

## Recommended Curriculum Guidelines for Family Practice Residents

# End-of-Life Care

*This document has been endorsed by the American Academy of Family Physicians and was developed in cooperation with the Association of Departments of Family Medicine, the Association of Family Practice Residency Directors and the Society of Teachers of Family Medicine.*

### Preamble

Caring for dying patients is inseparable from our efforts as physicians to improve our patients' lives. The increasingly large number of patients who are part of our aging population, along with technologic advancements, make it vitally important to improve and refine our teaching of end-of-life care.

One of medicine's most important missions is to allow terminally ill patients to die with as much dignity, comfort and control as possible. In patients for whom a cure is not possible, there is still an enormous amount of care and support that can and should be provided for patients and their families. Many of the tenets embodied in family medicine are very important in the care of the dying. A holistic approach to the patient's physical and psychosocial well-being, a focus on the family, continuity of care, and an emphasis on quality of life are four important principles that make the family physician uniquely suited to care for the terminally ill.

The end of life is one of the most critical times in the doctor-patient relationship. A family physician providing and coordinating hospice or other team care for a dying patient can palliate physical symptoms and provide social, emotional and spiritual support. The care and support provided can set the stage for some of the most meaningful experiences in which human beings participate. The time and care surrounding a loved one's death are not just remembered for days or weeks but are often recalled for lifetimes. Appropriate teaching and experiences in end-of-life care during residency training will not only provide needed information to help ease pain and suffering but also inspire family physicians to participate in the ultimate continuity of care: that of the terminally ill.

### Attitudes

The resident should exhibit awareness and sensitivity to:

- A. The process of "breaking bad news," including choice of setting, talking with the patient and family members, summarizing and using appropriate wording and questioning, and the impact of this process on the patient and family.
- B. Psychosocial issues and family dynamics affecting the terminally ill patient.
- C. Spiritual/Religious issues affecting the terminally ill patient.
- D. Family cultural issues and particular customs in the context of death and dying.
- E. The dying patient's need for palliative care, pain relief, control and dignity.
- F. Special issues associated with children, either as terminally ill patients or as family members of a terminally ill patient.
- G. The impact of attitudes and experiences about death and dying on how to care for terminally ill patients.

### The resident should demonstrate knowledge of:

- A. The philosophy of palliative care
  1. Home-based approach
  2. Family as care unit
  3. Pain control
  4. Symptom control
- B. Hospice team roles
  1. Physician
    - a. identification of appropriate patients for hospice care

1. cancer related
  2. Noncancer-related
    - pulmonary
    - cardiovascular
    - neurologic
    - infectious
  - b. Referral process and criteria
  - c. Insurance and medicare coverage
  - d. Cost of care for terminally ill in various settings
2. Nurses
  3. Social worker
  4. Pharmacists
  5. Home healthcare aides
  6. Volunteers
  7. Family
- C. Prognosis of terminal illness
    1. Accuracy of prognosis
    2. Clinical indicators of time until death
    3. Value of medical therapies
    4. Psychosocial stages of the dying process for patient and family
  - D. Major pain syndromes
    1. Neuropathic
    2. Bone pain
    3. Visceral pain
    4. Nonphysiologic pain
  - E. Pain control
    1. Opiates: long- and short-acting
    2. Nonopiates
    3. Addiction, habituation and dependence
    4. Baseline dosing and rescue
    5. Complementary and alternative medicines
    6. Nonpharmacologic pain control measures
    7. Side effects of pain control measures
  - F. Causes and treatment of nonpain symptoms
    1. Nausea
    2. Shortness of breath
    3. Loss of appetite
    4. Vomiting
    5. Sleeplessness
    6. Depression

- 7. Anxiety
  - 8. Cough
  - 9. Constipation
  - 10. Diarrhea
  - 11. Xerostomia
- G. Nutrition and hydration in the terminally ill
- 1. Artificial feeding
  - 2. Intravenous fluids
  - 3. Withholding feeding and fluids
- H. Care locations
- 1. Emergency department
  - 2. Inpatient
  - 3. Outpatient
  - 4. Extended-care facilities
  - 5. Home
- I. Data related to end-of-life care in the United States
- 1. Aging population
  - 2. Most common chronic illnesses
  - 3. Most common causes of death by age
  - 4. Cost of care for the terminally ill in various settings
  - 5. Where people die
- J. The bereavement process
- 1. Normal grief reaction
  - 2. Differentiate grief reaction from depression
- K. Legal issues
- 1. Patient competency
  - 2. Advanced directives
    - a. Do-not-resuscitate orders
    - b. Power of attorney for health care
    - c. Living will
  - 3. Estate planning for patient and family
  - 4. Withholding and withdrawing life support
  - 5. Pronouncement of death
  - 6. Completion of death certificate

- D. Effective use of alternative routes of analgesia
- 1. Rectal
  - 2. Topical (creams, gels, patches)
  - 3. Nasal
  - 4. Subcutaneous
- E. Correct use of pain scales to adjust medication dosage
- F. Effective referral of available social services for both patient and family
- G. Effective counseling of family and others
- 1. Grief reaction
  - 2. Continuing relationships with family members after a loss
- H. Self-care and seeking support when patients die

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End of Life/Palliative Education Resource Center. www.eperc.mcw.edu

Published: 07/98  
Revised: 06/03

## Implementation

This curricular segment lends itself to a combination of longitudinal and block learning experiences over the 36 months of training. The curricular content should be integrated into the core conference schedule and should include exposure to hospice care, home visits and bereavement counseling whenever possible. Relevant literature should be available in the resident library. An attempt should be made to include patients with terminal illnesses in all resident-patient panels. The faculty should function as role models for residents dealing with dying patients and their families. Active learning techniques such as role playing, simulated patients, case discussions and topic presentations are useful. ■

## Resources

*Caring for the dying and identification and promotion of physician competency*. A project of the American Board of Internal Medicine Committee on Evaluation of Clinical Competence, 1996.

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Kübler-Ross E. *On death and dying*. New York: Macmillan, 1969.

## The resident will demonstrate skills in:

- A. Physical assessment with attention to common findings of the terminally ill patient
- B. Correct compliance with regulations pertaining to use of controlled substances in the terminally ill patient in and outside the hospice
- C. Development of an initial and ongoing analgesic regimen to include the use of morphine equivalent dosages and other narcotic equivalents