The Clinical Case in Palliative Care Learning: The tip of a CanMEDs iceberg

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Territorial acknowledgement

We are in the traditional territory of the Robinson Huron Treaty and the land that we reside in is N'Swakmok (Sudbury) in conjunction with the neighbouring communities of Atikameksheng Anishnaabeg and Wahnipitae First Nation.
Disclosures

**Affiliations:**
We have no relationships with for-profit or not-for-profit organizations.

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Introductions

Who we are and why we are here...
Objectives

1- Consider learning as a holistic process that encompasses individuals and their interactions within a workplace culture.

2- Adapt teaching and learning using clinical cases in a way that addresses multiple CanMEDS roles and recognize how the structure of case presentation can privileges certain roles.

3- Recognize factors that impact Indigenous cultural safety in rural healthcare environments and how these relate to CanMEDS roles.
Workshop outline

• Examples of two different case presentation structures
• Build a case for your learning context
• De-brief
• Discussion and explore links to formative learner assessment
• Wrap up, next steps...
Assumptions we have made

1- The CanMEDS role of medical expert is privileged over other roles in medical education.

2- Teachers and learners bring their personal history, tacit judgements and implicit assumptions to the classroom and clinical workplace: learning happens at individual, social and cultural levels.

3- Learning is about more than knowing and doing; it is about thinking, feeling and being. Transformative learning involves ‘disruptive dilemmas’ that challenge previously held beliefs or ideas.

4- Palliative care is the domain of learning that we will use, but the concepts and ideas can be transferred to other domains
Example case: ‘The patient’

Roland is a 51 year old Indigenous man diagnosed with nonalcoholic steatohepatitis cirrhosis (NASH), severe ascites and mild splenomegaly. He had been previously hospitalized for hepatic encephalopathy and a GI bleed secondary to esophageal varices.
**Medications:**

- Furosemide 40mg po od
- Spironolactone 25mg po od
- Nadolol 40mg po od
- Lax a Day 1 tsp po od
- Salbutamol mdi 2 puffs qid prn
- Advair 250mcg diskus 1 inhalation bid
- Lorazepam 1mg po /sl prn
- Morphine 5mg po tid prn

**Medical History:**

- Diet controlled T2DM
- Fibromyalgia
- Anxiety
- Reactive airway disease
- Hernia
Social history:

Lives on home reserve
Separated 30 years
Sole provider for 9 year old grandson
Off work since diagnosis 3 years ago
Smoker 5-8 cigarettes per day x 35 years
No past history of ETOH or drug use
Follows healthy diet
Assistance with some ADLs

Symptoms:

Dyspnea
Bilateral peripheral pitting edema below the knee +2
Increasing abdominal girth with subsequent weight increase (10lbs/week)
Decreasing mobility
Cramps in hands and legs
Constipation
Urinary urgency and bladder pressure
Burden of requiring assistance with ADLs
Anxiety surrounding prognosis, burden of treatments, prejudice, and lack of long term management options
Where to next?
Refractory cirrhotic ascites (RCA)

**Definition:**
Ascites that does not respond to or recurs despite high dose diuretics, sodium restriction and/or mobilization (paracentesis)

**Pathophysiology:**
As cirrhosis advances escaping fluid overwhelms the lymphatics, reduces renal plasma low and increases Na reabsorption at the proximal tubules. Portal hypertension and Na retention cause a cascade of neurohumoral mechanisms via the SNS and RAA

**Treatment ascites:**
High dose diuretics = spironolactone 400mg, furosemide 160 mg
Na restriction: < 90 mmol/day
Refractory cirrhotic ascites (RCA)

**Management:**
**First line:**
Serial large volume paracentesis (LVP)

**Others:**
Indwelling peritoneal drain (e.g. PleurX catheter, pigtail catheter)
Porto-systemic shunts
Peritono-venous shunts
Investigational drugs
Liver transplant
And on and on....
Roland travels to his transplant appointment in Toronto. He returns in a confused state, lacking clarity and mixing up events. He is seen in his home where he is unable to form complete sentences and is not oriented to place or time. His family is unable to care for him in his home. He requires a police escort to the hospital. He repetitively voices his distrust of the health care system.

Roland is admitted to hospital with hepatic encephalopathy. He is aggressively managed over the course of the next few days.

Roland discloses to his primary care provider that he feels his interactions with some caregivers in hospital improve with his primary care nurse practitioner at the bedside.

Roland returned home.
Roland was able to have a discussion about his end of life wishes with his community team. He declined any return visits to the hospital preferring to be cared for at home by people who knew him.

The attending hospital team arranged for home care visits and provided Roland and his family with a symptom relief kit for comfort. Roland died 3 days later, at home, with his family at his bedside.
Where to next?
Cultural Safety

Is your clinical workplace culturally safe for an Indigenous person presenting with liver failure at end of life?
An approach that considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences. Practitioners are self-reflective/self-aware with regards to their position of power and the impact of this role in relation to patients. “Safety” is defined by those who receive the service, not those who provide it.

Communicator, collaborator, professional, health advocate

• United nations declaration on the rights of indigenous people (UNDRIP) 2007

• Truth and Reconciliation Commission Calls to Action, 2015

• NOSM Final Report Expert Panel Review Sept 2018
Our experience of this case

- Presenters spent most of their time on medical expert role, despite other intentions
- Participants were most interested in the complexities of physiology and medical management
- When ‘the patient’ is presented first, without a rich context, the medical expert is ‘foregrounded’
- Other CanMEDs roles may be seen as ‘afterthoughts’, having been foreshadowed by medical expert role
- This did not mirror the presenters’ lived experience of the challenges of caring for this man
Example case: ‘The person’

Gary 60-year-old man living in a rural First Nation community surrounded by many family members. His home is accessible by car over a rough road that is sometimes challenging in winter weather. Gary was diagnosed with an aggressive head and neck squamous cell cancer 1 year ago. Since then, it has infiltrated into the left side of his neck. He received radiation and palliative immunotherapy with the goal of slowing the disease progression.
Gary grew up on reserve with 4 siblings. He had a Catholic upbringing and attended residential day school until Grade 8. He is soft spoken but has a temper when people don’t address him frankly and directly about his care. He is keenly organized with all of his appointments and medications. He is well versed in his illness, treatment options, outcomes, and prognosis.
He no longer works due to a mental health disability. He lives on social assistance which provides him with a frugal but complete lifestyle. He owns a 2-story home. He uses wood to heat in the winter and maintains a vegetable garden in the summer. The house is well-kept but in need of repair. He has clean drinking water from a well source.

He lives with family who care for him. He never married. He finds much joy in the co-raising of his nephew who lives in the home. He has a few close friends and enjoys spending time watching TV. Gary does not smoke but does consume alcohol regularly. Gary can perform some activities of daily living but requires assistance with walking and transferring, bathing and meal preparation.
Gary is busy with health appointments. He receives dialysis 3 times a week, travelling an hour and a half each way. All other appointments are in Sudbury, 2 ½ hours of travel each way. He can’t afford to stay in Sudbury overnight so, for his weekly chemotherapy treatment, he does the entire journey within one day.

He takes a ‘one day at a time’ philosophy and makes the best of how he is feeling. He expresses gratitude for being alive. Even though he has a signed DNRc, his wish is to seek acute treatment to prolong his life. He wishes to continue chemotherapy and dialysis despite the daily challenges to attend.
What type of challenges do you foresee in providing a patient centered palliative care approach?
Medical History
- DM Type 2
- Hypertension
- Hypercholesterolemia
- Hypothyroidism
- Schizo-affective traits
- Smoker 45 pack year quit 1 year ago
- Alcohol related cirrhosis 20 years ago

Medications:
- Lansoprazole 30mg po bid
- Calcium 500mg po bid
- Synthroid 0.75mcg po od
- Diazepam 10mg po qid
- Mirtazapine 30mg po qhs
- Restoralax 17g po od prn
- Morphine 5mg (1mg/ml) suspension po q4h prn
Current symptoms:

- Intermittent left neck pain worse with sitting in dialysis
- Facial swelling, drooling and difficulty swallowing
- Peripheral edema +1 pitting below knees bilaterally
- Open wound on anterior right leg non-healing due to peripheral edema
- Poor sleep 2-3 hours per night
- General weakness
Next steps

- What do you think might be going on?
- What complications do you anticipate?
- What management strategies might you employ?

- What challenges can you anticipate in accessing medication for pain and symptom management in this situation?
- What factors do you need to consider when arranging active treatments in this context?
- How might you prepare for potential complications?
Build a case:

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# Case Study - Pain

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Discussion
Formative assessment reflective questions

What did you learn today?
How might it alter your practice?
Does this experience change the way you see yourself as an emerging physician?
Questions, comments ?
Selected references:


