Principles of Palliative Care Consultation Etiquette

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Objectives

- Describe 10 principles of palliative care consultation etiquette.
- Describe three methods to improve compliance with consulting recommendations.
- Describe three methods of resolving consultation conflicts.

1. Determine the question
2. Triage urgency
3. Gather your own data
4. Brevity
5. Specificity
6. Plan ahead
7. Honor turf
8. Teach with tact
9. Personal contact
10. Provide follow-up

Adapted from: Goldman L, Lee T, Rudd P. Arch Intern Med 1983.

A successful consultation is when . . .

You have met the needs of your stakeholders:

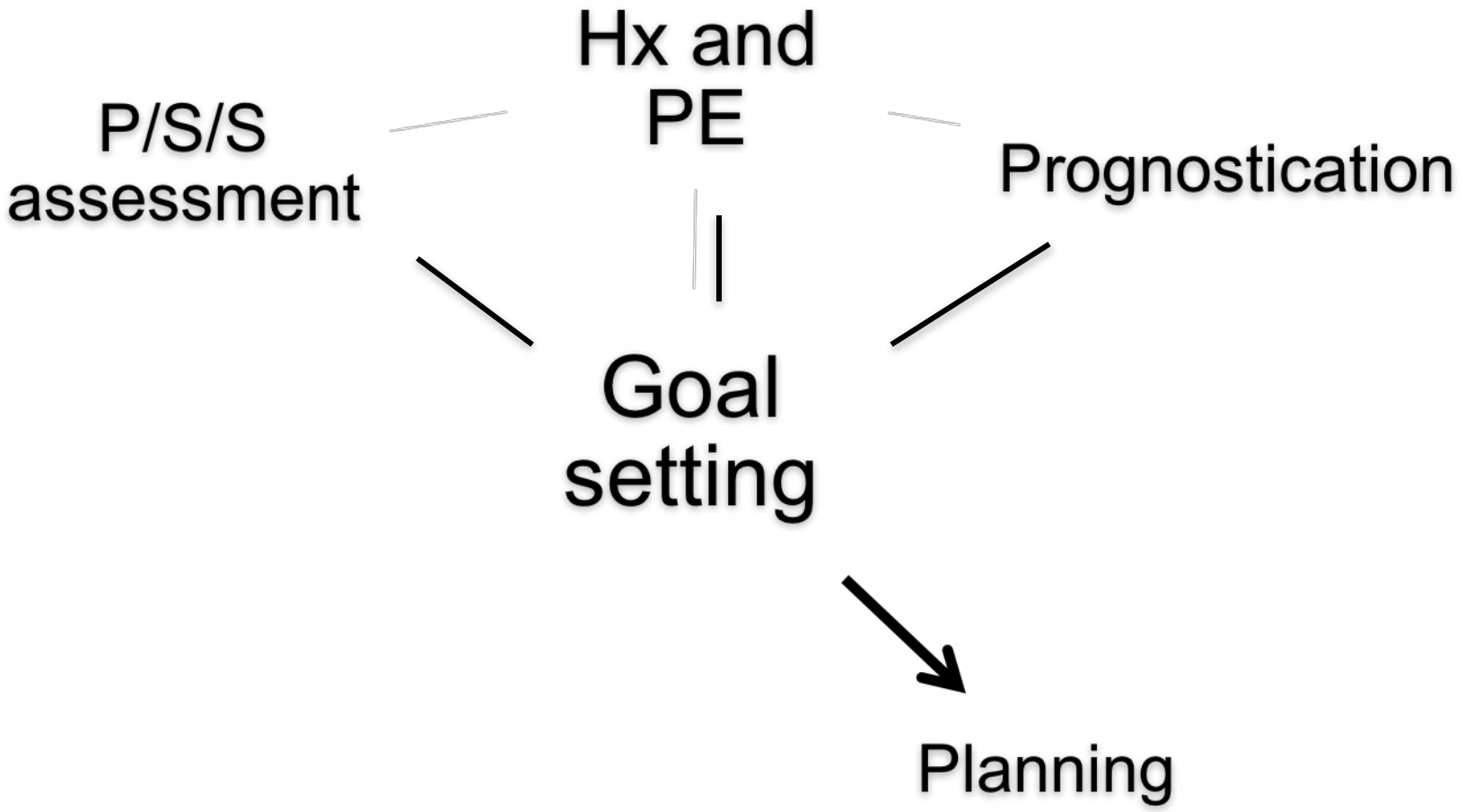
✓ Answered a question
✓ Provided leadership in decision making
✓ Improved symptom control
✓ Provided knowledge about prognosis
✓ Assisted in disposition planning
✓ Provided emotional support
✓ Improved clinician efficiency

Stakeholder

- The referring clinician is the *primary stakeholder* for your consultation service.

  ✓ Need their order
  ✓ Do good, or never “do” again

The Palliative Care Consultation



Weissman DE. Arch Intern Med 1997.

Etiquette is a code that influences expectations for social behavior according to contemporary conventional norms within a society, social class or group.

Rules of etiquette ***are usually unwritten/implicit . . .*** A rule of etiquette may reflect an underlying ethical code, or it may reflect a person's fashion or status.

Source: *Adapted from Wikipedia*

In your practice?

- What are the rules?
- What happens if you violate them?

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CAPC Campus On-Line: Consultation Etiquette; www.capc.org

1. Determine the Question

- Clarify what the referring physician wants/needs by a direct question:

  “Dr. Jones, how can we help you in the care of Ms. Smith?”

2. Triage urgency

1. **Emergent**
   - *Pain out of control*
2. **Urgent**
   - *ICU patient, no improvement on maximal therapy; goal setting is needed.*
3. **Elective**
   - *Patient set for discharge in 24 hours. Family has questions about hospice services.*

3. Gather your own data

Medical data:

- History and physical examination
- Lab and X-rays
- Pharmacy records
- Outside information

Psychosocial data:

- Family stress
- Locus of decision making
- Communication issues

Use the data to make your own independent medical and psychosocial assessment!

Common errors

Failure to review/gather/do:

- ✓ Physical exam
- ✓ X-rays
- ✓ Primary clinician
- ✓ Nursing home data
- ✓ All clinician input
- ✓ Personal assessment

4. Brevity

- Referring clinicians typically focus on the ***Assessment/Recommendations***.

5. Specificity

- ✓ **Consultants can increase hospital costs**
- ✓ **Fewer recommendations increase adherence.**
- ✓ **Written recommendations should be *goal-oriented*.**

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Brevity/Specificity: Example

- **Impression:** *Patient is dying; prognosis 2–8 weeks.*

- **Recommendations:**
  - *Family meeting for goal setting*
  - *Morphine 10 mg q2h prn dyspnea*
  - *Hospice referral*

6. Plan Ahead

- You should look ahead for expected problems.
  - ☑ *Physical and emotional symptoms*
  - ☑ *Drug/treatment side effects*
  - ☑ *Family concerns*
- Document suggestions for management.

6. Plan Ahead-Example

Patient is five days post massive stroke with pneumonia.

- Decision to withdraw antibiotics and tube feedings
- Family wants to take patient home w/ hospice care
- Expected prognosis: days

Anticipated problems

- ✓ Fever and respiratory changes
- ✓ Family concerns about comfort
- ✓ Family concerns about starvation

Print Fast Fact #139, #149

PALLIATIVE CARE NETWORK OF WISCONSIN

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EPERC > Fast Facts > Fast Facts Documents > # 139 Hospice Referral: Moving from Hospital to Home

139 Hospice Referral: Moving from Hospital to Home

FAST FACTS AND CONCEPTS #139 PDF

Author(s): Tara C Friedman MD

Background The transition from hospital to home for the patient about to be enrolled in home hospice care is complex. Miscommunication between hospital staff and hospice care providers regarding goals of care and medications occurs commonly and only heightens existing stress and fear among patients and their caregivers. This Fast Fact reviews key steps in the transition from the acute care hospital setting to home hospice care.

Clarify goals *Fast Fact* #38 reviews key do's and don'ts of the initial hospice discussion with patients and families. Prior to discharge additional steps to clarify the goals of care include:

- Clarify your role before you see the patient.
  - ✓ Order writing for symptom control?
  - ✓ Leadership for sensitive communication with patient/ family?
  - ✓ Leadership for disposition planning?

8. Teach with tact

- **Every consult is a teaching opportunity.**
  - Invite the referring clinician to participate
  - Debrief a sensitive communication encounter with the referring clinician.
  - E-mail a *Fast Fact*

9. Personal contact

- **Communicate before acting**
  - opportunity to teach and offer support.
- **Don’t argue in the record**
- **When in doubt ASK**

10. Provide follow-up

- **Clarify your role after the initial assessment.**
- **Follow through on recommendations.**
  - If you recommend a test/drug/intervention, be sure to follow up and assess the results.
- **Signing off issues.**

Improve Adherence

- A prompt response (< 24 hrs)
- Limit the number of recommendations
- Identify the most critical
- Personal communication
- Use definitive language
  - *"Patient is dying"* rather than *"Prognosis is poor"*
- Establish service standards

Cohn SL. Med Clin N Am 2003.

Service Standards

Service standards communicate to others the expectations you set for how your team will function.

- ✓ *New consults are seen within 24 hours*
- ✓ *Daily contact with referring physician*
- ✓ *Invitation to referring clinician to attend significant communication encounters*
- ✓ *Contact referring clinician with significant changes in patient status, medications or disposition planning*

Managing Conflicts

- **Reasons for Conflict**
  - ✓ Values conflict
  - ✓ You violated an etiquette principle
  - ✓ You failed to communicate effectively
  - ✓ You Incited fear:
    - Malpractice/family anger/insecurity/peer pressure
  - ✓ Personality clash

Managing Conflicts

- **Be self-aware.**
- **Help the referring clinician become self-aware.**
  - Make empathic statements
  - Put yourself in their shoes
- **Use Family Meeting skills**

Irresolvable Conflicts

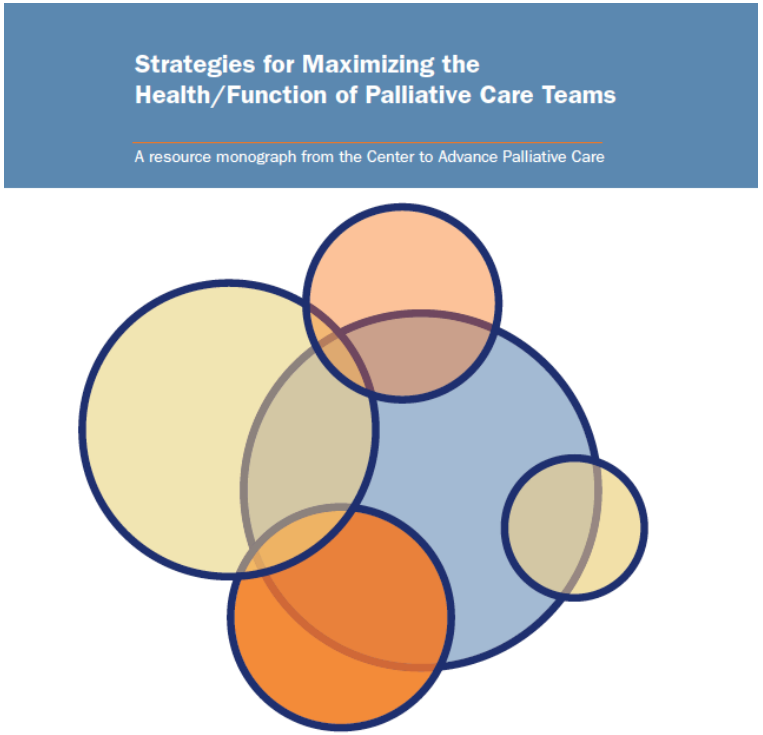
- Agree to disagree; stay engaged to support the patient as best you can OR withdraw from the consultation.

- Discuss with your team members
  - process your own emotions.

- Recognize that you may be the problem.

Team Self Assessment

- **Practice good team monitoring and self-reflection skills.**
- **Survey your stakeholders periodically**



Team Wellness Guildebook (CAPC)
https://www.mypcnow.org/program-resources

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