Improving residents’ skills and confidence on advance directive discussion: a quality improvement project

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ABSTRACT

Background: Advance directives have been established as a legal document that ensures patients’ wishes are followed if/when they cannot make medical decisions for themselves. The concept, advance directive, is rooted in the ethical principle of patient’s autonomy. New York State recognizes three types of advance directives: New York State Health Care Proxy, Living Will, and Do Not Resuscitate (DNR) order. A common misconception in healthcare is that advance directives are for the elderly or patients with terminal illness. As per New York State statues, everyone older than 18 years old should have an advance directive to avoid conflicts in times of crisis. It has been shown that most patients believe it is their physician’s responsibility to initiate an advance directive discussion and residents are at the forefront of most health facilities.

Objective: To assess the knowledge and attitude of internal medicine residents towards advance directive and to improve residents’ skills and confidence on advance directive discussion.

Design: We carried out a prospective study to assess the knowledge and attitude of the internal medicine residents towards advance directive to validate the need to implement didactic sessions and simulations.

Results: Fifty out of the 75 internal medicine residents of Harlem Hospital Center participated in the study. Most of the responders indicated that they lacked sufficient knowledge in advance directive discussion and indicated that they were interested in didactic sessions and simulations related to how to help patients with advance directives.

Conclusion: Our study showed that most of the residents lacked sufficient knowledge in advance directive discussions and the importance of its incorporation into residency training education.

1. Introduction

Advance directives are legal documents that are designed to help ensure a patient’s wishes are followed if they cannot make decisions for themselves. New York State recognizes three types of advance directives: New York State Health Care Proxies, Living Will and Do Not Resuscitate (DNR) order. A common misconception among the internal medicine residents at Harlem Hospital Center is the idea that advance directive is a discussion for elderly patients, patients in the intensive care units, patients who are terminally ill or patients with certain diagnosis like advanced cancers. New York statues state that everyone who is older than 18 years old should have an advance directive to avoid conflicts in times of crisis [1].

The US Senate passed the federal Patient Self-Determination Act in 1990 which requires hospitals and other health-care institutions to provide information about advance directives of patients and to keep a record of any completed documents. These facilities are also expected to inform patients of their rights concerning consent to or refusal of medical treatment [2]. The concept of advance directives is a core aspect of the ethical principle with regards to patients’ autonomy. This gives patients the opportunity to maintain autonomy during periods of incapacitation and at the end of life by carefully specifying advance directives (New York State Health Care Proxy, Living Will and Do Not Resuscitate [DNR] order) when fully functional. Oral statements are recognized ethically, and in some states legally, if properly documented. The documents associated with an advance directive are state-specific, and physicians need to be familiar with the applicable laws in their area [3]. Even though the Patient Self-Determination act is clearly written, the rate of advance directive completion has been disappointing: their value has been questioned and fewer than 10% of Americans have prepared advance directives [3,4].

Advance directive education is often incorporated into the curricula of medical schools; however, it is not commonly included in residency education. Residents must be able to provide patient care that
is compassionate, appropriate, and patient-centered, respecting the wishes and values of the patient; honoring a patient’s autonomy is an integral aspect of this [2,5].

While the accreditation council for graduate medical education (ACGME) does not have specific program requirements for internal medicine residency programs regarding minimal competencies in advanced care planning and end-of-life discussions with patients, it does affirm that residents must “demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients and their families” and ‘demonstrate respect for patient privacy and autonomy,’ both of which are key components of advanced care planning discussions [2,4].

2. Methodology

We obtained an exemption from informed consent for human research study from our institutional review board (IRB) and sought approval from the department of patient safety and quality improvement as required by the hospital policy. We did a prospective study to validate the need of having didactic sessions in the simulation center for internal medicine residents at Harlem Hospital Center. Fifty of the 75 residents of the Internal medicine department participated in the study which included residents from all year of training. The survey was developed by an interdisciplinary team, which included residents from internal medicine, palliative care, and hematology/oncology attending physician. The advance directives questionnaire was based on the validated questionnaire with permission [2]. The developed survey was designed to assess residents’ attitude and knowledge towards advance directive discussions.

3. Results

Survey response rate was 67%. Of the 50 residents who responded, 40% strongly disagreed that advance directive should only be discussed with patients over 60 years of age while 22% agreed. Forty-eight percent of the respondents felt that they had insufficient knowledge of advance directives while 32% agreed that they had sufficient knowledge. When asked if their experience of advance directives was adequate, 46% disagreed and 38% agreed. Fifty-four percent strongly agreed and 42% agreed that didactic sessions on advance directive should be offered at Harlem Hospital Center while only 2% disagreed. Most (90%) agreed/strongly agreed that they’re interested in participating in advance directive scenarios at the simulation center while 6% and 4% disagreed/strongly disagreed, respectively. Most (92%) disagreed/strongly disagreed that they do not need additional instruction on advance directives. Seventy-six percent of the residents agreed that the discussion about advance directive is not related to a patient’s health status and 78% reported that any physician should be able to discuss advance directive. Fifty-four of the residents responded that they have discussed advance directive with <10% their patients and 18% stated they have discussed with only 10–20% of their patients.

4. Discussion

There has been widely publicized court cases and litigations that stem on the importance of advance directives. In spite of these, the compliance with advance directives documentation is abysmal. An important healthcare setting where advance directives and chronically ill patients’ goals of care can be established is in the outpatient setting with a patient’s primary care provider. It has been shown that most patients believe it is their physician’s responsibility to initiate an advance directive discussion and patients prefer these discussions to occur at an earlier stage than physicians do [4,6]. Intending hospitals residents are often the physicians who have the most contact with the patients. Therefore, residents need to be trained and skilled to help patients with advance directives.

It is unclear if medical schools adequately prepare physicians for end-of-life discussions. As a result of this, many residents are uncomfortable in approaching patients and caregivers to discuss patients’ wishes; some altogether avoid end-of-life conversations. As a result, residents may need more interactive, experiential learning opportunities, including simulations, related supervision, and coaching over the course of their training in order to improve these communication skills [7]. In any medical setting or specialty, some core elements of palliative care, such as alignment of the delivery of care to the patient’s goals of care to maintain autonomy is needed [8]. As a result, it is important to know these goals while the patient’s decision-making capacity is still intact. Many specialists have proposed frameworks for communication strategies that residents can use as stepwise approach for end-of-life discussions. One way to gain competency in conducting these conversations would be to seek feedback and guidance from clinicians skilled in leading effective advance directive discussions [9]. To this end, we have partnered with the palliative care team to hold intermittent noon conferences to educate residents on the communication skills needed to hold these conversations. We also discussed with the Simulation center at our institution with possibilities of including advance directive discussions as part of the simulation training with appropriate feedback. The palliative care specialists will serve as mentors to trainees interested in improving their communication skills on advance directive.
In practice, most end-of-life discussions are conducted by non-palliative care specialists. End-of-life discussions are more often than not a difficult and uncomfortable topic for patients to discuss unless prompted. The discussions are particularly difficult in an academic setting as residents feel uncomfortable with end-of-life issues, moreover a structured curriculum to educate residents about this topic is lacking [10]. Residents may find it difficult to assess which patients would benefit from discussions of advance directives unless they have a current, life-limiting illness. Some residents may also perceive that patient satisfaction will be negatively affected by these discussions even though data show that patient satisfaction in academic primary care general internal medicine practice improves with these discussions [10]. Discussions of end-of-life care should be held prior to acute, disabling events. Many barriers to having such discussions during primary care visits exist. These barriers include time constraints, communication difficulties, and perhaps physicians’ anxiety that patients might react negatively to such discussions [11].

Acknowledgments

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Disclosure statement

No potential conflict of interest was reported by the authors.

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