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

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

2   Running Head: GOC COURSE FOR EPS DURING THE COVID-19 PANDEMIC
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36 **ABSTRACT**

37 BACKGROUND

38 COVID-19 increased the need for goals of care (GOC) discussions in the Emergency

39 Department (ED). Many Emergency Physicians (EPs) report no formal training in holding GOC

40 discussions. COVID-19 created unique teaching challenges given social distancing requirements.

41 METHODS

42 Eight teaching sessions were held using Zoom in March and April at an urban institution in the

43 United States. Sessions were limited to 4-8 participants. They were comprised of a 30-minute

44 lecture and 15 minutes of role-playing, in which providers read scripts to practice

45 communication skills. The lecture introduced vocabulary and models to shape GOC discussions.

46 Participants were invited to complete an eight-question survey about the effectiveness of the

47 session and of virtual teaching.

48 RESULTS

49 40 of the Department's 70 EPs participated (57%). 17 returned the survey (43%). Prior to the

50 session, zero physicians were extremely comfortable having goals of care conversations,

51 compared to 24% who ranked themselves as extremely comfortable afterwards. Prior to the

52 session, 24% of physicians were not comfortable at all or not so comfortable leading goals of

53 care conversations, compared to zero physicians who reported this after the session. 47% of

54 participants rated the virtual platform as extremely effective for teaching these skills, and 71%

55 said they had never received formal training about goals of care discussions.

56 CONCLUSIONS

57   There is a need for formal training in goals of care discussions for EPs. Patient-centered care

58   based on patient goals and values benefits the patient, providers and healthcare overall. Zoom is

59   an example of an effective virtual platform for teaching interpersonal skills.

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61

62 **INTRODUCTION**

63   When thinking about goals of care discussions, most people envision family members

64 crowded in an ICU room debating the pros and cons of intubation or CPR. However, goals of

65 care discussions should not be limited to the final stages of life. Ouchi et al. discusses how the

66 ED visit generates a teachable moment for the patient in terms of how to shape the rest of their

67 care, considering ED visits often signal the beginning of patient decline in those with serious

68 illness.[1] Moreover, overemphasis on code status and asking about CPR before addressing goals

69 and values leads to ineffective and misaligned goals of care discussions.[2]

70   Many patients arrive to the ED without an advanced directive. With many COVID-19

71 patients arriving to the ED at risk for rapid deterioration, it was imperative for these discussions

72 to be held in the emergency department by EPs. In response to this need, an EM/IM/Palliative

73 Care boarded physician implemented The Goals of Care Refresher Course for ED faculty at an

74 academic, urban emergency department.

75   Goals of care discussions enable the medical team to match a patient's goals with

76 recommended interventions and enable patient-centered care at all stages of illness. Depending

77 on the patient's stage of illness and prognosis, mapping out goals and making choices may

78 require tradeoffs, for example, between longevity and comfort. These conversations can be

79 difficult and nuanced, and require some training. The COVID-19 pandemic has shown how

80 imperative it is that EP physicians are facile in having these discussions. Table 1 is an example

81 of how prognosis can direct goals and appropriate interventions for patients.

82   These discussions become the cornerstone of patient advocacy in situations when patients

83 cannot speak for themselves. In laying out wanted levels of intervention, the patient can highlight

84 treatments that are unwanted, those which would cause undue prolongation of illness or

85   suffering. Having this framework for how patient goals inform interventions allows for an

86   appropriate use of resources in accordance with patient wishes, and promotes care of the patient,

87   not just treatment of the disease.

88   **MATERIALS AND METHODS**

89   Frameworks specific to having GOC conversations in the ED were covered in the lecture

90   to provide a mental map that providers can fall back on if they are having difficulty navigating

91   the discussion. The lecture introduced REMAP, REMAP with informed assent, and The Five

92   Minute ED Goals of Care Procedure.[3,4] The REMAP model developed by VitalTalk is a valuable

93   tool for late goals of care discussions when a decision is imminently needed, as often is the case

94   in the ED.[3] The steps in REMAP are outlined in Table 2, along with examples of how to

95   implement them. REMAP can be adapted to use with a surrogate when the patient is unable to

96   speak for themselves.

97   Specific language was introduced that conveys empathy and alignment with the patient,

98   and offers a reflective and non-judgmental assessment of the patient's goals and values.

99   Providers were encouraged to ask permission both to give serious news and before giving

100   recommended treatment plans. This affords the patient a moment to prepare for new and

101   potentially upsetting information, and to include family members in the discussions if so desired.

102   The phrase "I wish" was encouraged when providers respond to patient emotions, to impart non-

103   abandonment without providing false hope or diminishing the seriousness of a disease.

104   Statements like "I wish that you didn't have to go through this" or "I wish there was more time"

105   allow the physician to provide empathy in the face of bad news. Additionally, "I wish" can

106   replace "I'm sorry" in providers' vocabulary and provides a connotation of being on the same

107   team while also reinforcing the reality of the difficult news.

108   Phrases were suggested to assist physicians having difficulty starting this conversation.

109   Questions such as, "What do I need to know about you to take better care of you" are good

110   opening statements when finding out what is important to the patient. This question is a starting

111   point to have a more focused discussion – is the patient hoping to attend their daughter's

112   wedding next month? Has the patient had multiple rounds of chemotherapy and is no longer

113   willing to endure the side effects, and instead seeks to be comfortable? Is there something the

114   patient is afraid of, such as pain or dying alone? Asking the right questions can ensure we

115   provide patient-centered care and that interventions match values and goals.

116   The ethical principal of informed assent posits that not all interventions are right for all

117   patients. In fact, aggressive procedures like CPR or intubation, when unlikely to provide benefit,

118   may actually harm a patient. Informed assent advances that physicians should use their expertise

119   to elect not to offer intubation or CPR to a patient for whom the procedure is exceedingly

120   unlikely to provide benefit. "Informed assent may be a more acceptable approach to code status

121   discussions than medical futility and may be useful for patients in whom CPR is exceedingly

122   unlikely to allow a successful return to a quality of life they would find acceptable."[2]

123   Informed assent differs from informed consent, when a patient is given information about

124   all treatment options so they can voluntarily choose to accept or decline the recommended

125   treatment plan. The ethical principal of informed assent became a popular debate topic when the

126   medical world feared we would have to ration care because of the COVID-19 pandemic. The

127   concept gained further traction when we saw data that the death rates for intubated patients over

128   age 65 with comorbidities was uncommonly high.[5] REMAP can be adapted to incorporate

129   informed assent and provides a useful tool for having GOC discussions when survival is

130   exceedingly unlikely, and when a patient prioritizes quality or comfort over longevity.

131   In the second part of the goals of care refresher course, participants were paired together

132   to role-play to practice these techniques. Learners practiced with a scripts using a) REMAP, and

133   b) REMAP with informed assent with a surrogate to familiarize themselves with the flow and

134   terminology. After the course, participants were asked to take a survey, which was voluntary.

135   IRB approval was obtained, the study was deemed exempt.

136   **RESULTS**

137   Prior to the session, zero providers were extremely comfortable having goals of care

138   conversations and 24% of providers were either not so comfortable or not comfortable at all. The

139   majority, 58%, reported being somewhat comfortable and only 18% said they were very

140   comfortable. After the session, zero providers ranked as not comfortable at all and not so

141   comfortable, decreasing from 24%. There was an increase to 47% ranking themselves as very

142   comfortable and 24% ranking themselves as extremely comfortable having goals of care

143   discussions (Figure 1).

144   41% of participants ranked the role play as extremely effective, and 29% ranked it as

145   very effective (Figure 2). 47% of participants rated Zoom as a extremely effective platform for

146   teaching these skills, 35% of participants said very effective, and zero said not at all effective

147   (Figure 3). 71% of participants said they had not received any formal training in having goals of

148   care discussions.

149   **DISCUSSION**

150   Goals of care discussions are essential to ensure value concordant care. However, the

151   majority of EPs do not receive formal training in this area. COVID-19 emphasized the need for

152   these skills. The most important part of these discussions in defining a patient's values, and often

153   patients can be guided through this process using the idea of tradeoffs: longevity, quality, or

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

155   that matches those values.

156   EPs cite many barriers to having GOC discussions in the ED. Most commonly, they cite

157   lack of skills or lack of comfort with the skills, and lack of time.[6] The model used in this study,

158   REMAP, is a quick and effective way to hold these conversations, and is especially effective in

159   the ED setting.

160   The results of the study show that combining scripted role play with didactics is a highly

161   effective method for teaching these skills. After only 45 minutes, most EPs in this study felt

162   much more comfortable having these discussions. This shows that a huge time commitment is

163   not required to familiarize oneself with the skills needed. Further, virtual platforms are effective

164   tools for teaching interpersonal skills. Born out of necessity during the COVID-19 pandemic,

165   virtual teaching is likely here to stay because it is easy to use, convenient, and highly scalable.

166   **LIMITATIONS**

167   This study was limited by only 43% of participants responding to the post course survey.

168   This may be attributed to the reliance on voluntary survey completion. Also, although the

169   teaching sessions were held on multiple days and at varying times throughout the day to capture

170   as many faculty as possible, only 57% of faculty participated. This is possibly due to the course

171   not being mandatory.

172   **CONCLUSION**

173   There is a need for formal training in goals of care discussions for EPs. Two-thirds of

174   EPs in this study had not received training in facilitating these vitals conversations. Patient-

175   centered care based on a patient's goals and values benefits the patient, their family, providers

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

177   teaching interpersonal skills.

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179   **Author Contribution:**

180   M.S. contributed to the study concept and design, acquisition of the data, drafting and critical
181   review of the manuscript.
182   E.W. contributed to the analysis and interpretation of the data, drafting and critical review of the
183   manuscript.
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185   **Author Disclosure:**

186   M.S. has no conflicts of interest to disclose

187   E.W. has no conflicts of interest to disclose

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