A Resident-led Initiative to Review and Improve Training in Advance Care Planning

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Importance of ACP Training in Family Medicine

Advance Care Planning (ACP) has a myriad of patient-centered benefits, including improved patient quality of life, reduced stress for patients and their families, and reduced hospital admissions and length of stay. Despite these benefits, and despite the fact that 60% of Canadians want their healthcare provider to give them information on ACP, participation in ACP is low. In one national survey, only 9% of respondents indicated that they had discussed end-of-life care with their primary physicians. Moreover, physicians lack confidence in this area. Only 26% of primary care physicians are comfortable leading ACP discussions with their patients and 67% feel they need more resources in order to do this. Family physicians are best positioned to conduct these sensitive conversations with their patients, incorporating ACP as a routine part of chronic disease care.

Role of the CFPC SoR

Each year, the CFPC’s Section of Residents (SoR) undertakes a review of a specific aspect of Family Medicine Residency programs across Canada. The theme of the 2017 review is Advanced Care Planning (ACP). Our project involved three components:

1. We surveyed current Family Medicine residents in Dec 2016 regarding their training on ACP.
2. We reviewed best practices and existing resources in the teaching of ACP to medical learners.
3. We created a new simple, practical ACP point of care tool for residents to use in a clinical environment.

Results

~20% of Canadian family medicine residents responded (n = 267, ~50% first year, ~50% second (final) year). Results are summarized in Figures 1 and 2, and in Table 1.

Discussion/Conclusions

Currently, only ~40% of Canadian family medicine residents feel prepared to conduct ACP in practice. Our recommendations to program directors, and our Guide to ACP Conversations point of care tool may help address this training gap and improve resident preparedness for ACP. Follow-up studies on recommendation/tool uptake are pending.

The CFPC Section of Residents has found that there is a large, unmet need for more ACP training in Canadian family medicine residencies. In response to this need, we have developed recommendations for program directors as well as compiled best practices from around Canada into a point-of-care ACP point of care tool for residents (see below, left).

Recommendations to Program Directors

1. Incorporate a minimum of 3 – 5 hours of both didactic and clinical teaching specifically on ACP in your residency curriculum. This time should ideally be divided across multiple teaching and clinical sessions throughout residency.
2. Provide residents with opportunities to practice ACP in a supervised and safe environment (i.e. SIM, standardized patient simulators).
3. Distribute our point-of-care clinical tool, and direct your residents to your province-specific ACP resources.
4. Consider supporting research on ACP teaching in residency, specifically examining effective methods of teaching as well as resident-preparedness for ACP discussions and if this translates into patient-centered outcomes.
5. Invest in faculty development on ACP, so that effective skills and practices are modelled by preceptors in both clinical and teaching environments.

Table 1: Summary of Major Survey Findings

- 33% of residents report having received either formal didactic or formal clinical teaching on ACP during their residency training.
- Only 40% of residents indicate that they believe they will feel prepared to guide patients in ACP discussions following their residency.
- >75% of residents report wanting to have more didactic and clinical teaching on ACP during residency. Most report wanting 1-4 more hours of both didactic and clinical teaching.
- Residents requested more training on the practical aspects of performing ACP (i.e. an approach to ACP discussions, appropriate language to use), and opportunities to practice performing ACP.
- 80% of residents would find a clinical aid / “How-to-Guide” helpful/very helpful in performing ACP.

Guide to ACP Conversations point of care tool (DRAFT)

| Role of the CFPC SoR | ACP Conversations:
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<tr>
<td></td>
<td>Prepare patient for future health decision-making</td>
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<td>by asking &amp; understanding their values/goals</td>
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<td></td>
<td>Help patients decide on a surrogate decision maker</td>
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<td></td>
<td>Are for everyone, not just the seriously ill</td>
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<td></td>
<td>ACP conversations are NOT:</td>
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<td></td>
<td>Decisions that must be made after one consultation</td>
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<td>Just about goals of Care/resuscitation orders</td>
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Triage ACP conversations according to life situation:

1. Well patient
2. Sick patient or w/ chronic disease
3. Acute/medical/surgical
4. Acute/medical/surgical/coma
5. Deadly
6. Hospice

Understanding: How much do you (or your family) know about your illness? What information would you like from me?

Goals: What are the most important things you still want to do in life? What are some abilities in life you can’t do without?

Fears: What are your biggest fears and worries about your health? About your family?

Probabilities: If you get sicker, how much extra healthcare services are you willing to endure to gain more time?

Decide: Decide on a surrogate decision maker (SDM) and on a patient-centered treatment plan, but reassure that no medical decisions must be made now.

Document: Discuss the full discussion yourself. Encourage your patient (and their SDM) to write down all SDM values into a formal Personal Directive document, and make sure the patient reads other province-specific ACP documents (i.e. Power of Attorney, Goals of Care designation, etc.).

Recommendations to Program Directors

1. Incorporate a minimum of 3 – 5 hours of both didactic and clinical teaching specifically on ACP in your residency curriculum. This time should ideally be divided across multiple teaching and clinical sessions throughout residency.
2. Provide residents with opportunities to practice ACP in a supervised and safe environment (i.e. SIM, standardized patient simulators).
3. Distribute our point-of-care clinical tool, and direct your residents to your province-specific ACP resources as well as the national Speak Up! campaign’s Just Ask resource guides for physician-directed ACP discussions.
4. Consider supporting research on ACP teaching in residency, specifically examining effective methods of teaching as well as resident-preparedness for ACP discussions and if this translates into patient-centered outcomes.
5. Invest in faculty development on ACP, so that effective skills and practices are modelled by preceptors in both clinical and teaching environments.

REFERENCES