Helping patients articulate end-of-life wishes: a target for interprofessional participation

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Submitted Jan 26, 2013. Accepted for publication Feb 22, 2013.
doi: 10.3978/j.issn.2224-5820.2013.02.05
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A recent publication in the *Journal of Clinical Oncology* by researchers at the Massachusetts General Hospital described the effect of timely e-mail prompts to improve documentation of outpatient code status in adult patients with advanced lung cancer (1). This work builds on a 2009 paper describing the initial design and implementation of the code status module within the electronic ambulatory medical record (2). The code status module is a feature in the hospital's outpatient record that allows clinicians to document a patient's preferences for end of life care (e.g., full code, DNR/DNI, or other resuscitation options). In the report describing that initial implementation, researchers assessed impact by extracting information from hospital's clinical database to determine rates of documentation of electronic code status using the new module. In the 22-month period following introduction of the code status module, they found only 20% of patients with a documented outpatient code status (2).

In this most recent publication (1), the researchers build on this work using qualitative research techniques to design a targeted, electronic prompt system that would enhance documentation of outpatient code status by oncology clinicians. Patients receiving treatment at the outpatient cancer center with advanced lung cancer, but within 8 weeks of receiving the first dose of IV chemotherapy, were enrolled into the study. The intervention consisted of a uniform e-mail message (or reminder message) sent to the clinician caring for the patient on the morning of the next appointment. The email messages encouraged the clinician to document the patient's outpatient code status in the electronic medical record. The effect of the intervention was compared to a group of historical control patients from 2006-2008.

The intervention and control populations were well matched on all parameters including age, sex, and demographic factors as well as disease characteristics and measures of severity. At the end of a 1-year follow-up period, patients whose providers had received the intervention were 3 times more likely to have an outpatient code status documented in the electronic medical record (intervention 33.7% *vs.* historical control 14.5% OR 3.00, 95% CI, 1.43-6.31). It is notable that despite the targeted email messages, two-thirds of patients still had no documentation present.

This study was carefully planned to test the efficacy of the email prompt to alter documentation practices for patients with advanced lung cancer with an overall aim to encourage discussions about end of life care before a patient experiences life-threatening events or hospitalizations. Several publications recount the possible benefits to patients and to society as a whole when end of life decisions are made after an informed discussions with input from patients, their families and caregivers and the medical team. As noted by the authors in the discussion of this paper, such practices avoid the provision of unwanted or excessive (and costly) medical care and allow for earlier initiation of hospice services. The authors point out the disadvantages of using the historical control, namely that it is unable to control for increasing attention on issues that affect end of life documentation. In conclusion, the authors underscore the positive effect of the intervention in this study as rationale for a large-scale follow up project to determine the effectiveness of clinician-directed prompts in a variety of cancer populations and health care settings.

Patients expect clinicians to be able to effectively communicate in all aspects of care, including on end of life issues. For patients pursuing intensive treatment options, discussion of end of life planning with the treating physician may send conflicting messages and influence patient understanding of disease severity and likelihood of treatment success. Talking about death and dying is uncomfortable. It is not clear that all providers are equally comfortable with these discussions and providers may not wish to disclose their own discomforts with this skill. In the accompanying editorial (3), a convincing case is made to improve communication skills training for physicians in order to facilitate conversations about end of life preferences. The authors of the current study describe the process used to refine the clinician prompt, but did not elaborate on what (if any) educational intervention was used to educate clinicians about the rationale for early code status documentation and the possible effects of delayed documentation or to improve the communication skills of the providers in the study.

While improved physician training and electronic clinician prompts play a role in improving end-of-life planning, such a goal requires response from all clinicians that interact with patients with cancer or other life-threatening diagnoses including nurses, pharmacists, social workers, and members of the clergy (4,5). One study assessed the roles played by health care providers during end-of-life care discussion in the pediatric intensive care unit and described that roles were not, and maybe should not be, restricted to any one type of provider (6). Encouraging end-of-life care discussions between a patient and a non-physician provider may offer several benefits including increased opportunities to make interventions that help patients clarify the goals of the care, increased opportunities to document those goals (or the patient's stage in the decision making process) in the medical record, and enhanced attention to and experience with end of life discussions on the part of patients and providers across the entire health care system (4). Training on the use of the prompt could also be an opportunity to provide support and enhance skills related to facilitating discussions of end-of-life care. More broadly, providing quality end-of-life experiences has also been used as the organizing theme for more extensive interprofessional training (7).

For non-physician providers who do not feel that advanced care planning is within their normal scope of practice, it can be viewed as a chance to advocate for a patient's best interest. Providers can underscore the impact of advanced care planning and encourage the patient's participation in these important discussions. It would be interesting to learn how an interprofessional team might more effectively use this type of electronic code status documentation module as compared to the effects of a prompt sent to a single clinician.

Improving the public's understanding of the importance of care planning and the implications of a full code documentation status is also the aim of a variety of public health efforts and the focus on upcoming Institute of Medicine consensus study (8-10). Consistent messages about the importance of end-of-life planning from all health professionals who interact with patients may help patients and providers navigate this difficult emotional territory and ensure that interventions at the end of life are provided in accordance with the patient's goals for their care.

Ultimately, the work by Dr. Temel and colleagues is an important component in the efforts to optimize use of aggressive therapies for patients with terminal disease. Continued research into the use of clinician prompts, integration with medical record systems, communication skills training and the impact of the entire interprofessional care team are necessary to ensure that patients and caregivers have the best information as they articulate wishes for end-of-life care.

Acknowledgements

Disclosure: The authors declare no conflict of interest.

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Cite this article as: Kirwin JL, Edwards RA. Helping patients articulate end-of-life wishes: a target for interprofessional participation. Ann Palliat Med 2013;2(2):95-97. doi: 10.3978/j.issn.2224-5820.2013.02.05