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Training in Palliative & EOL Care For the Emergency Dept. Setting

The EPEC (Education in Palliative and End-of-Life Care) Project is in the process of adding on a new training program. Now, in addition to the initial EPEC Training Program and the EPEC-O (EPEC Oncology) Program which was rolled out in 2006 in conjunction with the American Society of Clinical Oncology, EPEC has rolled out for beta testing a train-the-trainer program in EPEC-EM (EPEC-Emergency Medicine) targetting pallaitive and end-of-life issues that arise in emergency department settings.

Having completed the EPEC train-the-trainer program, EPEC-Professional Development workshop and the EPEC-Oncology train-the-trainer program, and having utilized the EPEC-Geriatirc Modules (developed in 2003) in my teaching, I attended roll-out of the EPEC-EM program at the beginning of this August.

Just as the EPEC-O curriculum design was an improvement on the original EPEC curriculum by providing a much more robust set of subsections to teach the evaluation and treatment of the wide range of symptoms seen in chronic and terminally ill patients and a full module on practitioner burnout (in addition to modules focused specifically on issues relating to oncology patients), the EPEC-EM program's trigger tapes, contained multiple vignettes for each module, demonstrating both the appropriate and the inappropriate ways of addressing a situation, adding significantly to the utility of the trigger tapes as a teaching tool (in addition to focusing on palliative and end-of-life issues that are likely to arise in the emergency department).

EPEC-EM shares the robust educational functionality of the other EPEC programs in that a trainer may pick which slides to use, may modify the slides and the modules, and may add their own slides in order to tailor presentation to their respective audiences. In addition, one may lengthen or shorten a presentation based on time constraints in particular training situations, and utilize a variety of teaching techniques to present the various topics. Additionally, as do the other EPEC specialty programs, EPEC-EM focuses on the unique challenges of providing palliative and end-of-life care to a particular patient population.

Unlike prior EPEC train-the-trainer conferences, where almost all of the health care professionals being trained had practice experience and training

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being trained had practice experience and training in providing palliative and end-of-life (and with pallliative and end-of -life care issues in the context of crticial care, hospice, oncology or geriatric practice), here, a number of the participants were emergency medicine practitioners who did not have significant experience and exposure to palliative and end-of-life care training and practice, even though they have had to address pallaitive and end-of-life care issues that arose in in their ERs. It is noteworthy that some of the EPEC-EM facilitators were both emergency medicine and palliative care trained, but that is likely to be the exception among the larger group of emergency medicine practitioners. I have some concerns about the ability of ER staff to obtain needed preceptoring and mentoring in implementing palliative care in Emergency Department settings. Training sessions need to be followed up by bedside teaching, mentoring and preceptoring by practitioners experienced in palliative care in order for those practitioners to develop necessary palliative care skills and clinical knowledge.

Part of the training in palliative and end-of-life care, *particularly in the psychosocial-spiritual domains and in developing advanced communucation skills with individuals and families*, requires perceptoring/mentoring by persons already trained and experienced in these areas. Whereas preceptorship and mentoring in palliative and end-of-life care is increasingly available in crticial care, oncology and geriatric practice settings, it is not widely available in emergency room settings. Thus, if the EPEC-EM program is to be successful in accomplishing its very important goal of bringing quality palliative and end-of-life care to the ER setting, it will be necessary for emergency medicine departments to develop relationship with palliative-care trained and experinced health care professionals who can help the ER staff develop palliative and end-of-life care competence, particularly in the psychosocial-spiritual and communication areas.

Finally, as have all EPEC programs, the EPEC-EM program speaks of the importance of interdisciplinary collaboration, a critical element in holistic (bio-psycho-social-spiritual) total care of patients that is the hallmark of palliative care. EPEC needs to do more show this by example, having master facilitators who are not physicians. In EPEC-EM some of the master facilitators were nurses, certainly an improvement. However, none are clinical social workers. Of all of the health care professionals, clinical social workers are the best trained and most expert in addressing patient and family psychosocial needs. They are the health care professionals who have the most lengthy and robust training and supervised clinical experience geared towards honing their communication skills. It takes a clinical social worker at least five years of full-time post-graduate supervised clinical experience to become board certified by the American Board of Examiners in Clinical Social Work. It is important the clinical social workers be recognized and valued for their expertise and competence as health care professionals in palliative and end-of-life care, and that they be accepted as full partners in working

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with clinically and educating other health care professionals in palliative and end-of-life care.

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Comments

Any assistance in gaining answers or information on the following question would be greatly appreciated: What are, or where would one find, the standard of care and/or protocol for social workers in emergency department settings with respect to treating the family members of a non-surviving trauma victim?

Posted by: littrell7 | September 24, 2007 at 11:59 AM

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