Difficult Situations in Clinical Practise

Workshop Friday, 19th January

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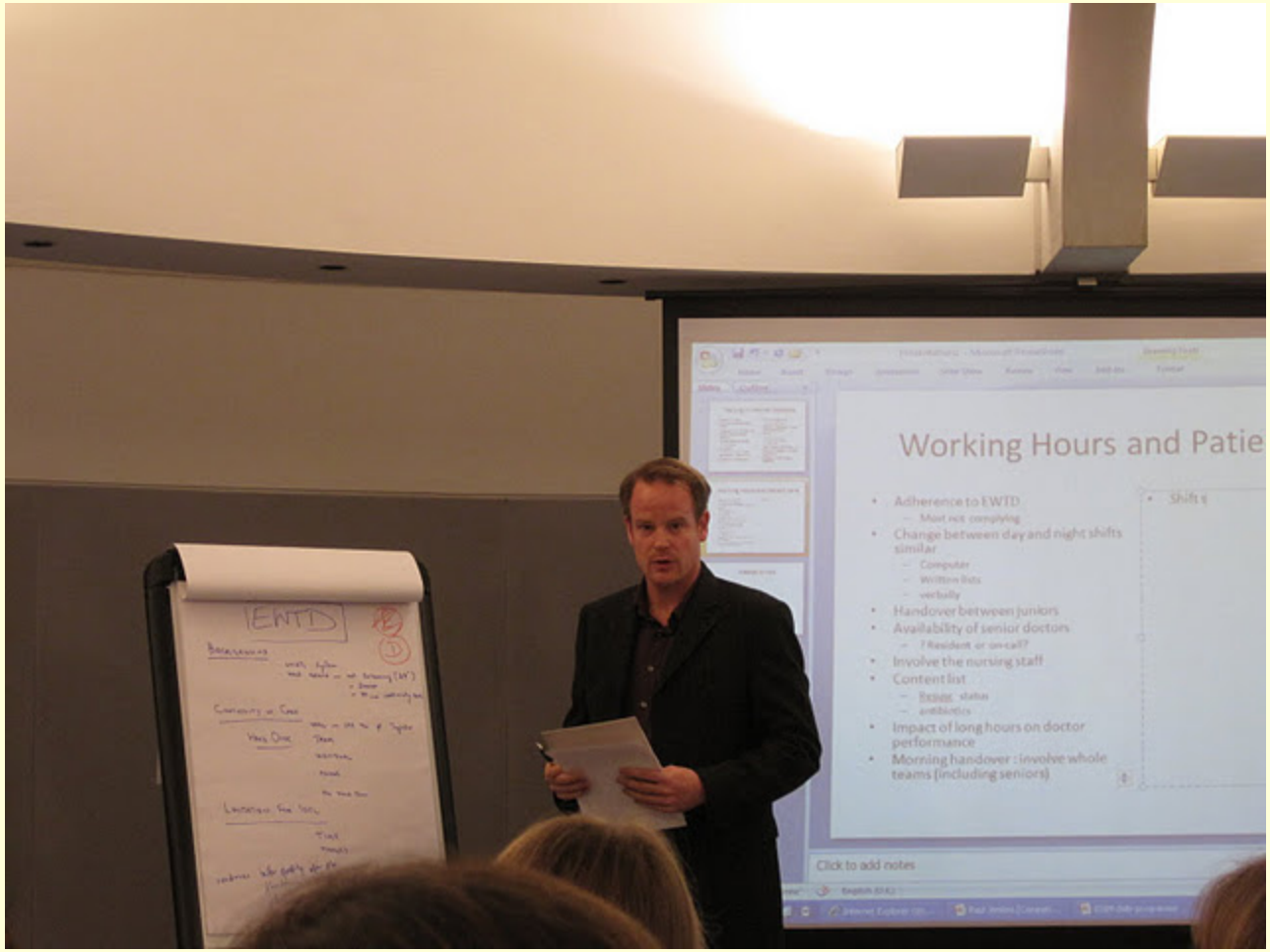
ESIM Brighton September 2011


EWTD
Working Hours and Patie
Adherence to EWTD
Change between day and night shifts similar
Computer
Written lists
verbally
Handover between juniors
Availability of senior doctors
? Resident or on-call?
Involve the nursing staff
Content list
Impact of long hours on doctor performance
Morning handover : involve whole teams (including seniors)
Click to add notes


Wine


NIVEA

Evening at the Royal College in London

Workshop:

Difficult situations in clinical practise

Group 1

Communication in difficult situations: bringing bad news

Group 2

Finding a decision for a critically ill patient

Group 3

Dealing with errors in clinical practise

Group 1

Communication in difficult situations: bringing bad news

Communication in difficult situations: Giving information?

- Patient side:
  - Patients often do not feel informed enough about their diagnosis and prognosis and the course of their treatment
  - „They were all very wonderful, very nice but I realized afterwards that nobody ever told me anything“ (breast cancer patient)
- Doctor side:
  - The doctor may think, that the patient will not understand the information or that it will discomfort him
  - The doctor has little time

Successfull comunication

- A successful patient-doctor communication will:
  - Reduce fear and distress on the patient side
  - Improve patient satisfaction
  - Improve understanding and patient compliance
- A successfull patient-doctor communication starts with developing a common point of view

Talking about palliative care: The SPIKE-P-S Model (Baile 2000, Oncologist)

- **S**etting (time, room, involved persons, position in room)
- **P**erception (appropriate situation, common level of information, ask about concerns)
- **I**nformation Need (how much information does the patient want, how much can he take?)
- Providing **K**nowledge (clear language, small units of information,consider rest periods, ask-tell-ask strategy)
- Responding with **E**mpathy (react to emotions, express understanding and support)
- Discuss **P**alliative care (quality of life, treatment of symptoms, support options)
- **S**ummary (ensure understanding, allow questions, offer further support, arrange time to talk again)

Conveying bad news: preparation

- Find an appropriate location, take enough time (allow about 15-20 min)
- Try to avoid disturbances (phone)
- Create a warm and confidential atmosphere

- Be sure that the patient is ready to take the information you have to transfer
- Clarify the role of the family

- Be prepared yourself (have all information at hand, have a strategy, know about your own emotional attitude)

Conveying bad news: dialogue

- Find out about the patient´s level of information
- Say openly that you are bringing bad news – do not prolong
- Adjust your language and the amount of information you give to the patient´s capacity (less information, more time)
- Explore and name the patient´s emotional reactions
- Do not escape emotional situations by changing to the factual level
- Do not start talking too much to hide your own insecurity – allow rest periods
- Assure the patient your presence and support, give room for hope
- Pay attention to your own feelings and emotional reactions

Conveying bad news: follow up

- Clarify how much of your information the patient has understood

- Get a picture of the patient´s resources (coping strategies, family support, beliefs)
- Respect the patient´s coping strategies

- Inform the patient about the future treatment plan to reduce fear
- Do not let the patient´s or the family´s worries irritate your professional point of view
- Make a follow up appointment for further questions

- Inform the people involved (nurses)

- Talk about your own feelings to a friend or colleague
- Develop strategies to get distance from the situation

The case

- If a patient denies his diagnosis this may help him to cope (defence mechanism)

- The family transfers their distress to outer circumstances (projective) – but it can help to look at the worries behind this behaviour and to actively name this („I have the feeling that you are very worried and sad.“)

Group 2

Finding a decision for a critically ill patient

The critically ill patient

- In Internal Medicine we often face critically ill or dying patients
  - As doctors we are not supposed to prolong the process of dying – but when is the patient dying?
  - What do we know about the patient or how can we find out?
  - What helps us with finding a decision?

The health care proxy

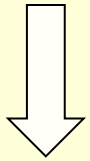
- A person named by the patient to make decisions on his behalf
- Written document that applies when the patient is incapable of making decisions for himself
- A person close to the patient, who follows the patient´s will, not his own ideas
- Accepted by law without further formalities (in Germany)

The advance directive

- Document that describes the course of treatment to be followed when a person cannot speak for himself any more
- Pre-printed forms
- Include:
  1. Circumstances when the directive shall apply (permanent brain damage, incurable illness)
  2. Life sustaining medical treatments refused or accepted (ventilation, antibiotics, feeding tube)
  3. Further requests and personal information (beliefs, special care wishes)

The advance directive is valid when…

- … It has been made by a person over 18 years old who was at the time mentally able to make the decision
- … It has a written form (not necessarily signed by a notary)



In Germany a valid advance directive is legally binding (not in all European countries)

The advance directive: limits and alternatives

- The acute patient´s will always has the priority
- The patient cannot ask for things that are against the law
- If no directive exists the doctor should consider the assumed will of the patient (ask family and friends)
- When no information exists it can be assumed that the patient agrees to the medically indicated treatment

The advance directive: controversy

- If the doctor and the health care proxy are discordant: appeal to a comission
- If the family and the doctor disagree about a medical indication of further treatment: act with special consideration

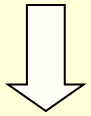
- Questions:
  - Does the advance directive actually apply to the situation you are facing?
  - Can a non-expert have sufficient background knowledge to make decisions about medical treatment?
  - When are we treating an acute illness and when are we prolonging chronic suffering?

Group 3

Dealing with errors in clinical practise

Levels of harm: juridical terms

- Negligence (required accuracy was not observed)
- Gross negligence (more severe level)
- Deliberate intention (doing harm deliberately and with knowledge)



Mistakes in treatment are almost always cases of negligence

Civil law

- The compensation for pain and suffering is decided in a civil process (compensation money paid to the patient or the family)
- It has to be proved that the mistake causally led to the harm on the patient side – which is often difficult
- The compensation money is usually paid by the insurance of the hospital that employs the doctor

Criminal Law

- The doctor is responsible himself when accused of a crime like
  - Negligent homicide
  - Wilful homicide
  - Breaking the professional secrecy

- Penalties or the loss of the licence to practise can result

Culture of dealing with errors

- You are not obliged to report a mistake or to accuse yourself of anything
- How openly you can speak about errors depends on your team spirit and how safe you feel within your team and with your superiors
- Do patients or their families want to be confronted with medical errors?
- Noone wants to harm a patient – yet it will happen: work on your coping skills

Thank you … and take care