Medical Education for Care near the End of Life. Acad Med 1999;74(5), 499-505.
13. Weissman, D.E. and Block, S.D. ACGME requirements for end-of-life training in selected residency and fellowship programs: a status report. Acad Med 2002;77(4), 299-304.
14. Edinger, W. Using standardized patients to teach clinical ethics. Robertson, J., Skeel, J., and Schoonmaker, J. Medical Education Online 1999;4, 1-7. Available from URL: <http://www.med-ed-online.org/issue2.htm#v4>
15. Gordon, G.H. and Tolle, S.W. Discussing life-sustaining treatment. A teaching program for residents. Arch Intern Med 1991;151(3), 567-570.
16. Aronson, S.G., Kirby, R.W. Improving knowledge and communication through an advance directives objective structured clinical examination J Palliat Med 2002;5(6), 916-919.
17. Kuhl, D.R. A workshop for first-year residents on discussing "code status" in hospitals. Calam, B. and Westwood, M. Acad Med 2001;76(5), 560-561. (Abstract)

18. Ganstal, A. Living with an Incurable illness. Riley, S and Perkins, D. *Mediscan* 1996;14(5), 7-8.

Authors

Christopher Frank MD, CCFP, Care of the Elderly

Assistant Professor, Department of Medicine

Queen's University, Kingston, Ontario

Natalie Whiting, MD, CCFP, Certificate in Palliative Care

Assistant Professor, Department of Family Medicine

Queen's University

Address for Correspondence

Christopher Frank, MD, CCFP

Providence Continuing Care Centre

340 Union Street, PO Box 3600

Kingston, ON K7L 5A2

Tel: (613) 548-7222, ext. 2208

Fax: (613) 544-4017

E-mail: frankc@pccchealth.org