5-1-2021

Goals-of-Care Course for Emergency Physicians during the COVID-19 Pandemic.

Mari Siegel
Thomas Jefferson University

Erica Westlake
Thomas Jefferson University

Goals of Care Course for Emergency Physicians During the COVID-19 Pandemic

Running Head: GOC COURSE FOR EPS DURING THE COVID-19 PANDEMIC

Authors:
Mari Siegel, MD
Associate Professor of Emergency Medicine[1] and Attending Physician[2]
Mari.siegel@jefferson.edu

Erica Westlake[1]
MD Candidate, Class of 2022
eaw019@students.jefferson.edu

[1]Sidney Kimmel Medical College, Thomas Jefferson University Hospital
Philadelphia, Pennsylvania

[2] Keystone Palliative Care, Temple University Hospital
Philadelphia, Pennsylvania

Corresponding author and first author:
Mari Siegel, MD
Thomas Jefferson University Hospital
Department of Emergency Medicine
1025 Walnut Street, Suite 300 College Building
Philadelphia, Pennsylvania, 19107
Mari.siegel@jefferson.edu
617-251-3526

Keywords: Goals of care, COVID-19, emergency physician, role play

ABSTRACT

BACKGROUND

COVID-19 increased the need for goals of care (GOC) discussions in the Emergency Department (ED). Many Emergency Physicians (EPs) report no formal training in holding GOC discussions. COVID-19 created unique teaching challenges given social distancing requirements.

METHODS

Eight teaching sessions were held using Zoom in March and April at an urban institution in the United States. Sessions were limited to 4-8 participants. They were comprised of a 30-minute lecture and 15 minutes of role-playing, in which providers read scripts to practice communication skills. The lecture introduced vocabulary and models to shape GOC discussions. Participants were invited to complete an eight-question survey about the effectiveness of the session and of virtual teaching.

RESULTS

40 of the Department's 70 EPs participated (57%). 17 returned the survey (43%). Prior to the session, zero physicians were extremely comfortable having goals of care conversations, compared to 24% who ranked themselves as extremely comfortable afterwards. Prior to the session, 24% of physicians were not comfortable at all or not so comfortable leading goals of care conversations, compared to zero physicians who reported this after the session. 47% of participants rated the virtual platform as extremely effective for teaching these skills, and 71% said they had never received formal training about goals of care discussions.

CONCLUSIONS

There is a need for formal training in goals of care discussions for EPs. Patient-centered care based on patient goals and values benefits the patient, providers and healthcare overall. Zoom is an example of an effective virtual platform for teaching interpersonal skills.

INTRODUCTION

When thinking about goals of care discussions, most people envision family members crowded in an ICU room debating the pros and cons of intubation or CPR. However, goals of care discussions should not be limited to the final stages of life. Ouchi et al. discusses how the ED visit generates a teachable moment for the patient in terms of how to shape the rest of their care, considering ED visits often signal the beginning of patient decline in those with serious illness.[1] Moreover, overemphasis on code status and asking about CPR before addressing goals and values leads to ineffective and misaligned goals of care discussions.[2]

Many patients arrive to the ED without an advanced directive. With many COVID-19 patients arriving to the ED at risk for rapid deterioration, it was imperative for these discussions to be held in the emergency department by EPs. In response to this need, an EM/IM/Palliative Care boarded physician implemented The Goals of Care Refresher Course for ED faculty at an academic, urban emergency department.

Goals of care discussions enable the medical team to match a patient's goals with recommended interventions and enable patient-centered care at all stages of illness. Depending on the patient's stage of illness and prognosis, mapping out goals and making choices may require tradeoffs, for example, between longevity and comfort. These conversations can be difficult and nuanced, and require some training. The COVID-19 pandemic has shown how imperative it is that EP physicians are facile in having these discussions. Table 1 is an example of how prognosis can direct goals and appropriate interventions for patients.

These discussions become the cornerstone of patient advocacy in situations when patients cannot speak for themselves. In laying out wanted levels of intervention, the patient can highlight treatments that are unwanted, those which would cause undue prolongation of illness or

suffering. Having this framework for how patient goals inform interventions allows for an appropriate use of resources in accordance with patient wishes, and promotes care of the patient, not just treatment of the disease.

MATERIALS AND METHODS

Frameworks specific to having GOC conversations in the ED were covered in the lecture to provide a mental map that providers can fall back on if they are having difficulty navigating the discussion. The lecture introduced REMAP, REMAP with informed assent, and The Five Minute ED Goals of Care Procedure.[3,4] The REMAP model developed by VitalTalk is a valuable tool for late goals of care discussions when a decision is imminently needed, as often is the case in the ED.[3] The steps in REMAP are outlined in Table 2, along with examples of how to implement them. REMAP can be adapted to use with a surrogate when the patient is unable to speak for themselves.

Specific language was introduced that conveys empathy and alignment with the patient, and offers a reflective and non-judgmental assessment of the patient's goals and values. Providers were encouraged to ask permission both to give serious news and before giving recommended treatment plans. This affords the patient a moment to prepare for new and potentially upsetting information, and to include family members in the discussions if so desired. The phrase "I wish" was encouraged when providers respond to patient emotions, to impart non-abandonment without providing false hope or diminishing the seriousness of a disease. Statements like "I wish that you didn't have to go through this" or "I wish there was more time" allow the physician to provide empathy in the face of bad news. Additionally, "I wish" can replace "I'm sorry" in providers' vocabulary and provides a connotation of being on the same team while also reinforcing the reality of the difficult news.

Phrases were suggested to assist physicians having difficulty starting this conversation. Questions such as, "What do I need to know about you to take better care of you" are good opening statements when finding out what is important to the patient. This question is a starting point to have a more focused discussion – is the patient hoping to attend their daughter's wedding next month? Has the patient had multiple rounds of chemotherapy and is no longer willing to endure the side effects, and instead seeks to be comfortable? Is there something the patient is afraid of, such as pain or dying alone? Asking the right questions can ensure we provide patient-centered care and that interventions match values and goals.

The ethical principal of informed assent posits that not all interventions are right for all patients. In fact, aggressive procedures like CPR or intubation, when unlikely to provide benefit, may actually harm a patient. Informed assent advances that physicians should use their expertise to elect not to offer intubation or CPR to a patient for whom the procedure is exceedingly unlikely to provide benefit. "Informed assent may be a more acceptable approach to code status discussions than medical futility and may be useful for patients in whom CPR is exceedingly unlikely to allow a successful return to a quality of life they would find acceptable."[2]

Informed assent differs from informed consent, when a patient is given information about all treatment options so they can voluntarily choose to accept or decline the recommended treatment plan. The ethical principal of informed assent became a popular debate topic when the medical world feared we would have to ration care because of the COVID-19 pandemic. The concept gained further traction when we saw data that the death rates for intubated patients over age 65 with comorbidities was uncommonly high.[5] REMAP can be adapted to incorporate informed assent and provides a useful tool for having GOC discussions when survival is exceedingly unlikely, and when a patient prioritizes quality or comfort over longevity.

In the second part of the goals of care refresher course, participants were paired together to role-play to practice these techniques. Learners practiced with a scripts using a) REMAP, and b) REMAP with informed assent with a surrogate to familiarize themselves with the flow and terminology. After the course, participants were asked to take a survey, which was voluntary. IRB approval was obtained, the study was deemed exempt.

RESULTS

Prior to the session, zero providers were extremely comfortable having goals of care conversations and 24% of providers were either not so comfortable or not comfortable at all. The majority, 58%, reported being somewhat comfortable and only 18% said they were very comfortable. After the session, zero providers ranked as not comfortable at all and not so comfortable, decreasing from 24%. There was an increase to 47% ranking themselves as very comfortable and 24% ranking themselves as extremely comfortable having goals of care discussions (Figure 1).

41% of participants ranked the role play as extremely effective, and 29% ranked it as very effective (Figure 2). 47% of participants rated Zoom as a extremely effective platform for teaching these skills, 35% of participants said very effective, and zero said not at all effective (Figure 3). 71% of participants said they had not received any formal training in having goals of care discussions.

DISCUSSION

Goals of care discussions are essential to ensure value concordant care. However, the majority of EPs do not receive formal training in this area. COVID-19 emphasized the need for these skills. The most important part of these discussions in defining a patient's values, and often patients can be guided through this process using the idea of tradeoffs: longevity, quality, or

comfort. Once the patient's values are known, a recommendation is offered by the medical team that matches those values.

EPs cite many barriers to having GOC discussions in the ED. Most commonly, they cite lack of skills or lack of comfort with the skills, and lack of time.[6] The model used in this study, REMAP, is a quick and effective way to hold these conversations, and is especially effective in the ED setting.

The results of the study show that combining scripted role play with didactics is a highly effective method for teaching these skills. After only 45 minutes, most EPs in this study felt much more comfortable having these discussions. This shows that a huge time commitment is not required to familiarize oneself with the skills needed. Further, virtual platforms are effective tools for teaching interpersonal skills. Born out of necessity during the COVID-19 pandemic, virtual teaching is likely here to stay because it is easy to use, convenient, and highly scalable.

LIMITATIONS

This study was limited by only 43% of participants responding to the post course survey. This may be attributed to the reliance on voluntary survey completion. Also, although the teaching sessions were held on multiple days and at varying times throughout the day to capture as many faculty as possible, only 57% of faculty participated. This is possibly due to the course not being mandatory.

CONCLUSION

There is a need for formal training in goals of care discussions for EPs. Two-thirds of EPs in this study had not received training in facilitating these vitals conversations. Patient-centered care based on a patient’s goals and values benefits the patient, their family, providers

and health care overall. Zoom proves to be an example of an effective virtual platform for teaching interpersonal skills.

Author Contribution:

M.S. contributed to the study concept and design, acquisition of the data, drafting and critical review of the manuscript.
E.W. contributed to the analysis and interpretation of the data, drafting and critical review of the manuscript.

Author Disclosure:

M.S. has no conflicts of interest to disclose

E.W. has no conflicts of interest to disclose

Funding Disclosure: no funding was provided for this project.

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