

Original Research Background. Effective communication with patients and families is a core competency of residency education. While internal medicine residents frequently hold goals-of-care discussions with patients and families, they report inadequate training in goals-of-care communication (GOCC). Direct observation presents opportunities for formative feedback and competency-based assessment of resident GOCC. However, resident perceptions of direct observation as a teaching modality for enhancing goals-of-care communication have not been described.

Research Objectives. To describe resident perspectives on use of direct observation as a method for improving GOCC among residents.

Methods. Fifteen semi-structured interviews were conducted and recorded. Recordings were transcribed, de-identified, and thematically analyzed in grounded theory framework using NVivo 11. A codebook representing salient themes was created. Two reviewers established strong post-inter-rater reliability, $\kappa = .98$ with 3 (20%) of the interviews.

Results. Residents broadly shared negative attitudes towards direct observation as a learning tool, such as feeling uncomfortable or anxious or that the experience was artificial (53%). However, they reported a willingness to be observed, noting that the observation exercise is valuable in their development of GOCC skills (53%). The majority of residents described GOCC as “higher stakes” than other patient-provider communication (60%). Careful preparation and structuring of the direct observation encounter helped mitigate resident unease about direct observation of GOCC. Residents expressed preference for direct observation by faculty with expertise in GOCC (53%). The primary barrier to direct observation of GOCC was time conflicts (60%).

Conclusion. Residents described the experience of direct observation for GOCC as an uncomfortable, yet useful exercise due to the higher stakes nature of these discussions. The challenges to conducting direct observations did not stem from resident unwillingness, but rather logistics.

Implications for Research, Policy, or Practice. Direct observation of GOCC should be encouraged, and procedures should be put in place to set expectations and allow for time for observation and feedback surrounding resident GOCC.

How Family Caregivers Assist with Upstream Healthcare Decision-Making by Community-Dwelling Persons with Advanced Cancer: A Qualitative Study (S821)



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Objectives

1. Describe the roles of family caregivers in patients' healthcare decision-making in the context of advanced cancer.
2. Describe two implications for outpatient and community-based early oncology palliative care concerning enhancing decision support for family caregivers.

Original Research Background. In the palliative care context, the family caregiver role in patients' healthcare decision-making has focused on being a surrogate decision-maker at end-of-life. Less is known about family caregiver's role in supporting upstream patient decision-making in advanced cancer.

Research Objectives. Describe how family members assist community-dwelling relatives with advanced cancer with current and prospective healthcare decisions.

Methods. Qualitative descriptive study consisting of one-on-one, semi-structured interviews with persons with metastatic cancer and their family caregivers. We elicited family members' perspectives on how they assist their relatives with any current and prospective healthcare decisions. Transcribed interviews were analyzed using a thematic analysis approach. Co-investigators reviewed and refined themes.

Results. Caregivers (n=20) averaged 56 years of age and were mostly female (95%), White (85%), and the patient's partner/spouse (70%). Patients (n=18) averaged 58 years of age and were mostly male (67%) in “fair” or “poor” health (50%) with genitourinary (33%), lung (17%), and hematologic (17%) cancers. Themes describing family member roles in supporting patients' decision-making were: 1) seeking information about the cancer, its trajectory, and different treatments options; 2) identifying treatment and disease decision points, including decisions about

seeking emergent care; 3) ensuring family members have a common understanding of the patient's plan of care; 4) initiating and facilitating conversations with patients about coping, values, beliefs, and "what if" scenarios about current and potential future health states and treatments; 5) implementing choices (e.g., providing transportation) and addressing "spillover" decisions (e.g., work arrangements) resulting from medical treatment choices; and 6) making upstream healthcare decisions on behalf of patients who preferred to have decisions made by their family caregivers.

Conclusion. These data highlight a previously unreported and understudied set of critical decision partnering roles that cancer family caregivers play in patient healthcare decision-making.

Implications for Research, Policy, or Practice. Optimizing these roles may represent novel targets for early palliative care decision support interventions for family caregivers.

A Codified Process for Multidisciplinary Team Consensus Around the Termination of Life Sustaining Treatments (LST) in France: An Interview Study (S822)



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Objectives

1. Describe three ways that the LAT process used at the Paris hospitals in this study enabled nurses and other allied health professionals to feel empowered to co-create consensus surrounding LST decision-making.
2. Demonstrate how a LAT-type process might be applied to an American context to improve consensus, ethical decision-making, and nurse/staff empowerment.

Original Research Background. In 2005, French lawmakers passed the Claeys-Leonetti (C-L) Law, which prohibits futile care and authorized withholding or withdrawing (WD/WH) of futile treatments. This law allowed patients to refuse futile treatments and physicians to WD/WH LST where appropriate, and provided a framework for mandatory multidisciplinary team consensus around LST.

Research Objectives. The objective of this study was to understand how the C-L law influences multidisciplinary team dynamics, clinician empowerment, and the intensity of end-of-life care.

Methods. Semi-structured in-depth interviews were conducted with 13 physicians and 6 nurses (with

additional interviews underway) at two hospitals in Paris. Participants were purposively sampled by seniority and profession/specialty to provide a range of perspectives and contribute to understanding emerging patterns and themes. Transcripts were analyzed using thematic analysis.

Results. Decisions to WH/WD LST are achieved through consensus of the entire multidisciplinary team including physicians, nurses, and at times other allied health professionals. Meetings to decide upon termination of LSTs (réunion de Limitation et Arrêt des Thérapeutiques Actives (LAT)) are an important part of the process and can be called by any team member. Treatment decisions generally do not proceed until every team member is in agreement. This procedure improved nurse and junior physician empowerment, although the degree to which individuals felt comfortable/empowered to speak up was variable.

Conclusion. Since the passage of the C-L Law, decision-making practices at two Parisian hospitals have adapted procedures that provide time and space to achieve consensus amongst the entire interdisciplinary team. These procedures encourage consensus and ethical decision-making around WD/WH of LSTs. More research is needed to determine how best to implement interdisciplinary consensus and the impact on quality of decision-making.

Implications for Research, Policy, or Practice. An intervention using the LAT procedures could improve multidisciplinary team consensus and improve nurse and junior physician empowerment around end-of-life decision-making in the United States.

Defining Palliative Opportunities in Pediatric Patients with Bone and Soft Tissue Tumors (S823)



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Objectives

1. Define and recognize palliative opportunities that occur during a patient's disease course, including how many and when these occur in a patient's course with a bone/soft tissue tumor.
2. Describe the palliative opportunities that preceded a palliative care consultation and the timing of palliative care consultation during these patients' illness.

Original Research Background. Pediatric patients with solid tumors have many opportunities for increased primary or specialty palliative care (PC).