3 papers that changed my practice

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SFD-Great Update 2017

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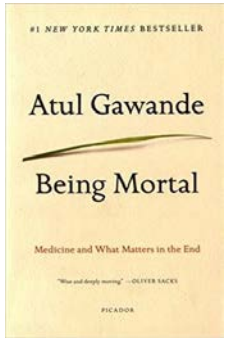
- Does a paper really change your practice?

3 papers? 3 inspirations

1) Interprofessional collaboration:
   Family practice 2017

2) Learner-centered teaching skills mirroring the patient centeredness
   «our paper» 2016

3) Palliative care: Being mortal *by Atul Gawande*
   Book in french 2015



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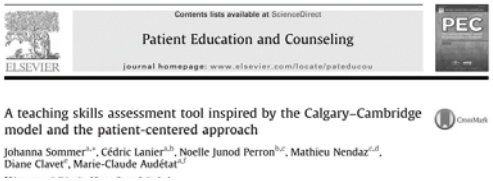

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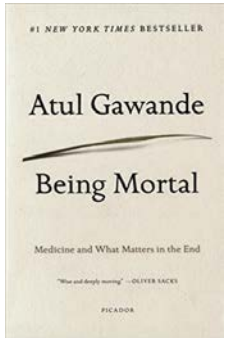

Interprofessional collaboration

Understanding collaboration in general practice: a qualitative study

McInnes S, Peters K, Bonney A, Halcomb E.

Fam Pract. 2017 Mar 8. ahead of print

https://doi.org/10.1093/fampra/cmx010

Personal questionning

Mrs N…92 years old.. Living at home. Weekly visits of nurses , and help for bath 3x/week, falls+

- What is «good» interprofessional collaboration?
- How do I collaborate?
- How can I improve my collaboration to improve multimorbid patient’s (as Mrs N’s) care?

Context

- Increasing chronic conditions increasing demand in general practice (with fewer workforce)
- Interprofessional collaboration is recommended by WHO (decreases morbidity, complications, hospitalisations, mortality, costs; increase quality of care, patient's satisfaction, etc)
- Needs for interdisciplinary collaboration with the skills and expertise to deliver high-quality care
- General practitioners in Australia work mostly as small private enterprises

Method

- Semi-structured interviews with volunteers on type and definition of collaboration (anonymised)
- 22 general practitioners and nurses

- Verbatim transcription
- Data analysis, coding until saturation
- Cross-checking by 3 authors

Results

1. **Interpreting collaboration**
2. **Modes of communication**
3. **Facilitators of collaboration**
4. **Collaboration in practice**

Results

1. **Interpreting collaboration:**
   key focus: optimize outcomes
   teamwork = working together
   collaboration = exchanging ideas
2. **Modes of communication**
   Clear and open
   Mostly informal (door stop, sms, email)
   Little long term goals and decision making

Results

3. **Facilitators of collaboration**
   Formal collaboration-meetings
   specific training/knowledge of nurse
   equity of roles as colleagues
4. **Collaboration in practice**
   -Participants perceived collaboration
   - mostly parallel loads/work in isolation

What changed in my practice?

Mrs N..

- Organize formal regular meetings with patient, nurses, sometimes family
- Exchange ideas for patient care
- Define common strategies, long term goals with other professionals

>less falls
>better controlled symptoms
>less anxiety

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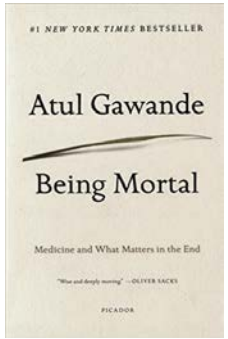


2) Learner-centered teaching skills mirroring patient centeredness

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

A teaching skills assessment tool inspired by the Calgary–Cambridge model and the patient-centered approach

Johanna Sommer[a,*], Cédric Lanier[a,b], Noelle Junod Perron[b,c], Mathieu Nendaz[c,d], Diane Clavet[e], Marie-Claude Audétat[a,f]

2016, vol. 99, p. 600-609

Personnal questionning

With Larissa , 6th year student

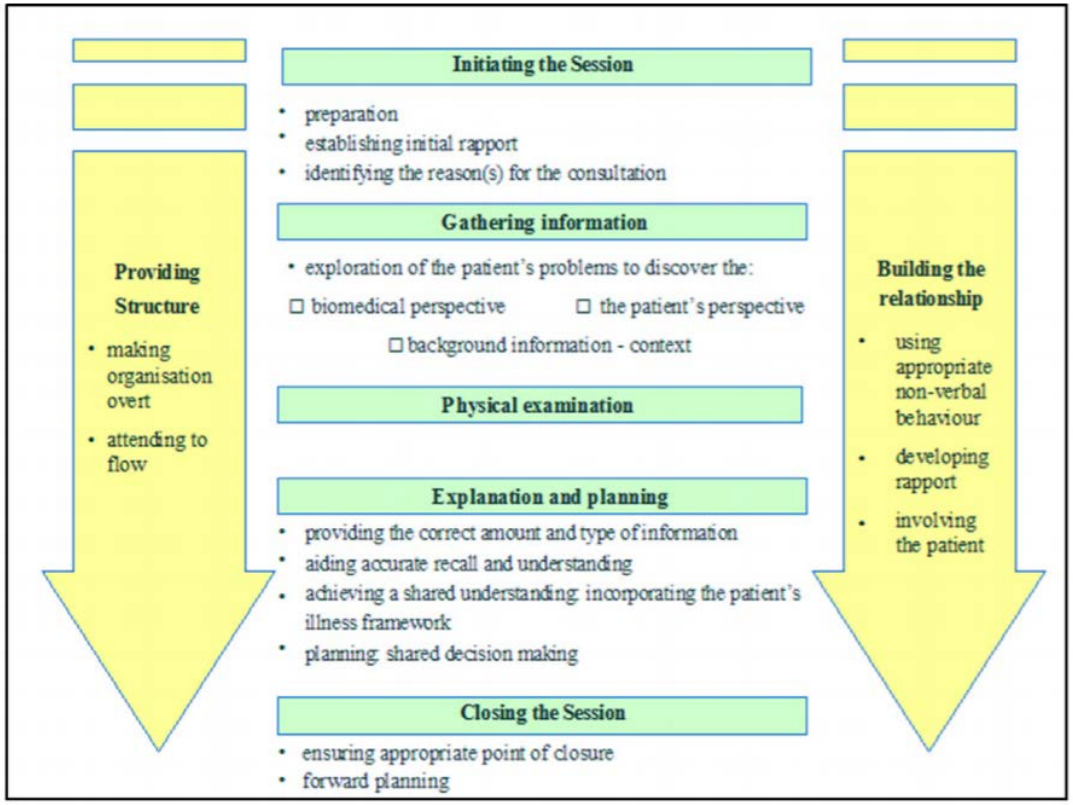
«Good clinician» doesn’t mean good teacher

- How to teach medicine to young colleagues in a short time?

Method: descriptive tool of expected teaching skills

- Action research
- Participants: 12 clinical teachers and 3 experts in medical education.
- Content validation
- Validation of interrater reliability:
  3 senior clinical teachers coded 30 audiotaped standardized learner-teacher interactions
  (Kendall's coefficient)

Method for developing the tool:
analogy between clinical encounter…



Calgary-Cambridge guide for consultation

Outils et stratégies pour communiquer avec le patient. Ed Méd. et Hygiène 2010

Method for developing the tool:

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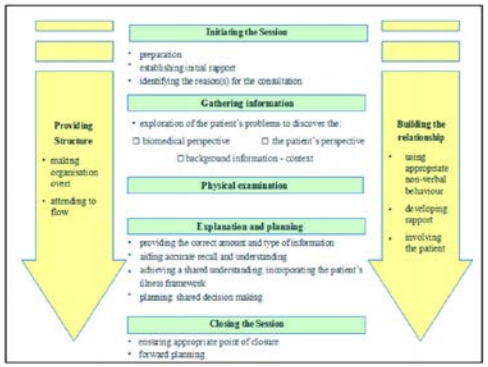
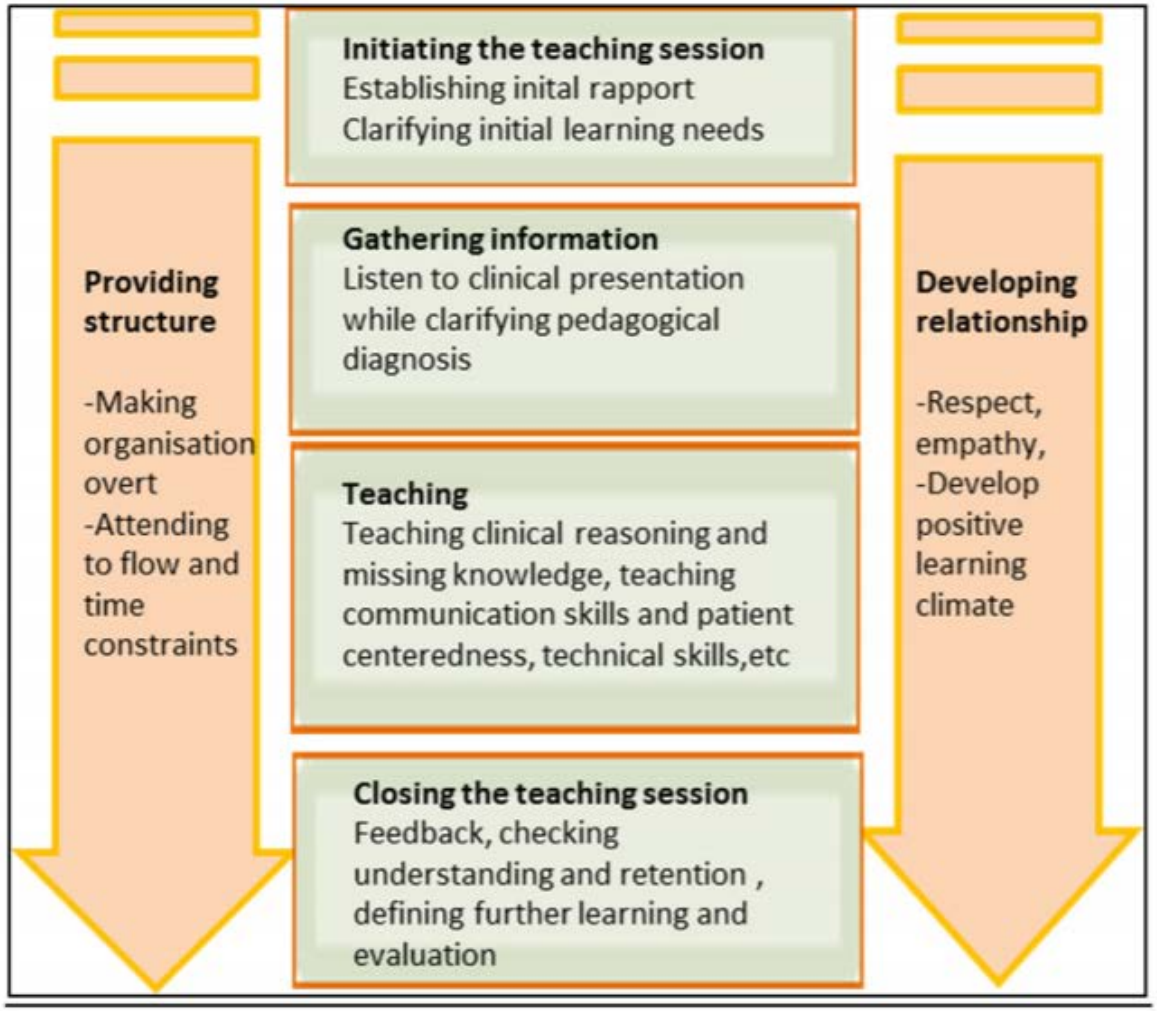


…and supervisions

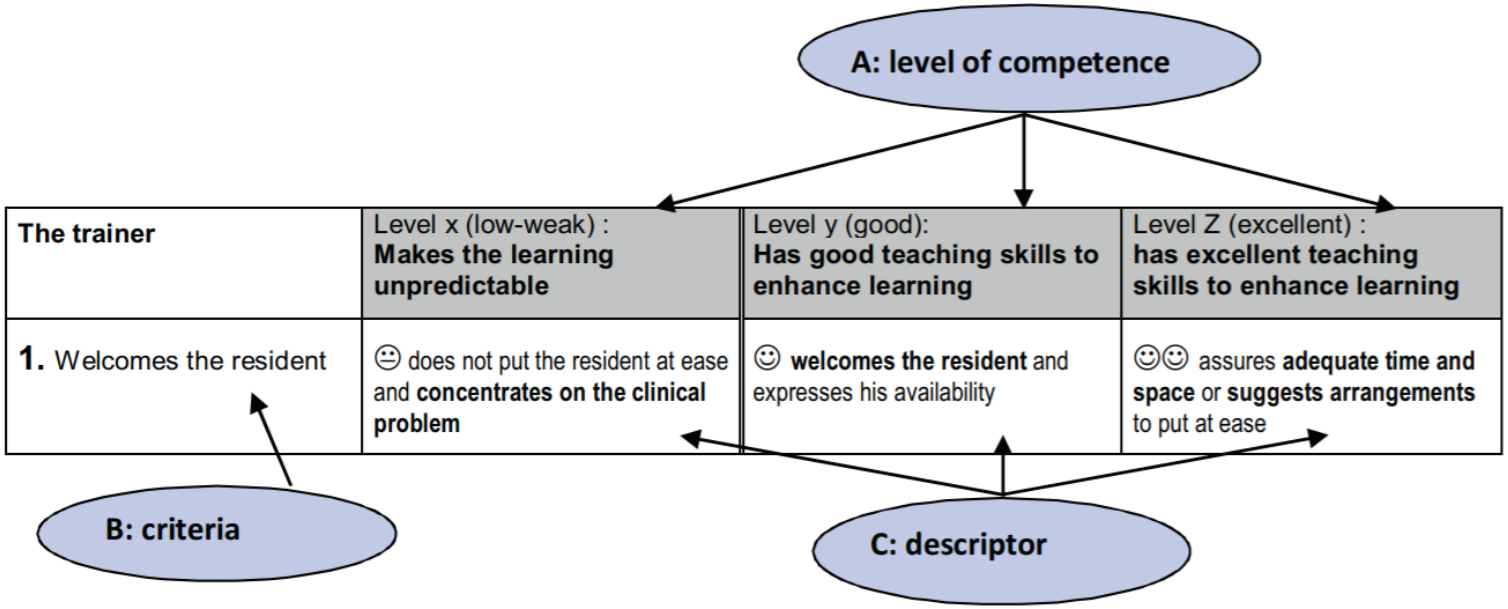


Result: observation tool («grille»)
validated for 11*/16 items structuring supervisions

Step 1: Structures the supervision
a) **Welcoming*** and b) defining **learner's needs***
Step 2: Teaching
a) **Clinical reasoning***, **knowledge***, **patient's perspective***
b) clinical skills: **history taking/clinical exam***, **procedure***
c) **interpersonnal communication skills***
d) definition of **action plan,** adaptation **to patient's context*,** check **implementation**
e) limits of knowledge, **uncertainty**
Step 3: Conclusions
a) **Strengths***
b) **New learning***
c) What has **to be learned***
d) Evaluation of **supervision process**

* $p<0,005$

Result: descriptors of expected behavior for 3 levels of competence



Result: observation tool for peer review of teaching skills

Can be used

- feed-back to peers
- Self-assessment
- Train clinical teachers

Observation and learning tool for clinical supervision **Name :** J Sommer 2.4.2015

The supervisor	Level X (low-weak) : makes the learning unpredictable	Level Y (mean-good): has good teaching skills to enhance learning	Level Z (very good): has excellent teaching skills to enhance learning
Step 1 : organises the supervision			
1. Welcomes the resident	☹ does not put the resident at ease and **concentrates on the clinical problem**	☺ **welcomes the resident** and expresses his availability	☺☺ assures **adequate time and space** or **suggests arrangements** to put at ease
2. Drives the supervision according to the resident's needs	☹ listens to the case presentation without asking the resident's own question or needs to drive the supervision	☺ let the resident express the **problem** that **prevents him to solve the case** (before or just after the case presentation)	☺☺ **clarifies/reflects** what prevents the **resident to solve the case (learning needs)** (before or just after the case presentation) or discusses the case aiming explicitly at the **resident's needs**
Step 2: helps the resident to learn from the case			
3. **Discusses the case and explores** a. the **clinical reasoning**	☹ **a. interrupts the resident** so as to get more informations following his **own medical reason-** **ning** or thinks aloud without implying the resident	☺ a. asks the **resident** what hypotheses **has driven his reasoning** Or **speaks** aloud involving the **resident**	☺☺ a. encourages the resident to **argue** or **complete the hypotheses of his medical reasonning**
b. the **underlying medical knowledge**	☹ b. questions/explains **theoretical notions without clear link** with the case or does not discuss any related knowledge	☺ b. teaches the **knowledge related to the missing notions** or wrong interpretations of the resident	☺☺ b. stimulates the resident to **remember the relevant knowledge** , or **helps to find relevant missing knowledge** (gives tools/references)
c. the **relevant psychosocial elements** and **patient's perspective**	☹ c. **does not question or underline psychosocial context or patient's perspective** relevant to solve the problem	☺ c. **questions** or **underlines the relevant psychosocial or patient's perspective details**	☺☺ c. underlines the **link between patient's perspective or psychosocial elements and the relevance for the problem solving** or values when the resident is taking it into account
4. **Teaches or corrects** a. the **history taking** or **clinical exam**	☹a. tells what the resident should do **without explanation nor modeling** Or does not teach the history taking or clinical exam	☺a. teaches history taking or clinical examination **by explanation or modeling**	☺☺a. **lets the resident demonstrate** a skill of history taking or clincal examination
b. an **interpersonal/communicati onal skill**	☹b. tells what the resident should do **without explanation nor modeling** or does not teach interpersonal skills	☺b. teaches relevant interpersonal /communicational skills **by explanation or modeling**	☺☺b. **lets the resident demonstrate** an interperonal/communicational skill
c. a **technical skill** (technical procedure,venous puncture, joint puncture,stitching, etc)	☹c. tells what the resident should do **without explanation nor modeling** or does not teach technical skills	☺c. teaches relevant technical skill **by explanation or modeling**	☺☺c. **lets the resident demonstrate** a technical skill
5. **Discusses the plan :** a. **developing an action plan**	☹ a. after the diagnosis or definition of the problem, tells the resident what to do	☺ a. **asks the resident to express an action plan** (investigations, treatment and follow up) or expresses action plan **involving the resident**	☺☺ a.**asks the resident to argue and discuss** own action plan
b. **adapting the action plan** to the patient's psychosocial context and individual perspective	☹ b. does not take the psychosocial context (nor the patient's perspective) into account when defining the action plan	☺ b. **encourages the resident** to take into **account the patient's psychosocial context** and perspective when defining the action plan	☺☺ b. **values an action plan that takes into account the patient's psychosocial context or perspective** **or stresses the importance** to take it into **account** so as to improve the treatment
c. **verifying the strategies of application**	☹ c. does not check the residents strategies of application or tells the action plan to the patient without discussing it with the resident	☺ c. **asks the resident if he feels confident to apply the action plan** (the « what ») **or offers help** for the application of the action plan (to go with him to see the patient)	☺☺ c. checks **how the resident will apply** the action plan **Or makes a role play**
6. Adressing **own limits of knowledge**	☹ Expresses no doubt about the medical knowledge	☺ **expresses the limits of his own knowledge or his doubts**	☺☺ **expresses the doubts or limits of his knowledge and defines with the resident a** way to find the **needed information** to overcome the doubts
Step 3 : Ends the supervision			
7. States : **a. strenghts /what is mastered**	☹ a. does not value or reflect on residents strengths that helped him to solve the problem	☺ a. stresses the residents strengths that helped him to solve the problem and values them ☺ **b. tells the resident what he should remember**	☺☺ **a. encourages the resident to reflect on own strengths** before valuing them
b. **new learning**	☹ b. does not speak about what should be remembered		☺☺ **b. asks the resident what he will remember and can add some suggestions** (or asks for some transfer to other case) or asks the resident for **some general** principle/rules that can be deducted from present case
c. **what has to be learned**	☹ c. does not speak about what should be learned on behalf of the discussion	☺ c. suggests some ideas to enhance his ongoing learning	☺☺ c. defines with the resident a **learning plan** (actions, literature, timing, evaluation)
8. **Evaluation of supervision process**	☹ does not speak about the supervision process	☺ checks if supervision has **answered his learning needs (content)**	☺☺ checks if supervision has answered the learning needs and if supervision process is adequate **or asks for suggestions of improvement in supervision process**

What changed in my practice
With Larissa

- **Being learner-centered**
  - -defining learner's needs
  - -good relation and safe learning environement
  - -clarifying what learner learned and has to learn
- **Teaching the process (clinical reasoning**) as much as the content (medical knowledge)
- Being a **role model** teaching patient-centeredness
- **Reflectiveness** (on my practice and teaching)

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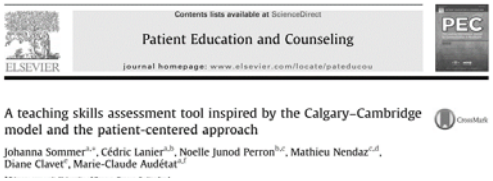

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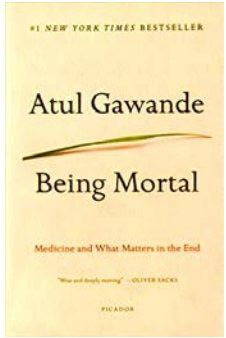


3) Palliative care:
Being Mortal *by Atul Gawande (1965-)*

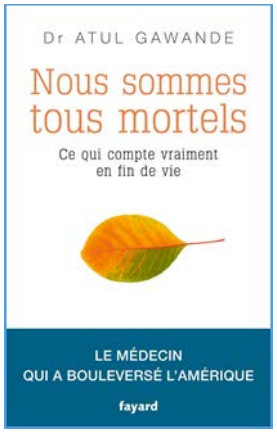
- Chirurgien (américain/ parents indiens) à Harvard

- 2009 *The Checklist Manifesto*

  (NEJM 2009 Réduction du taux d'erreurs et complications chirurgicales sur 3733 patients:
  complications de 11>7% et décès de 1.5>0,8%)

- 2015 *Nous sommes tous mortels:*

  Ce qui compte vraiment en fin de vie



Personal questionning

Mrs S. 79, breast cancer treated in 85, 2017: metastatic lung adenocarcinoma

- What is my role in severe cancer patient's care?
- How do I improve respect of patient's treatment and end-of life choices?

Being mortal

Reflexion on palliative care, **end-of life**, and **attitude of doctors**:

< From Dr «Paternalist»: «Doctor knows best»
> To Dr «Informative»: neutral balanced information

- **Dr Guide**

How to share information?
Ask-Tell-Ask

Ask: clarify understanding, questions to be answered, values, goals

Tell: give useful information regarding this patient

Ask : ask for understanding, consequences, decisions

Hard conversations
what if the condition worsened??

- **Dare to start** the conversation («I am worried that..»)
- **Understanding**? What **matters** most ?
- What **fears** ?
- What **goals** ?
- Discuss **limits and trade-offs**
- When to consider **hospice care** and how?
- Decisions about **end-of-life**?

What changed in my practice?

Mrs S:
Informations must guide patient's decisions

«Ask-tell-ask»

Dare to discuss openly with her:

- Values/aims? What matters really?
- Fears?
- Limits and trade-offs?

What changed in my practice?

Development of a protocol (with S.Pautex and D.Haller) :

Continuous follow-up by primary care physicians facilitating early palliative care for patients with advanced cancer

- meet the patient even if he/she is treated in oncology
- assess the patient's values and choices
- promote the definition of advance directives
- facilitate early palliative care
- check the relatives' need of support
- provide coordination between different healthcare providers

Conclusions
«My checklist»

- How can I better collaborate with other professionals to optimize this patient's care?

- Did I define this learner's needs?
  Am I teaching the process (clinical reasoning) as much as the content (knowledge)?

- Did I talk openly with this advanced cancer patient and do I know what matters for him? Do I support his choices and preferences when situation evolves?