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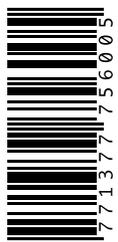
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Effective education for palliative care

Communication as a procedure

Palliative care for critically ill patients in the intensive care unit is increasingly in the mainstream, and palliative care principles are vital to ensure comprehensive patient care. *ICU Management & Practice* spoke to Caroline J. Hurd, MD, Director of Education Operations at UW Cambia Palliative Care Center of Excellence, about the purpose of palliative care education and ways to include the interprofessional team.

Why do intensivists and critical care specialists need palliative care education?

What families will remember, long after their loved one dies, or survives the ICU, is not whether the central line was placed perfectly or a ventilator was titrated just right. They will remember the members on the healthcare team who had the best communication and supported their family during the most difficult moment of their life. When done poorly, this can worsen an already stressful situation, but when done well, people can view their ICU experience as meaningful. We are finally starting to think about communication skills in the ICU as a procedure that is just as important as hands-on procedural skills like central lines, intubations and thoracenteses.

Delivering serious news, facilitating a family conference, or providing anticipated guidance should be viewed as a set of defined, intentional skills, that can be improved with deliberate practice. At the Cambia Center we are building and integrating serious illness communication skills into our ICU rotations with a stepwise process that involves simulations, real-time observation and structured feedback, as we help learners through increasing levels of independence.

Why does palliative care education need to be interprofessional?

We do our best work when we work as a team. The ICU is a 24-hour environment that requires clinicians from all disciplines to contribute to whole-patient care. It is just not humanly possible for any one of us to be everything for each patient and their family. It is also inefficient and less effective for disciplines to work

in isolation from one another. To give one example, our old model for ICU rounds was for the resident to present each patient, including overnight events and current clinical status. We realised that in doing this, the person most knowledgeable about these components, the nurse, was being sidelined, and key data was being omitted or was inaccurate. We now have our nurses present the patient data they collect as part of their routine assessment, residents present other diagnostic and exam data, both present insights from discussions with the patient and/or family and then together a plan of care for the day is created. We also find that relationships and rapport with families in the ICU is the key to continuity, trust and collaborative decision making. Sometimes the person who has the closest relationship with the family is the physician, while for other families that might be the chaplain or the social worker. If religious practice is central to this family's story, our chaplain may start a family conference with a prayer. This demonstrates mutual respect and alignment in a way that can set the stage for a healthy therapeutic alliance. For so long our disciplines have trained in parallel, but new training, with a focus on team communication and coordination, allows us to understand each other's strengths and best utilise our resources to benefit the patient and family.

What is an effective way to educate intensivists in palliative care consultations?

Effective education comes when facilitating communication is treated as a procedure (Whitaker et al. 2016). When interns start their one-month ICU rotation here at UW, the first

day is a workshop on procedures. Half of the workshop is on leading a family conference, and half the workshop is on hands-on procedures. Combining these skills sends the message that these are equally important procedural skills for ICU clinicians. For the family conference curriculum, they start by completing a few short self-directed online modules. Then they practise during the workshop with trained actors using the VitalTalk evidence-based methodology for learning serious illness communication skills. They are then expected to do two of each procedure, including central line placement, thoracentesis, and observed family conferences during their 1-month rotation. Residents log these procedures, and their level of independence is assessed each week by an attending physician. We have also trained faculty to provide real-time observation and feedback to residents. The basics can be taught didactically, but this is reinforced with experiential learning. VitalTalk is a national model for small group serious illness communication. The pedagogy is about how small groups are facilitated and feedback given, with one of the most powerful components being labelling communication skills. This provides a common language and framework amongst learners and faculty. For example, the feedback might be: "the respect statement you used when talking to the patient's daughter de-escalated her anger." This helps learners identify skills they can translate to other settings. This training has shifted the whole culture in our ICU and raised the floor for everyone in serious illness communication skills.

Why is narrative important in palliative care?

One of my mentors, the late Stu Farber always

said, "It is not our job to tell our patients' stories, it is our job to be good editors of their stories." Often the person's lived history is what is driving their decision-making. In my experience, conflict and moral distress, especially in the ICU, occur because we have not taken the time to understand our patients' stories. One of the best examples of this was a woman with end-stage renal disease and dementia. Despite repeated hospitalisations for infections, progressive functional decline and critical illness, her daughter continued to request full medical treatment. Palliative care was consulted and one of our physicians elicited the patient's story. He found out that the patient, who was an African-American civil rights activist, had spent her life fighting for access to medical care. Her daughter could eloquently acknowledge that she would never want these interventions for herself, but she felt responsible to honour her mother's wishes of wanting all available medical treatment, even if this came at the cost of physical suffering. For the nurses and the care team, knowing about this patient's life history changed their lens; suddenly what was viewed as

physical pain became meaningful. This appreciation changed every interaction with the family. We stopped trying to readdress code status each day and just walked with them in the journey. This new dynamic actually opened the space for her daughter to consider other options and the patient was transitioned to comfort care, dying shortly after. Knowing narrative is what creates the opportunity for alignment and shared goals.

How are patients and families educated about palliative care?

What is exciting about the field of palliative care is that education to the public is happening at many levels, and the messaging that palliative care is about goal-concordant care that aligns with values, as opposed to only a focus on end-of-life care, has been central to its dissemination. We are starting to normalise conversations about advance care planning, serious illness and challenging the status quo of our broken healthcare systems. A huge credit goes to organisations like the Center to Advance Palliative Care (CAPC) and their national initiatives to increase access

to palliative care through advertising campaigns, public service announcements, health policy and online resources like getpalliativecare.org. Other leaders, such as Ellen Goodman who started the conversation project (theconversationproject.org) are speaking directly to patients and families and meeting a deep need in our communities. Because of efforts on many levels, palliative care is being integrated and offered further upstream as just good medical care for patients with serious illness. In our health system, we are working on trigger tools and embedded models of palliative care to increase availability and exposure to patients and families. The common theme among all of these efforts is that palliative care is filling a large gap that has been palpable in our health systems for some time. Patients and families who receive palliative care immediately feel this gap being filled, and that one-on-one impact still remains the best resource for of education and awareness. ■

Reference

Whitaker K, Kross EK, Hough CL et al. [2016] A procedural approach to teaching residents to conduct intensive care unit family conferences. *J Palliat Med*, 19(10): 1106-9.

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