Why Should Palliative Care Faculty Attend on General Medicine Teaching Services?

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INTRODUCTION

Effective internal medicine practice requires a palliative care skill set often developed during residency training. Most internists care for seriously ill patients who need effective pain and symptom management, particularly as they approach end of life.¹ Skilled communication is equally important for serious illness care² and is relevant to nearly every clinical encounter. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) has identified Interpersonal and Communication Skills as a core competency for resident trainees, and effective communication with patients and caregivers as an expected educational milestone. Despite the importance of such primary palliative care skills, trainees report inadequate preparedness to manage serious illness conversations and end of life care.^{3–5}

While multiple strategies exist to teach these skills, we contend that palliative care faculty involvement as general medicine teaching attendings provides a unique and underutilized opportunity for resident education. As specialists who attend on the medicine wards, we have found that the palliative care skills essential to internist practice may be taught most effectively when they are woven into daily bedside care. Existing palliative care education often occurs within established teaching settings (i.e. daily conferences and morning report discussions) or special didactic sessions (i.e. communication skills workshops). While valuable, these experiences may be siloed from residents' clinical work. A rotation with a palliative care consult service is another space to learn these skills; however, this experience may not be available to all medical residents, can require use of limited elective time, and may not demonstrate as clearly how these skills manifest in generalist practice. When palliative care faculty attend on the wards, they can help residents develop a more perceptive eye for unmet palliative care needs and begin to address them

during routine inpatient care. In this article, we explore the educational benefits of increased integration of palliative care faculty into general medicine teaching services.

WHAT ARE THE BENEFITS OF INTEGRATING PALLIATIVE CARE FACULTY?

As the general medicine attending, palliative care physicians can provide teaching on key topics related to care of the seriously ill. They can instruct trainees on management of pain, nausea, dyspnea, delirium, and the care of the imminently dying. They can also model collaboration with interdisciplinary team members and highlight when another discipline's skill set may be of particular importance to a patient's care. Yet their most valuable teaching concerns training residents in core communication skills and cultivating awareness of disease trajectory and prognosis.

Palliative care specialists can demystify effective communication. They can provide coaching and feedback as trainees deliver serious news, discuss prognosis, and navigate goals of care conversations. Additionally, they can teach communication skills germane to nearly every encounter, including responding to emotion and providing information in a succinct, accessible way. While teaching communication skills can feel challenging within a time-limited inpatient environment, palliative care attendings may employ established frameworks to do this teaching efficiently. We often use the structure described by Back et al., which involves prompting the learner with key questions before the encounter to identify a learning goal, highlighting afterward what the learner did skillfully, processing what felt challenging in the conversation, and solidifying take-away points that can be applied to future cases.⁶

Embedded palliative care faculty can also help residents hone their sense of disease trajectory and prognosis, and approach management decisions with this context. Palliative care specialists routinely consider relevant questions regarding the patient's illness trajectory, prognosis, and psychosocial concerns, with the aim of providing goal-concordant, whole-person care (Table 1). Answers to these questions often inform decisions regarding medication management, the urgency of advance care planning discussions, involvement of psychosocial clinicians, and disposition planning. Palliative care

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Table 1 Learning to consider the context of serious illness: Questions for internal medicine residents

Domain	Key Questions
Understanding illness trajectory	<ul style="list-style-type: none"> •What do I imagine will be this patient's likely course over the coming days? Over the coming weeks and months? •Am I worried this patient could get sicker in the near future? •What is this patient's understanding of his/her illness?
Estimating prognosis	<ul style="list-style-type: none"> •What is my sense of this patient's prognosis? (i.e. range of days, weeks, months, or years) •Would I be surprised if this patient died in the next year? In the next six months? •Am I worried time could be short for this patient? •If so, what conversations and care decisions should we approach now?
Psychosocial concerns and care of the whole person	<ul style="list-style-type: none"> •Who are this patient's main social supports? •Who helps this patient make decisions about his/her care? •Are there key hopes and worries this patient has, which might impact decisions about his/her medical care? •What does a "good day" look like for this patient? •Where is this patient likely to receive care as he/she becomes sicker and nears end of life?

attendings can teach residents to "step back" and consider these contextual questions as they manage each patient's care.

In teaching residents about prognosis, we have found the "surprise question" ("Would you be surprised if this patient died in the next 12 months?")⁷ to be a powerful learning tool. This question can highlight the palliative care needs of a medically ill patient who otherwise appears to be having a routine admission. Like the "sick versus not sick" paradigm that we expect residents to develop, palliative care attendings can help residents develop a "worried versus not worried" perspective. *Am I worried that time could be short for this patient? Am I worried that this patient may get sicker in the near future?* If the resident indeed has these concerns, that may prompt discussion of the patient's care goals during the current admission.

WHAT CHALLENGES EXIST TO INTEGRATING PALLIATIVE CARE FACULTY?

A minority of residents may express disinterest or lack of "buy-in" around the importance of palliative care skills. Other residents may worry that palliative care faculty have inadequate experience to supervise inpatient care (compared with hospitalists or cardiologists, for example). Some palliative care faculty may share this latter concern, worried they no longer possess the knowledge base or medical management skills required of the general internist. In our experience, on-service time itself quickly assuages these concerns.

Inpatient medicine teams provide rich opportunities for collaboration and camaraderie. As the palliative care physician joins the residents in managing both challenging and rewarding aspects of inpatient care, a sense of bonding and deepened respect can emerge. Residents can see the palliative care skillset woven into daily care, amidst antibiotic selection and volume status assessment, and their concerns that such skills are "soft" or separate from more "medical" aspects of care begin to dissipate.

Additionally, while not all palliative care physicians are trained as internists, a majority are, and we believe that they are well-suited to the general medicine attending role. Effective palliative care practice is built on the essentials of internal medicine. The ability to integrate multiple medical concerns and groove with a patient's dynamic, often unexpected clinical course, all while considering their psychosocial needs and disposition, is crucial to both palliative care and hospital medicine. We both ask, "How do you put this patient together?" with a lens toward process-oriented, whole-person care.

Some programs, including our own, use a co-attending model, pairing a subspecialist with a general internist or hospitalist. While palliative care faculty can be effective in a solo or co-attending role, our experience is largely in the latter, which we believe has particular advantages. The co-attending structure can provide valuable support when unfamiliar clinical concerns arise, foster productive discussion between experts, and enhance learning opportunities for residents and attendings alike. The palliative care attending may call upon the hospitalist's expertise when managing a medically decompensating patient, to review the case and ensure no important steps in care are missed. The hospitalist may similarly involve the palliative care attending when a difficult pain management or communication concern arises. For on-service residents, the dialogue between the co-attendings can model collaborative decision-making and normalize consulting a colleague when faced with a clinical challenge.

CONCLUSIONS

When palliative care faculty serve as general medicine attendings, they provide a unique opportunity for resident education in skills essential to internist practice. In our experience, incorporating communication and prognostication teaching into daily inpatient care can increase residents' awareness of unmet palliative care needs and sharpen their use of primary palliative care skills.

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REFERENCES

1. **Quill TE, Abernethy AP.** Generalist plus specialist palliative care—creating a more sustainable model. *N Engl J Med.* 2013;368(13):1173-1175.
2. **Bernacki RE, Block SD,** American College of Physicians High Value Care Task Force. Communication about serious illness care goals: a review and synthesis of best practices. *JAMA Intern Med.* 2014;174(12):1994-2003. doi:<https://doi.org/10.1001/jamainternmed.2014.5271>
3. **Berns SH, Camargo M, Meier DE, Yuen JK.** Goals of Care Ambulatory Resident Education: Training Residents in Advance Care Planning Conversations in the Outpatient Setting. *J Palliat Med.* 2017;20(12):1345-1351.
4. **Gorman TE, Ahern SP, Wiseman J, Skrobik Y.** Residents' end-of-life decision making with adult hospitalized patients: a review of the literature. *Acad Med.* 2005;80(7):622-633.
5. **Rhodes RL, Tindall K, Xuan L, Paulk ME, Halm EA.** Communication About Advance Directives and End-of-Life Care Options Among Internal Medicine Residents. *Am J Hosp Palliat Care.* 2015;32(3):262-268.
6. **Back AL, Arnold RM, Baile WF,** et al. Faculty development to change the paradigm of communication skills teaching in oncology. *J Clin Oncol.* 2009;27(7):1137-1141.
7. **Pattison M, Romer AL.** Improving Care Through the End of Life: launching a primary care clinic-based program. *J Palliat Med.* 2001;4(2):249-254.

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