# The Educational Challenge of End-of-Life Conversations for Our Junior Doctors

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## Abstract

**Background:** In current medical practice we face an increasing array of possible medical interventions, multi-morbid patients and an ageing population. End-of-life (EOL) conversations are key to navigating this complex landscape and ensuring that our patients receive the care most appropriate for their needs. **The Challenges:** The emotive nature of this topic is well recognised and uncertainties of diagnosis and prognosis can add to the difficulties of these discussions. Junior doctors face some specific challenges in acquiring and practising the necessary skills for EOL conversations in the workplace. Their educational needs are discussed in this article. **Educational approach:** The educational needs of junior doctors include provision of appropriate resources and reflection on experiences. A coaching style of supervision, with recognition of their skills and support for experiential learning facilitates ongoing development.

**Keywords:** End-of-life, medical education, palliation, terminal illness

## Introduction

Current evidence supports early discussions about end-of-life (EOL) care in patients with chronic, life-limiting illness.[1-4] Despite major advances in medical technology and treatment over recent years, rates of cardiopulmonary resuscitation survival (even in the intensive care setting) are low, with only one in six surviving to discharge from hospital.[5,6] Community expectations are often not well matched with the reality of what can be achieved at EOL, and the greater availability of options in management may result in inappropriate burden for patients. Effective planning for patients at EOL is essential to ensure that care is appropriate and well targeted. This planning necessitates frank and open discussion with patients, their carers, and families about what to expect at EOL. Patients need to be informed about prognosis, options for management, and likely outcomes. Health professionals need to explore patients' wishes, concerns, and understanding of EOL, to facilitate their understanding and assist them in navigating the complex web of decision-making.

Despite the clear need, rates of EOL conversations in patients admitted to hospital are low, ranging from 10% to 30%.[7-13] Thus, the need for change still exists. One aspect highlighted in literature is the need for more education in this domain. Junior doctors represent an obvious target for our efforts in this endeavor, as they are most often present at pivotal times of patient admission and deterioration. Furthermore, they represent the future workforce and training them will pay future dividends in caring for our aging population. Recent changes to legislation in some states of Australia around Advance Care Planning have increased the educational focus on this topic. In South Australia, the implementation of new legislation in 2014–2016 was accompanied by the development of accessible online educational resources and opportunities to attend formal education sessions on this topic.[14] Anecdotally, this appears to have been beneficial and many junior doctors feel better prepared for these conversations. Nevertheless, this area is still perceived as a difficult one with good reason.

*"Obviously the consultants have best experience at sort of judging that, but they are often not the ones who have the discussion or make the decision"*

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Care Directives in South Australia. Both authors provided educational workshops for junior medical officers during the period of the implementation of legislation in South Australian hospitals in 2014–2016. In this article, we draw on our experience in the implementation of the new legislation and the literature, to present the challenges facing junior doctors in enacting EOL conversations. We propose a framework for the education of junior clinicians, aimed at improving their confidence and increasing the rates of EOL discussions.

## The Challenges

*"I find it striking and sometimes confronting that this is someone who has lived for so long and done so many things and … we are in our twenties and we have this ridiculously short amount of time to basically decide what level of intervention is appropriate"*

The literature tells us that there are multiple perceived barriers preventing junior doctors from initiating EOL conversations. These include a lack of confidence on the part of the junior doctor; lack of experience in EOL care; lack of time and workload constraints; fear of causing emotional distress to the patient or their family; a lack of educational framework and role models; language barriers; feeling hopeless about lack of cure; and difficulty predicting prognosis and decline.[15-19] These themes are consistent with our experience of junior doctors' concerns. In a small pilot study by the authors in 2016, a focus group was held 2 months after running formal education sessions for junior doctors in a General Internal Medicine Department of a large hospital. Participants were 4-year postgraduation and undertaking physician training. They were encouraged to reflect on the challenges they faced in enacting EOL discussions. Illustrative quotes are included from the transcript.

Workflow and time constraints play a major part in junior doctors' struggle to initiate conversations about EOL. During a hospital admission, an early conversation would ideally allow optimal planning and avoid inappropriate invasive management. At the time of admission, a junior doctor will likely be grappling with diagnostic uncertainty and incomplete information, which has implications for prognosis. Understandably, a junior doctor may feel less confident about initiating a discussion at this stage, but given prognosis is often uncertain or unreliable, this is not a sufficient reason to delay discussion.

*"They want you to be really confident that this is the right pathway and you feel like you might be compromising on that if you express your own uncertainty"*

EOL is a topic laden with emotion and doctors are keen to avoid causing undue stress for people at a difficult time. There is a perceived potential for promoting conflict when raising this topic, despite the evidence that patients and carers need and want these conversations.[20] We tend to disproportionately remember those conversations with negative outcomes, and this becomes a powerful disincentive. Furthermore, the delicate nature of this topic means that EOL conversations are often time-consuming even when a patient and family are welcoming of the discussion. Cognitive impairment, hearing impairment, or the need to use an interpreter may further increase the time required for a conversation.

*"It often happens at 8 o'clock at night and if you have another bunch of people to see and this is going to add 20 min to your workload essentially you can say I could have half finished seeing the next patient you are going to be influenced by that"*

Junior doctors have already spent many years in training in communication skills through their medical school years and subsequent induction to the workplace. Despite often having acquired many of the necessary skills and knowledge to undertake EOL conversations, junior doctors may struggle to know where their responsibilities begin and end in the hierarchical medical environment. While expected to act independently with minimal supervision, they are also in a situation where seniors can overrule their decisions. By the very nature of their stage of training, they are in a liminal state, progressing from supervised practitioner to established clinician.[21] They do not identify fully with either role and tend to switch between roles inconsistently; vacillating from deferring to their seniors and shouldering responsibility.[22,23] As a result, junior doctors may be hesitant to initiate EOL conversations. Despite the documented barriers, we believe that the way forward is to provide junior doctors with a framework for dealing with this complex area.

*"I think it's so hard for (junior doctors)… How can they have those conversations when they don't have the experience to go with it"*

## Educational Approach

Targeted education sessions for EOL discussions have previously been shown to improve outcomes in health-care settings including increased rates of advance care plan completion[24] and increased junior doctor comfort with EOL discussions and decisions.[25] In addition to formal education sessions, training for junior doctors should address the known challenges in EOL discussions. This includes supervision, coaching, mentoring, and role modeling in the workplace. In Table 1, we outline possible learning activities that can be used to address these challenges.

Utilization of established adult learning principles can provide a sound theoretical framework to underpin successful teaching and learning [Table 2].[26] Knowles coined the term "andragogy" to describe the features and needs of adult learners and highlighted the need for adult learners to be involved in the preparation for their learning.[27] This can include surveying the group or holding focus groups to identify what their concerns are and what they perceive to be the barriers preventing them enacting these important conversations. It may also involve liaising with the group to ensure suitable timing and setting for the education sessions to optimize participation.

**Table 1: Addressing the challenges for junior doctors in end-of-life discussions**

| Challenge | Suggested learning activity | Examples |
|---|---|---|
| Difficulty in determining prognosis | Demonstrate how evidence-based resources can be used to give a consistent scientific basis for EOL discussions | Case-based discussions in workshops may be used to "road-test" tools<br>Prognostic tool examples<br>SPICT[28]<br>E.prognosis.org[29]<br>Present statistics around resuscitation outcomes |
| Lack of experience | Provide frameworks for discussions, opportunities for practice and role-modeling of EOL discussions | Workplace role modeling by supervisor<br>Role play (in educational settings)<br>Framework examples:<br>SPIKES[30]<br>Clinical practice guidelines[16] |
| Transitional phase of development | Appropriate level of workplace supervision | Confidential debrief by supervisor following encounters where trainee is observed. This can take the form of recognized formative assessment, e.g., Mini Clinical Evaluation Exercise (mini-CEX)[31]<br>Discussion after role-modeled conversations by supervisor, allow learner to ask questions |
| Emotive topic, fear of causing distress | Use published resources to give a consistent trusted basis for discussions | Ethical CPR decision model[32]<br>Patient resources for advance care planning, e.g., Palliative Care Australia[33] |
| Workload and time constraints | Sharing information about strategies to incorporate EOL discussions into workflow | Supervisor role modeling and sharing about strategies<br>Collegiate discussions with peers in a workshop setting about effective strategies<br>Discuss benefits of initiating EOL discussions in stable multimorbid patients on discharge |
| Language barriers | Provide frameworks for the use of interpreters, opportunities for practice and role-modeling of EOL discussions | Role-play EOL discussions utilizing interpreters<br>Structured debrief after role play[34] |

EOL: End-of-life, SPICT: Supportive and palliative care indicators tool, CPR: Cardiopulmonary resuscitation

**Table 2: Utilising adult learning principles for education on end-of-life discussions**

| Adult learning principle | Attributes of education session |
|---|---|
| Adults need to be involved in the planning and evaluation of their instruction | Involve the junior doctors in planning of session content and any other relevant aspects, e.g., Timing of sessions, venue. Consider preworkshop surveys or focus groups |
| Experience (including mistakes) provides the basis for the learning activities | Format should utilize small groups, sharing experience, with discussion and reflection. Teacher acts as a facilitator, encourages open nonjudgemental and collegiate discussion |
| Adults are most interested in subjects that have immediate relevance and impact to their job or personal life | Ensure relevant content from the results of surveys and focus groups. Target junior doctors at times when they are experiencing EOL discussions in the workplace |
| Adult learning is problem-centered rather than content-oriented | Limit "information giving" and didactic teaching in the workshop. Tools and resources may be provided for learners to take away for further self-directed learning |

EOL: End-of-life

Adult learners thrive with experiential learning and often learn by making mistakes. This poses a dilemma in clinical practice, as we seek to avoid unnecessary harm to patients. However, junior doctors should be encouraged to share their bad experiences with EOL conversations to learn from them. Simulation is a useful tool and can be used to role-play difficult EOL conversations, incorporating self-reflection to maximize educational benefit. Such teaching modalities necessitate a respectful setting, where learners are not judged for disclosing previous mistakes or for their performance within the workshop. Attention should be paid to the relationship of those conducting sessions and the power relationship between participants, as this may inhibit participation. The principles of simulation debrief provide a useful framework in this regard.[34]

Constructing problem-based rather than content-based learning is a useful strategy. Junior doctors can be encouraged to present real cases or tasked with problems to solve, and issues can be discussed as a group. Adult learners utilize internal motivation and are therefore more likely to engage in active problem-solving. This can be achieved through educators adopting the role as a facilitator rather than expert teacher and minimizing didactic presentation of content. Facilitators may employ other active learning devices such as case studies, role-play, online polls, and group tasks such as the construction of mind maps. Where content-based delivery is necessary, it should be kept brief and interspersed with activity.

Junior doctors require relevant education content that they can directly apply to their work. Involvement of learners in planning will help ensure that they receive education targeted to their perceived needs. Providing practical clinical tools will further improve the value of education sessions [Table 2]. Such tools may be applied to cases during education sessions as a learning activity. Details of tools can be provided as handouts for later perusal to avoid overwhelming participants with content during the workshops.

Transformative learning theory states that adult learners need to challenge their frames of reference to change long-held preconceptions about topics.[35,36] This deep and fundamental shift in attitudes often involves a situation, which causes some discomforts to the learner, where the act of resolving this dilemma moves the learner to a new understanding. Reflection on real-life situations that cause discomfort or the deliberate creation of disorienting dilemmas is one way to enable this process.[35] Learners need to feel safe to share their views, be open to consider other beliefs, and have their own views challenged. Education sessions require explicit ground rules about respectful interaction and facilitators should cultivate a safe and warm environment. Setting expectations is important and may include the use of "icebreaker" exercises at the start of sessions.

In addition to formal education sessions, ongoing supervision, targeting the transition to "established clinician" is an important adjunct and will be useful for many aspects of a junior doctor's professional development.[37] A coaching model of supervision that encourages them to test their own style and independence in difficult consultations is likely to be most effective.[38,39] Supervision from a skilled clinician can take many forms including direct observation and feedback or case-based discussion. Electronic exchanges may be considered as a way to allow a transitioning individual to articulate thoughts and feelings, with flexibility of timing.[39] Junior doctors should be encouraged to seek out mentors with whom they can share honest dialog, to help them transition into confident senior clinicians.

## Conclusion

In an environment of increasing potential for intervention and an aging population with complex comorbidity, the need for EOL conversations is vitally important to determine the best approach for all patients. Doctors recognize the importance of having early EOL conversations but are faced with multiple barriers to initiating these conversations including heavy workloads, competing demands, and language barriers. Recognizing the specific barriers that junior doctors' face is key. Providing a framework for them to enact EOL conversations serves to build confidence, which in turn will improve the experience and avoid unnecessary distress for patients, their families, and the clinical staff caring for them. We propose that sound educational principles should be used in designing formal sessions to ensure optimal effectiveness. Appropriate supervision to provide ongoing support in the workplace, will help prevent junior doctor disillusionment with this profoundly important topic. Role modeling, feedback, and debrief are techniques that enable juniors to maximize learning from workplace experiences.

Education sessions to improve the confidence of junior doctors in initiating EOL conversations should include the junior doctors' participation in the planning and preparation stage to promote self-directed learning and to ensure the content is relevant. A workshop format is most suitable, allowing small group collegial discussions including opportunity for junior doctors reflect on their own experiences, perform role-play, and learn through making mistakes in a safe environment. We recommend utilizing disorienting dilemmas to challenge the students' preconceptions and values and multiple media formats in short segments to improve attention and retention. Teaching should be problem-focused, and the facilitator should act as a facilitator and co-learner rather than instruct from a position of authority. Finally, to cement the learning, the students should be encouraged to be self-directed and apply their new knowledge in their everyday practice and regroup to reflect on their experiences at a later date.

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