CLINICAL TEACHING VIGNETTE FOR PALLIATIVE CARE

In February 2007, six US medical schools were selected in an initiative funded by the Robert Wood Johnson Foundation to develop and implement a required Palliative Care clinical curriculum for 3rd year medical students. To ensure effective delivery of the additional palliative care curriculum required us to enlist a number of diverse clinical sites, some community based and some academic based. To meet the logistical and educational demands of training to yield "comparable and equivalent" experiences at all sites required by LCME standards, we developed a palliative care clinical teaching vignette to evaluate the students' skills in specific areas of palliative care, hoping to enrich and standardize the learning experience for students at diverse training sites. This vignette is completed during the one week palliative care rotation as part of the 12 week Medicine clerkship.

PALLIATIVE CARE CLINICAL TEACHING VIGNETTE

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Student Name:____

Teaching Faculty Name:_______________________________________

Dates of rotation: ____

INSTRUCTIONS:
Faculty: recommended teaching points are highlighted and on your copy only. The student version of the case includes black text only.

You are assigned to complete this clinical vignette that is designed to evaluate your skills in specific areas of palliative care. It is separated into parts: Once you have read the clinical case material, complete the questions on the following page. One page of questions should be completed after each day on your clinical site, starting the first Monday night on service. The following day, your palliative care faculty will read your written responses and grade them according to a set grading rubric. Discussion of the questions and answers are encouraged to enrich and standardize the learning experience for students at diverse training sites. By the end of the week long rotation on palliative care, all student responses to questions should be completed and graded. These completed, graded pages must be turned in to Amy Kiper in the medicine office in order to receive credit for the project. Completion of the project, grading/discussion of the project with faculty, retention of the graded papers, and delivery of the graded project to the IM office are the responsibility of the student. Students will receive 4 extra credit points on this project for timely and responsible completion of the project **without** prompting from site faculty.

Once you have answered the questions, give the question page to your palliative care faculty member the next day for grading. It is important that each set of questions is completed and graded before going on to the next part of the vignette. Please complete one set of questions nightly until all of the questions have been completed and graded. This means that you will be working on a page from this case every evening from Monday-Thursday and discussing a page of this case with your faculty every day of your rotation from Tuesday-Friday of your week on service.

PLEASE CONTINUE READING THE VIGNETTE BELOW. ONCE YOU HAVE READ IT, PLEASE ANSWER THE QUESTIONS ON THE OPPOSITE PAGE.

Mr. Xavier Sperry, a 73-year-old male, is hospitalized due to shortness of breath and weight loss. On initial workup in the ER, he is found to have an infiltrate on chest xray. A CT of his chest shows a 4x6 cm mass that appears consistent with lung cancer, with associated hilar lymphadenopathy and hypodense areas scattered throughout the liver consistent with metastatic disease. His clinical condition is stable, and his dyspnea improves with the administration of oxygen and antibiotics. Various family members are with the patient around the clock waiting to see what the attending physician has to say. You round in the morning with the attending physician, who stops with his hand on the door and says “We are going to have to tell Mr. Sperry the bad news about his CT scans today.”

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COMPLETE ON MONDAY, SHOW TO FACULTY TUESDAY TO GRADE. . .

DO NOT MOVE AHEAD TO THE NEXT PART OF THE VIGNETTE UNTIL ALL QUESTIONS HAVE BEEN ANSWERED ON THIS PAGE AND GRADED/DISCUSSED WITH YOU BY YOUR CLINICAL FACULTY ON TUESDAY. Retain this page and turn in to Amy Kiper for credit.

Outline a 10 step approach to use when discussing the bad news with Mr. Sperry—list the recommended steps, in order. An asterisk is placed next to the steps where a sample sentence that you could say to this family is required for credit.

1. Optimize the setting—(quiet environment, chairs, sitting down, chaplain or other support staff available)

2. Optimize the personnel (personal grooming, turn pager off, are you the most qualified person available to do this?)

3. Check readiness to receive information—(if patient is in pain or uncomfortable, has cognitive deficits or extreme emotional distress, consider postponing meeting. Ask patient if they want to know or if they want others to know what the tests showed before proceeding)

*4. Determine what patient/family already knows—"Tell me what you already know about your health/problems/illness"

*5. Deliver a warning shot—"I am afraid I have some bad news."

*6. Present bad news succinctly and clearly without ambiguity or jargon—"The biopsy shows that you have cancer" NOT "The biopsy was possibly consistent with malignancy"

7. Allow silence and respond to emotion

*8. Invite questions—"I've given you a lot to think about. What questions do you have right now?"

*9. Make a follow-up plan—"I'll see you tomorrow and we'll talk again. Make sure to write down or tell your family any questions you have so we can talk about them next time we meet."

10. Document in chart—who was present, briefly review content of discussion

Explain the recommended physician response if the patient/family becomes very emotional (crying, distraught) after receiving bad news:
Use of silence, reflective listening, empathy
What three items must be documented in the patient's chart after a "bad news" discussion?
1. Who was present
2. What was discussed
3. Plan for follow-up

Total possible points=15 Total points awarded:___

TUESDAY NIGHT–CONTINUE BELOW. . .

PLEASE CONTINUE READING THE VIGNETTE BELOW. ONCE YOU HAVE READ IT, PLEASE ANSWER THE QUESTIONS ON THE OPPOSITE PAGE.

The attending discusses the CT result with Mr. Sperry and makes plans for a biopsy of the liver lesions. The biopsy shows poorly differentiated adenocarcinoma. Plans are made for outpatient follow-up, and the patient is discharged home with home oxygen at 2 LPM via nasal cannula.

Although cure of the cancer is deemed impossible, the oncologist participating in this patient's care believes that his life may be prolonged with systemic chemotherapy. Mr. Sperry consents, and begins outpatient chemotherapy. Two months into the chemotherapy regimen, Mr. Sperry visits his primary care doctor complaining of back pain. Plain spine xrays show vertebral compression fractures at T8 and T12. A follow-up spine MRI shows multiple thoracic metastases but no spinal cord compression..

Mr. Sperry states that his pain is 8/10 at rest and 10/10 with movement. The pain has been getting worse for the past two weeks. The pain is a constant, dull aching pain and well localized to the back; the pain worsens with movement or coughing. He visits the office in a rented wheelchair due to the unbearable pain when he walks. When asked, he reports decreased sleep for the last week due to the pain, and inability to complete his usual self-care and household tasks.

COMPLETE ON TUESDAY, SHOW TO FACULTY WEDNESDAY TO GRADE. . .

DO NOT MOVE AHEAD TO THE NEXT PART OF THE VIGNETTE UNTIL ALL QUESTIONS HAVE BEEN ANSWERED ON THIS PAGE AND GRADED/DISCUSSED WITH YOU BY YOUR CLINICAL FACULTY ON WEDNESDAY. Retain this page and turn in to Amy Kiper for credit.

What else would you like to know before developing an opioid analgesic regimen:

1. What drug and non-drug treatments have been tried for pain?
2. Renal function
3. Pulmonary status
4. Prior experience with opioids
5. Does the patient have any opioid phobias?
6. Does the patient have any prior or current history of addiction?

Please write out an initial opioid drug regimen for this patient; include generic name, strength/dosage, whether scheduled or prn and dosing interval, and an appropriate bowel regimen:

1. Long acting opioid: ex: MS Contin 30 mg PO q 8 hours—goal here is just to check their understanding that this needs to be a scheduled med rather than prn, and that the dosing interval is reasonable—they will likely not have much idea about the right dose to start with.
2. Short acting opioid: ex: Morphine 10 mg PO q 2 hours prn pain uncontrolled by MS Contin—goal here is to understand that the short acting is to be used prn, that it will get "on board" quickly but leave quickly, and that if your long acting agent is titrated correctly the prn requirement should diminish with time.
3. Bowel regimen: ex: Senna-S PO q 12 hours inclusion of a stimulant plus a stool softener on a scheduled basis is the goal here. Discussion points include not waiting until a patient is constipated to treat and that people on a scheduled opioid require more than just a wetting agent.

The patient follows up with his physician in one week and reports that the back pain has improved, but is still 4-5/10 at rest, increasing with movement. He is still not sleeping well due to the pain despite using his short-acting medication eight to ten times a day. He is not having any adverse side effects of the medication, has had normal bowel function, and he is careful not to drive when taking his medication as ordered. His physician wishes to adjust his medication regimen to allow for better pain control. Please suggest a dose or drug adjustment to your original prescription:

Teaching points include: Should escalate original long acting agent rather than switch agents, explain will take longer to see effect of escalating long acting med, so may need to double up on dosing of short acting med for the first day or so and then cut back, explain that frequent use of prn short acting med is a sign that better long acting coverage is needed, recognize that pain is moderately uncontrolled and escalate original dose 25-50% the total daily dose that is being used (not just daily dose of long-acting opioid)

Convert this new, adjusted prescription for oral pain control into an IV equivalent that would meet his needs if he was unable to take PO pain medications: teaching point: use of equianalgesic PO→ IV pain medication conversion tools.

Total possible points=12 Total points awarded:___

WEDNESDAY NIGHT—CONTINUE BELOW

PLEASE CONTINUE READING THE VIGNETTE BELOW. ONCE YOU HAVE READ IT, PLEASE ANSWER THE QUESTIONS ON THE FOLLOWING PAGE.

Mr. Sperry's pain control improves. The new spine metastases indicate that the first-line chemotherapy was not effective. The patient and oncologist decide to begin a second-line chemotherapy regimen. Two weeks after the start of the new chemotherapy, he is hospitalized for chemotherapy complications of neutropenia and oral mucositis.

On hospital day two, Mr. Sperry is found to be disoriented and agitated. He states his name when asked, but does not know where he is, and does not recognize family members at the bedside. His speech is 50% incoherent, and he cannot remember three items long enough to repeat them back to the examiner, and is inattentive during the mini-mental status exam. Nurses caring for him report that he has been awake all night, and he is in constant motion during your exam, picking at his bedclothes and bedrails. His concerned son is at the bedside and asks you what is wrong with his father.

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COMPLETE ON WEDNESDAY, SHOW TO FACULTY THURSDAY TO GRADE. . .

DO NOT MOVE AHEAD TO THE NEXT PART OF THE VIGNETTE UNTIL ALL QUESTIONS HAVE BEEN ANSWERED ON THIS PAGE AND GRADED/DISCUSSED WITH YOU BY YOUR CLINICAL FACULTY ON WEDNESDAY. Retain this page and turn in to Amy Kiper for credit.

What formal diagnosis best fits Mr. Sperry's change in status?
delirium

What is the differential diagnosis of the cause of this patient's change in mental status? (List five common causes for this diagnosis, with examples of each)

1) Drugs (overdose, withdrawal, side effects)
2) Infection (UTI, pneumonia)
3) Metabolic (hypoglycemia, lytes, MI, malnutrition, hyperammonemia, hypoxia)
4) CNS disease (mets, bleed, sleep deprivation)
5) Imminent death

Name at least five drug classes that commonly contribute to this problem

1) Sedatives/hypnotics—ex. benzodiazepines
2) Anticholinergics/antidepressants—ex. amitriptyline
3) Opiates—ex. morphine
4) Steroids—ex. prednisone
5) Antihistamines, phenopyrazines—ex. benadryl, phenergan

Describe at least 2 non-drug treatments for this problem, as well as one pharmacologic treatment of this problem. For the drug treatment, write an appropriate order for the drug's administration.

Non-drug—orientation techniques, lighting room, family/familiar person present, avoiding restraints, holding all offending meds

Drug—haloperidol or "major tranquilizers"—Haldol 1 mg IV q hour prn delirium

Total possible points=15 Total points awarded:___

THURSDAY NIGHT—CONTINUE BELOW

PLEASE CONTINUE READING THE VIGNETTE BELOW. ONCE YOU HAVE READ IT, PLEASE ANSWER THE QUESTIONS ON THE FOLLOWING PAGE.

Mr. Sperry's mental status improves with the recommended measures. Unfortunately, his hypoxia worsens over the course of his hospital stay. By hospital day 7, his oxygen saturations are 90% on 2 LPM via face mask, and he is obviously dyspneic. His respiratory rate is 28, and his heart rate is 100 with a blood pressure of 100/70. He is sleeping most of the day despite absence of recent medication changes, and requires IV administration of medications and hydration due to continued mouth pain from resolving mucositis. His weight is down to 90 pounds (His healthy weight was 160 pounds, and his weight at diagnosis was 130 pounds.) On CT scan, his lung tumor has continued to grow rapidly and is now occluding his left mainstem bronchus completely, with whiteout of the left lung field. His oncologist discusses his care and the lack of response of the tumor to chemotherapy with the attending physician family, and states that further chemotherapy is futile and will not be offered prior to signing off the case.

Mr. Sperry and his family are tearful and upset. They had previously heard the oncologist say that curing the cancer was not possible, but had still hoped the chemo would work. They do not know what to expect now that he will no longer be receiving chemotherapy. In addition, Mr. Sperry complains of feeling tired, "wore out" and severely short of breath and tearfully says, "Help me, doc!" You and your attending discuss his case and decide to have a family meeting this afternoon to address his goals of care.

COMPLETE THURSDAY, SHOW TO FACULTY FRIDAY TO GRADE. . .THEN YOU'RE FINISHED!!!

Retain this page and turn in to Amy Kiper for credit after grading and discussion with faculty.

What steps can a meeting leader unfamiliar to the family take to build relationships and trust with the patient and family during this discussion? (name five steps)

Introduce yourself and others
Identify med decisionmaker
Ask about non-medical stuff
Review goals
Establish ground rules

You ask the family and patient what they already know about his illness. They look at each other and say, "We know he has lung cancer and that his cancer doctor says chemotherapy won't help anymore." Write out a succinct "big picture" medical review you could say to this family to help him understand his medical status.

"Your cancer is worse, based on further functional decline and increasing shortness of breath, I believe you are dying"

Mr. Sperry and his family ask "How long do you think he has?" What prognosis would you give, based on his clinical status and symptoms:

Days to weeks OR less than 3 months

The patient and family are appropriately tearful and upset but appreciate your attending's honesty and clear communication. The main goal of his care becomes comfort, and his family asks what you can do to ease his shortness of breath. What are two specific non-drug interventions and one specific pharmacologic treatment can you offer to improve Mr. Sperry's dyspnea?

Fan, sitting upright, morphine PO or IV

Write a sample drug order to treat a patient with terminal dyspnea who is unable to swallow:

Morphine 2-5 mg IV or SQ q 10 min prn dyspnea

Mr. Sperry's family is worried about your proposed drug treatment for his terminal dyspnea. (They are worried that he will stop breathing due to side effects of the drug, and one of them asks if it is the same as physician-assisted suicide.) What can you tell them about this concern?(2 points)

Morphine is the best medicine available to make him comfortable. He is dying and respiratory depression, if it occurs, is an acceptable side effect of the medication if it makes him more comfortable at the end of his life. You are using the medication to control his symptoms, not to hasten his death. It is not acceptable to withhold symptom control in a dying patient out of concern for possible sedation/side effects

Total possible points=18 Total points awarded:___

GRADING RUBRIC FOR CLINICAL VIGNETTE—FACULTY USE ONLY
Please do not give to students—they will give it to each other in an attempt to save time, which makes this case useless for their learning!!!! POINTS POSSIBLE FOR PROJECT=60 TOTAL (1 point per item on list, plus 4 points for professional approach to assignment/taking responsibility for completion and follow-up)

Tuesday: Discussing bad news with a patient/family= 15 points	**Done**	**Not Done**
Described optimizing environment/stage setting for a bad news discussion		
Described optimizing personnel/themselves for a bad news discussion		
Checked patient preparedness to hear bad news		
Checked what patient already knew about their illness/problem		
Gave a warning shot "I'm afraid I have some bad news"		
Expressed bad news clearly and succinctly with empathy "I'm sorry, but…"		
Used silence and reflective listening to respond to patient emotion		
Asked for questions from the patient/family		
Made a follow-up plan		
Documented in the chart		
Wrote at least one sentence that could actually be said to this patient		
Explained the use of silence and reflective listening in response to strong emotion		
Charting: recording WHO was present for bad news discussion		
Charting: recording WHAT was revealed to patient for bad news discussion		
Charting: recording follow-up plan in chart after bad-news discussion		

Wednesday: Starting an opioid drug regimen for pain= 12 points	**Done**	**Not Done**
Asked about drug and non-drug treatments has the patient tried at home for pain		
Asked about creatinine prior to stating pain medications		
Asked about pulmonary status prior to starting pain medications		
Asked about past experiences with opioids		
Asked about common opioid phobias		
Asked about addiction/abuse of drugs or alcohol in past		
Initially prescribed a long acting opioid to be taken on a scheduled basis		
Initially prescribed a short acting opioid to be taken PRN for breakthrough pain with a prn dose approximating 10-15% of total daily long-acting opioid dose		
Started a scheduled bowel regimen that included a laxative/stimulant		
Increased dose of long-acting opioid by at least 25-50% for moderate uncontrolled pain		
Did not change the long acting opioid agent when dose increased		
Correctly changed PO dose of opiate to equianalgesic IV dose		

Thursday: Delirium= 15 points	Done	Not Done
Correctly identified the formal diagnosis: delirium, NOT "altered mental status"		
Causes of delirium: infection (pneumonia, UTI)		
Causes of delirium: medications/drug withdrawal/overdose		
Causes of delirium: metabolic (electrolyte imbalance/malnutrition/hypoglycemia)		
Causes of delirium: sleep deprivation, CNS event (bleed, tumor etc)		
Causes of delirium: imminent death		
Drugs that cause delirium: sedative/hypnotics/benzos		
Drugs that cause delirium: anticholinergics/anitemetics/antidepressants		
Drugs that cause delirium: opiates		
Drugs that cause delirium: steroids		
Drugs that cause delirium: antihistamines, phenopyrazines		
Treating delirium: AVOIDED the use of physical restraints		
Treating delirium: Recommended orientation techniques for the delirious patient		
Treating delirium: Recommended holding all offending medications		
Treating delirium: Recommended haloperidol or "major tranquilizer" and wrote Haldol 1 (or 2) mg IV q hour prn delirium		

Friday: Goals of Care Meeting and Terminal Dyspnea= 18 points	Done	Not Done
Building relationships: Introduced self and others		
Building relationships: Identified medical decisionmaker		
Building relationships: Asked about non-medical aspects of patient's life (what are your hobbies? How many children do you have?)		
Building relationships: Reviewed goals of conference		
Building relationships: Established ground rules—everyone can talk, etc.		
Medical big picture: MUST tell patient the cancer is worse		
Medical big picture: MUST tell patient they are dying		
Prognosis: Days to weeks **OR** less than 3 months		
Dyspnea: identified 2 non-drug treatments (fan, sitting upright,etc.)		
Dyspnea: identified morphine as the drug of choice		
Dyspnea: prescribed Morphine 2-5 mg IV or SQ q 10 min prn dyspnea		
Dyspnea: Avoided recommending intubation or mechanical ventilation as a treatment for terminal dyspnea		
Dyspnea: explained to family morphine is best drug for dyspnea in a dying patient		
Dyspnea: explained goal of morphine was symptom control, not euthanasia		
Student took assignment seriously and was proactive in completion, seeking faculty feedback and grading…**please give 4 additional points here ONLY if you agree with that statement.**		