Group work, Monday 22 November:

**Palliative medicine: Concepts, definitions and core values**

1. Share in the group one or two of your immediate reactions or reflections after having read the chapter “Core concepts in palliative care” in Oxford Textbook. Did any specific part of the chapter resonate with you, or the opposite? (If you want to jog your memory - you can find the chapter here)

*Communication issues between different health care levels regarding ambitions of care (palliative vs therapeutic)*
*Special challenges in the relationship with hematologists*
*In palliative care “easier” to the extent that it is already clear from the outset that ambition is palliative (easing symtoms)*
*Good and important to have established with patient that treatment goal is palliative*
*Many value words which are not fully developed*
*Humility and audacity are words that resonate with group members - our responsibility to not react with nihilism in the face of situations that cannot “be fixed”*
*Physicians’ “chameleon capacity” - to be the kind of physician a particular patient needs - to be able to read the patient and understand what she wants*
*The team also has this challenge - and the possibility to “read” the patient*
*Regarding empathy: an empathic relationship-building may improve the medical situation considerably - sometimes relationship, safety and trust is as important as medication*

2. How are the values that are highlighted in the chapter manifested in the palliative care service where you work?

- *When we meet denial in patients/families this may mean that the family is reluctant to accept palliative care (they want curative therapy instead)*
- *Tiring to work with the whole family*
- *We have family meetings - sometimes this changes the patients symptoms!*
- *We work holistically and this means seeing the context in its entirety and inviting views etc from the family (as opposed to “standard care” which is much more focussed on only the patient)*
- *We educate so many people about end of life issues, and this knowledge with time may spread in society*

- *Death is a taboo topic in society - start off by checking the patient/family's view on death - where are they? - start talking about death in a clear way*
- *A clinical example: comparing end of life with pregnancy and delivery - sometimes goes without medical help and sometimes it's medically complex. As in pregnancy it is important to listen to the body and the body decides.*
- *Focus on hopes and fears and ask patients to talk about that.*

3. In your opinion, what are the differences between palliative medicine and other medical specialties – if any?

*In many other specialities it is impossible or out of the customary to work holistically*

*Some discussions are easier because the "decision frame" is set beforehand- everybody knows that it is a palliative situation*

4. What do you see as limitations for palliative care?

*Tricky interaction with other specialities*

*Misunderstanding from management and society that pallaitive medicine is "giving up" and "doing nothing"*

*Lack of highly advanced technical knowledge (in small teams)*

*Many people dont want palliative care because they are afraid of palliative medicine*

*Variation in competence among municipal care givers*

*Physical distance challenges - time lost at the road*

5. Why did you choose to work in palliative care? This is mostly a question for self-reflection, but you may share your thoughts in the group if you want to.

6. What do you hope to get from the Nordic course?

*Become better palliative physicians*
*Reflect on our own practise*
*Take home new knowledge to our teams*
*Network, nationally and internationally*

**Monday afternoon, 22 November**

Please discuss these scenarios, define one or more relevant research questions, and suggest one or more approaches for a course project to answer the question(s).

1. Two years ago, ESAS was implemented in three advanced home care units in a Swedish county. At present, only one of the units is still using the tool. The responsible physician is eager to know why implementation was successful in one unit and not the others, and how she should go about to have the tool implemented in the other two locations.

2. One of your colleagues works in a palliative care team in a hospital in a rural area. One day he experiences a difficult situation treating a terminally ill patient with an ICD (implantable cardioverter-defibrillator). No plans had been made for deactivation of the ICD.
Your colleague wants his hospital to be better prepared for the next dying patient having an ICD. He thinks this will be a nice project for the Nordic course. How should he go about it?

3. An oncologist with a special interest in palliative care has been admitted to the Nordic course. She has the clear impression that while physical and psychological symptoms are reasonably well addressed in her department, the patients do not receive adequate spiritual care. Suggest a course project to address this assumption.

*FGD with team about spiritual care - barriers to spiritual care, intercultural aspects*
*Quality improvement project with spiritual workshop - measure knowledge before and after*
*Introduce a questionnaire of spiritual issues to patients - measure amount of spiritual discussions during our visists before and after*
*Translation of research questionnaire on the topic.*

4. Your special interest is cancer pain management. Working as a palliative care consultant in a university hospital, you have the clear impression that less epidural catheters have been inserted during the last two years, compared to the years before. Is this a coincidence, or has there been a change in policy? How can you find out?

*Study policy papers - have there been any changes in policy?*
*Measure incidence over a five year period*
*Interview palltive team about barriers to catheters*

5. As a consultant in a hospital-based palliative care team you attend the EAPC congress and read a poster presenting somatostatin (octreotide) as a treatment for refractory chemotherapy-induced diarrhoea. You wonder whether you should try this treatment in your own hospital. Give an idea for a course project addressing this issue.

*Literature review of existing evidence*
*AVOID trying to make an intervention, would need a large population to make a RCT*

6. During a meeting for palliative care physicians in a region in one of the Nordic countries, it became evident that the doctors prescribed corticosteroids very differently. They did not use the same doses, and not even the same drugs. One of the younger physicians thinks this is very strange - how can he know how he himself should prescribe these drugs? Give some ideas for projects to explore this situation and help your young colleague.

*Literature review on guidelines*
*Measure prescription patterns*
*Write a local guideline*
*Audit the local practise against a national guideline*

7. A physician has just been accepted to the 10th NSCPM. She has no research experience and is not tempted by statistics and large databases. Her interests are more in the field of arts and crafts. Give her some suggestions for a course project that could fit her inclinations.

*Literature review on arts in medicine in the palliative setting, in her own country or in England - music therapy, animals in hospice, bookclubs for relatives etc. "Green rehabilitation" (but not rehabilitation!)*

*Design a project plan for an arts in medicine, which could be used to petition money*

*Qualitative project to investigate patients or families or staff attitudes to arts in medicine*

8. Since several course participants probably will choose an audit for their course project, we asked you to read the chapter on audit in palliative medicine in Oxford Textbook before coming to this module.

What topic or process would you want to audit at your own workplace? How would you plan this audit?

*Are breast cancer patients underrepresented opn our ward? Consequtive count of all patients on the ward for one month*

*The use of steroids - do we use them as suggested (dosage and indications) or are there unwarranted individual variations*

*One team screens all patients with a screening tool - audit what symtoms the patients have, and study edical records to see whether all issues have been accounted for*

*ONe team is about to start a pallaitive ward - a descpritive analysis of all patients enrolled during the first half year including diagnosis and reason for in-patient care*