SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Date: 08/12/2018

From
Dr. C. Aravind
Professor and Head,
Department of General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

To
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

Sub: Permission to conduct value-added course: EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS

Respected Madam,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: "Explaining prognosis to a patient with terminal illness" on 04/01/2019. We solicit your kind permission for the same.

Kind Regards

Dr. C. Aravind

Dr. C. ARAVIND, M.D.
Reg.No:68432
Professor & HOD, General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
No. 3, Sri Lakshmi Nagar, Kottakuppam, Puducherry-605 501

FOR THE USE OF DEAN OFFICE

Names of Committee members for evaluating the course:

The Dean: Dr. Jayalakshmi

The HOD: Dr. C. Aravind

The Expert: Dr. Arul Murugan

The committee has discussed about the course and is approved.

Dean

Subject Expert

HOD

Dr. C. ARAVIND, M.D.
Reg.No:68432
Professor & HOD, General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
No. 3, Sri Lakshmi Nagar, Kottakuppam, Puducherry-605 501

OFFICE OF THE DEAN

Sri Lakshmi Narayana Institute of Medical Sciences

OSUDU, AGARAM VILLAGE, VILLIANUR COMMUNE, KUDAPAKKAM POST,
PUDUCHERRY - 605 502.
[Recognised by Medical Council of India, Ministry of Health letter No. U/12012/249/2005-ME (P -II) dt. 11/07/2011]
[Affiliated to Bharath University, Chennai - TN]

Circular

14/12/2018

Sub: Organising Value-added Course: EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS reg

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research**, is organising a Value added course, titled, "EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS" between January 2019 and April 2019 . The course content is enclosed below.

The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 29/12/2018. Applications received after the mentioned date shall not be entertained under any circumstances.

Dean

Encl: Copy of Course content

COURSE PROPOSAL

Course Title: **Explaining prognosis to a patient with terminal illness**

Course Objective: **To create an awareness among students of the Second year M.B.B.S on how to explain prognosis to a patient with terminal illness**

Course Outcome: **The importance of explaining prognosis to a patient with terminal illness has been explained. The psychological aspect of such a news on the clinician, the patient and the family has been explained.**

Course Audience: **A batch of 25 students belonging to the Second year of M.B.B.S**

Course Coordinator: **Dr. C. Aravind**

Course Faculties with Qualification and Designation:

1. Dr. Arul Murugan
   Associate Professor
   Department of Medicine
2. Dr. Venkatasamy
   Professor
   Department of Medicine

Course Curriculum/Topics with schedule

SlNo	Date	Topic	Time	Hours	Name of the faculty
1.	04/01/2019	Terminal illness	5 pm to 8 pm	3 hours	Dr. Arul Murugan
2.	11/01/2019	Preparing to share the news	4: 30 pm to 7: 30 pm	3 hours	Dr. Venkatasamy
3.	25/01/2019	Communicating with the patient and family about the illness	5 pm to 8 pm	3 hours	Dr. Arul Murugan
4.	08/02/2019	Providing options	5 pm to 8 pm	3 hours	Dr. Venkatasamy
5.	22/02/2019	Dealing with grief	5 pm to 8 pm	3 hours	Dr. Arul Murugan
6.	08/03/2019	Making a plan of action	4: 30 pm to 7: 30 pm	3 hours	Dr. Venkatasamy

7.	22/03/2019	Chemotherapy - pros and cons	5 pm to 7 pm	2 hours	Dr. Arul Murugan
8.	29/03/2019	Advancements in radiotherapy	5 pm to 7 pm	2 hours	Dr. Venkatasamy
9.	05/04/2019	Pain relief in terminal illness	4 pm to 6 pm	2 hours	Dr. Arul Murugan
10.	12/04/2019	The healer needs healing too!	4 pm to 7 pm	3 hours	Dr. C. Aravind
11.	19/04/2019	Preparing for the worst	4 pm to 7 pm	3 hours	Dr. Arul Murugan
			Total Hours	30	

REFERENCE BOOKS:

1. **HARRISON'S PRINCIPLES OF INTERNAL MEDICINE; 18th EDITION**
2. **OXFORD TEXTBOOK OF MEDICAL ONCOLOGY**

VALUE ADDED COURSE

1. Name of the programme and code

   EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS; IM10

2. Duration & period

   30 hrs; between January 2019 – April 2019

3. Information Brochure and course content of value-added courses

   Enclosed as Annexure – I

4. List of students enrolled

   Enclosed as Annexure – II

5. Assessment procedures:

   Short notes – Enclosed as Annexure – III

6. Certificate model

   Enclosed as Annexure – IV

7. No. of times offered during the same year

   1; January 2019 – April 2019

8. Year of discontinuation

   2019

9. Summary report of each program year wise:

VALUE ADDED COURSE: January 2019 – April 2019					
Sl. No.	Course code	Course name	Resource persons	Target Students	Strength and year
1	IM10	EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS	Dr. Arul Murugan Dr. Venkatasamy	Second year MBBS	25 (January 2019 – April 2019)

10. Course feedback

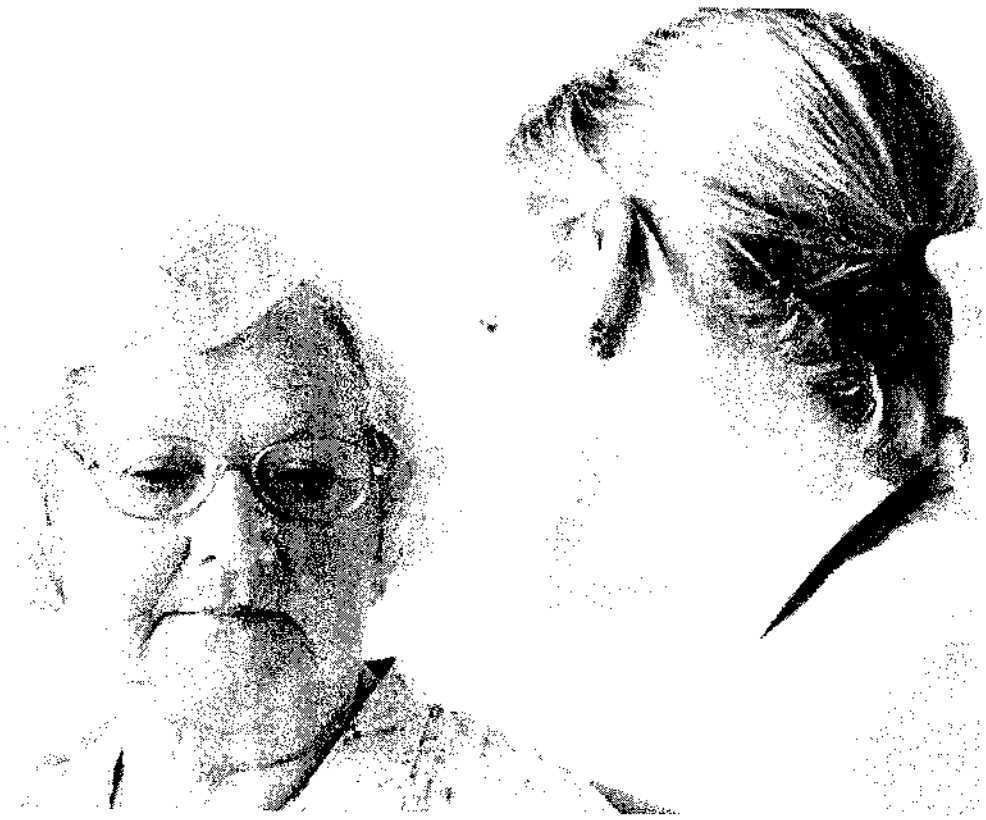
    Enclosed as Annexure - V

RESOURCE PERSON – Dr. Arul Murugan

COORDINATOR – Dr. C. Aravind

ANNEXURE – I

PARTICIPANT HANDBOOK



EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS

COURSE DETAILS

PARTICULARS	DESCRIPTION
Course title	EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS
Course code	IM10
Objective	1. Terminal illness 2. Preparing to share the news 3. Communicating with the patient and family about the illness 4. Providing options 5. Dealing with grief 6. Making a plan of action 7. Chemotherapy – pros and cons 8. Advancements in radiotherapy 9. Pain relief in terminal illness 10. The healer needs healing too! 11. Preparing for the worst
Key competencies	On successful completion of the course, the students will have a better knowledge on how to explain prognosis to a patient with terminal illness
Target students	Second year MBBS
Duration	30 hours; between January 2019 – April 2019
Assessment procedure	Short note questions

EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS

Terminal illness or end-stage disease is a disease that cannot be cured or adequately treated and is reasonably expected to result in the death of the patient. This term is more commonly used for progressive diseases such as cancer or advanced heart disease than for trauma. In popular use, it indicates a disease that will progress until death with near absolute certainty, regardless of treatment. A patient who has such an illness may be referred to as a terminal patient, terminally ill or simply terminal. There is no standardized life expectancy for a patient to be considered terminal, although it is generally months or less. Life expectancy for terminal patients is a rough estimate given by the physician based on previous data and does not always reflect true longevity. An illness which is lifelong but not fatal is a chronic condition.

Terminal patients have options for disease management after diagnosis. Examples include caregiving, continued treatment, hospice care, and physician-assisted suicide. Decisions regarding management are made by the patient and his or her family, although medical professionals may give recommendations or more about the services available to terminal patients.

Lifestyle after diagnosis varies depending largely on management decisions and also the nature of the disease, and there may be living restrictions depending on the condition of the patient. Oftentimes, terminal patients may experience depression or anxiety associated with oncoming death, and family and caregivers may struggle with psychological burdens as well. Psycho-therapeutic interventions may help alleviate some of these burdens, and is often incorporated in palliative care.

Because terminal patients are aware of their oncoming deaths, they have more time to prepare advance care planning, such as advance directives and living wills, which have been shown to improve end-of-life care. While death cannot be avoided, patients can still strive to die a good death.

By definition, there is not a cure or adequate treatment for terminal illnesses. However, some kinds of medical treatments may be appropriate anyway, such as treatment to reduce pain or ease breathing.

Some terminally ill patients stop all debilitating treatments to reduce unwanted side effects. Others continue aggressive treatment in the hope of an unexpected success. Still, others reject conventional medical treatment and pursue unproven treatments such as radical dietary modifications. Patients' choices about different treatments may change over time.

Palliative care is normally offered to terminally ill patients, regardless of their overall disease management style, if it seems likely to help manage symptoms such as pain and improve quality of life. Hospice care, which can be provided at home or in a long-term care facility, additionally provides emotional and spiritual support for the patient and loved ones. Some complementary approaches, such as relaxation therapy, massage, and acupuncture may relieve some symptoms and other causes of suffering.

Communication and continuous assessment of management goals are key components to addressing terminal illnesses. Physicians must be clear about the likely outcome of the illness(es) and provide an anticipated schedule with goals and landmarks in the care process. When the goals of care have changed from cure to palliation, that transition must be clearly explained and defended.

CAREGIVING

Terminal patients often need a caregiver, who could be a nurse, licensed practical nurse or a family member. Caregivers can help patients receive medications to reduce pain and control symptoms of nausea or vomiting. They can also assist the individual with daily living activities and movement. Caregivers provide assistance with food and psychological support and ensure that the individual is comfortable.

The patient's family may have questions and most caregivers can provide information to help ease the mind. Doctors generally do not provide estimates for fear of instilling false hopes or obliterate an individual's hope.

In most cases, the caregiver works along with physicians and follows professional instructions. Caregivers may call the physician or a nurse if the individual:

- experiences excessive pain.
- is in distress or having difficulty breathing.
- has difficulty passing urine or is constipated.
- has fallen and appears hurt.
- is depressed and wants to harm themselves.
- refuses to take prescribed medications, raising ethical concerns best addressed by a person with more extensive formal training.
- or if the caregiver does not know how to handle the situation.

Most caregivers become the patient's listeners and let the individual express fears and concerns without judgment. Caregivers reassure the patient and honor all advance directives. Caregivers respect the individual's need for privacy and usually hold all information confidential.

PALLIATIVE CARE

Palliative care focuses on addressing patients' needs after disease diagnosis. While palliative care is not disease treatment, it addresses patients' physical needs, such as pain management, offers emotional support, caring for the patient psychologically and spiritually, and helps patients build support systems that can help them get through difficult times. Palliative care can also help patients make decisions and come to understand what they want regarding their treatment goals and quality of life.

Palliative care is an attempt to improve patients' quality-of-life and comfort, and also provide support for family members and carers.Additionally, it lowers hospital admissions costs. However, needs for palliative care are often unmet whether due to lack of government support and also possible stigma associated with palliative care. For these reasons, the World Health Assembly recommends development of palliative care in health care systems.

Palliative care and hospice care are often confused, and they have similar goals. However, hospice care is specifically for terminal patients while palliative care is more general and offered to patients who are not necessarily terminal.

HOSPICE CARE

While hospitals focus on treating the disease, hospices focus on improving patient quality-of-life until death. A common misconception is that hospice care hastens death because patients "give up" fighting the disease. However, patients in hospice care often live the same length of time as patients in the hospital. A study of 3850 liver cancer patients found that patients who received hospice care, and those who did not, survived for the same amount of time. In fact, a study of 3399 adult lung cancer patients showed that patients who received hospice care actually survived longer than those who did not. Additionally, in both of these studies, patients receiving hospice care had significantly lower healthcare expenditures.

Hospice care allows patients to spend more time with family and friends. Since patients are in the company of other hospice patients, they have an additional support network and can learn to cope together. Hospice patients are also able to live at peace away from a hospital setting; they may live at home with a hospice provider or at an inpatient hospice facility.

MEDICATIONS FOR TERMINAL PATIENTS

Terminal patients experiencing pain, especially cancer-related pain, are often prescribed opioids to relieve suffering. The specific medication prescribed, however, will differ depending on severity of pain and disease status.

There exist inequities in availability of opioids to terminal patients, especially in countries where opioid access is limited.

A common symptom that many terminal patients experience is dyspnea, or difficulty with breathing. To ease this symptom, doctors may also prescribe opioids to patients. Some studies suggest that oral opioids may help with breathlessness. However, due to lack of consistent reliable evidence, it is currently unclear whether they truly work for this purpose.

Depending on the patient's condition, other medications will be prescribed accordingly. For example, if patients develop depression, antidepressants will be prescribed. Anti-inflammation and anti-nausea medications may also be prescribed.

CONTINUED TREATMENT

Some terminal patients opt to continue extensive treatments in hope of a miracle cure, whether by participating in experimental treatments and clinical trials or seeking more intense treatment for the disease. Rather than to "give up fighting," patients spend thousands more dollars to try to prolong life by a few more months. What these patients often do give up, however, is quality of life at the end of life by undergoing intense and often uncomfortable treatment. A meta-analysis of 34 studies including 11,326 patients from 11 countries found that less than half of all terminal patients correctly understood their disease prognosis, or the course of their disease and likeliness of survival. This could influence patients to pursue unnecessary treatment for the disease due to unrealistic expectations.

TRANSPLANT

For patients with end stage kidney failure, studies have shown that transplants increase the quality of life and decreases mortality in this population. In order to be placed on the organ transplant list, patients are referred and assessed based on criteria that ranges from current comorbidities to potential for organ rejection post transplant. Initial screening measures include: blood tests, pregnancy tests, serologic tests, urinalysis, drug screening, imaging, and physical exams.

For patients who are interested in liver transplantation, only patients with acute liver failure have the highest priority over patients with only cirrhosis. Acute liver failure patients will present with worsening symptoms of somnolence or confusion (hepatic encephalopathy) and thinner blood (increased INR) due to the liver's inability to make clotting factors.Some patients could experience portal hypertension, hemorrhages, and abdominal swelling (ascites). Model for End Stage Liver Disease (MELD) is often used to help providers decide and prioritize candidates for transplant.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide (PAS) is a highly controversial concept, only legal in a few countries. In PAS, physicians, with voluntary written and verbal consent from the patient, give patients the means to die, usually through lethal drugs. The patient then chooses to "die with dignity," deciding on his/her own time and place to die. Reasons as to why patients

choose PAS differ. Factors that may play into a patient's decision include future disability and suffering, lack of control over death, impact on family, healthcare costs, insurance coverage, personal beliefs, religious beliefs, and much more.

PAS may be referred to in many different ways, such as aid in dying, assisted dying, death with dignity, and many more. These often depend on the organization and the stance they take on the issue.

Some groups favor PAS because they do not believe they will have control over their pain, because they believe they will be a burden on their family, and because they do not want to lose autonomy and control over their own lives among other reasons. They believe that allowing PAS is an act of compassion.

While some groups believe in personal choice over death, others raise concerns regarding insurance policies and potential for abuse. According to Sulmasy et al., the major non-religious arguments against physician-assisted suicide are quoted as follows:

(1) "it offends me", suicide devalues human life;

(2) slippery slope, the limits on euthanasia gradually erode;

(3) "pain can be alleviated", palliative care and modern therapeutics more and more adequately manage pain;

(4) physician integrity and patient trust, participating in suicide violates the integrity of the physician and undermines the trust patients place in physicians to heal and not to harm"

Again, there are also arguments that there are enough protections in the law that the slippery slope is avoided. For example, the Death with Dignity Act in Oregon includes waiting periods, multiple requests for lethal drugs, a psychiatric evaluation in the case of possible depression influencing decisions, and the patient personally swallowing the pills to ensure voluntary decision.

Physicians and medical professionals also have disagreeing views on PAS. Some groups, such as the American College of Physicians (ACP), the American Medical Association (AMA), the World Health Organization, American Nurses Association, Hospice Nurses Association, American Psychiatric Association, and more have issued position statements against its legalization.

The ACP's argument concerns the nature of the doctor-patient relationship and the tenets of the medical profession. They state that instead of using PAS to control death: "through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter."

Other groups such as the American Medical Students Association, the American Public Health Association, the American Medical Women's Association, and more support PAS as an act of compassion for the suffering patient.

In many cases, the argument on PAS is also tied to proper palliative care. The International Association for Hospice and Palliative Care issued a position statement arguing against considering legalizing PAS unless comprehensive palliative care systems in the country were in place. It could be argued that with proper palliative care, the patient would experience fewer intolerable symptoms, physical or emotional, and would not choose death over these symptoms. Palliative care would also ensure that patients receive proper information about their disease prognosis as not to make decisions about PAS without complete and careful consideration.

MEDICAL CARE

Many aspects of medical care are different for terminal patients compared to patients in the hospital for other reasons.

DOCTOR–PATIENT RELATIONSHIPS

Doctor–patient relationship is crucial in any medical setting, and especially so for terminal patients. There must be an inherent trust in the doctor to provide the best possible care for the patient. In the case of terminal illness, there is often ambiguity in communication with the patient about his/her condition. While terminal condition prognosis is often a grave matter, doctors do not wish to quash all hope, for it could unnecessarily harm the patient's mental state and have unintended consequences. However, being overly optimistic about outcomes can leave patients and families devastated when negative results arise, as is often the case with terminal illness.

MORTALITY PREDICTIONS

Often, a patient is considered terminally ill when his or her estimated life expectancy is six months or less, under the assumption that the disease will run its normal course based on previous data from other patients. The six-month standard is arbitrary, and best available estimates of longevity may be incorrect. Though a given patient may properly be considered terminal, this is not a guarantee that the patient will die within six months. Similarly, a patient with a slowly progressing disease, such as AIDS, may not be considered terminally ill if the best estimate of longevity is greater than six months. However, this does not guarantee that the patient will not die unexpectedly early.

In general, physicians slightly overestimate the survival time of terminally ill cancer patients, so that, for example, a person who is expected to live for about six weeks would likely die around four weeks.

A recent systematic review on palliative patients in general, rather than specifically cancer patients, states the following: "Accuracy of categorical estimates in this systematic review ranged from 23% up to 78% and continuous estimates over-predicted actual survival by, potentially, a factor of two." There was no evidence that any specific type of clinician was better at making these predictions.

HEALTHCARE SPENDING

Healthcare during the last year of life is costly, especially for patients who used hospital services often during end-of-life.

In fact, according to Langton et al., there were "exponential increases in service use and costs as death approached."

Many dying terminal patients are also brought to the emergency department (ED) at the end of life when treatment is no longer beneficial, raising costs and using limited space in the ED.

While there are often claims about "disproportionate" spending of money and resources on end-of-life patients, data have not proven this type of correlation.

The cost of healthcare for end-of-life patients is 13% of annual healthcare spending in the U.S. However, of the group of patients with the highest healthcare spending, end-of-life patients only made up 11% of these people, meaning the most expensive spending is not made up mostly of terminal patients.Many recent studies have shown that palliative care and hospice options as an alternative are much less expensive for end-of-life patients.

PSYCHOLOGICAL IMPACT

Coping with impending death is a hard topic to digest universally. Patients may experience grief, fear, loneliness, depression, and anxiety among many other possible responses. Terminal illness can also lend patients to become more prone to psychological illness such as depression and anxiety disorders. Insomnia is a common symptom of these.

It is important for loved ones to show their support for the patient during these times and to listen to his or her concerns.

People who are terminally ill may not always come to accept their impending death. For example, a person who finds strength in denial may never reach a point of acceptance or accommodation and may react negatively to any statement that threatens this defense mechanism.

IMPACT ON PATIENT

Depression is relatively common among terminal patients, and the prevalence increases as patients become sicker. Depression causes quality of life to go down, and a sizable portion of patients who request assisted suicide are depressed. These negative emotions may be heightened by lack of sleep and pain as well. Depression can be treated with antidepressants and/or therapy, but doctors often do not realize the extent of terminal patients' depression.

Because depression is common among terminal patients, the American College of Physicians recommends regular assessments for depression for this population and appropriate prescription of antidepressants.

Anxiety disorders are also relatively common for terminal patients as they face their mortality. Patients may feel distressed when thinking about what the future may hold, especially when considering the future of their families as well. It is important to note, however, that some palliative medications may facilitate anxiety.

COPING FOR PATIENTS

Caregivers may listen to the concerns of terminal patients to help them reflect on their emotions. Different forms of psychotherapy and psychosocial intervention, which can be offered with palliative care, may also help patients think about and overcome their feelings. According to Block, "most terminally ill patients benefit from an approach that combines emotional support, flexibility, appreciation of the patient's strengths, a warm and genuine relationship with the therapist, elements of life-review, and exploration of fears and concerns."

IMPACT ON FAMILY

Terminal patients' families often also suffer psychological consequences. If not well equipped to face the reality of their loved one's illness, family members may develop depressive symptoms and even have increased mortality. Taking care of sick family members may also cause stress, grief, and worry. Additionally, financial burden from medical treatment may be a source of stress.

COPING FOR FAMILY

Discussing the anticipated loss and planning for the future may help family members accept and prepare for the patient's death. Interventions may also be offered for anticipatory grief. In the case of more serious consequences such as depression, a more serious intervention or therapy is recommended.

Grief counseling and grief therapy may also be recommended for family members after a loved one's death.

DYING

When dying, patients often worry about their quality of life towards the end, including emotional and physical suffering.

In order for families and doctors to understand clearly what the patient wants for himself or herself, it is recommended that patients, doctors, and families all convene and discuss the patient's decisions before the patient becomes unable to decide.

ADVANCED DIRECTIVES

At the end of life, especially when patients are unable to make decisions on their own regarding treatment, it is often up to family members and doctors to decide what they believe the patients would have wanted regarding their deaths, which is a heavy burden and hard for family members to predict. An estimated 25% of American adults have an advanced directive, meaning the majority of Americans leave these decisions to be made by family, which can lead to conflict and guilt.

Although it may be a difficult subject to broach, it is important to discuss the patient's plans for how far to continue treatment should they become unable to decide. This must be done while the patient is still able to make the decisions, and takes the form of an advance directive. The advance directive should be updated regularly as the patient's condition changes so as to reflect the patient's wishes.

Some of the decisions that advance directives may address include receiving fluids and nutrition support, getting blood transfusions, receiving antibiotics, resuscitation (if the heart stops beating), and intubation (if the patient stops breathing).

Having an advance directive can improve end-of-life care.It is highly recommended by many research studies and meta-analyses for patients to discuss and create an advance directive with their doctors and families.

DO-NOT-RESUSCITATE

One of the options of care that patients may discuss with their families and medical providers is the do-not-resuscitate (DNR) order. This means that if the patient's heart stops, CPR and other methods to bring back heartbeat would not be performed. This is the patient's choice to make and can depend on a variety of reasons, whether based on personal beliefs or medical concerns. DNR orders can be medically and legally binding depending on the applicable jurisdiction.

Decisions like these should be indicated in the advance directive so that the patient's wishes can be carried out to improve end-of-life care.

SYMPTOMS NEAR DEATH

A variety of symptoms become more apparent when a patient is nearing death. Recognizing these symptoms and knowing what will come may help family members prepare.

During the final few weeks, symptoms will vary largely depending on the patient's disease. During the final hours, patients usually will reject food and water and will also sleep more, choosing not to interact with those around them. Their bodies may behave more irregularly, with changes in breathing, sometimes with longer pauses between breaths, irregular heart rate, low blood pressure, and coldness in the extremities. It is important to note, however, that symptoms will vary per patient.

GOOD DEATH

Patients, healthcare workers, and recently bereaved family members often describe a "good death" in terms of effective choices made in a few areas:

Assurance of effective pain and symptom management.

Education about death and its aftermath, especially as it relates to decision-making.

Completion of any significant goals, such as resolving past conflicts.

In the last hours of life, palliative sedation may be recommended by a doctor or requested by the patient to ease the symptoms of death until he or she passes away. Palliative sedation is not intended to prolong life or hasten death; it is merely meant to relieve symptoms.

Seven steps are involved in establishing goals:

1. Ensure that the medical information is as complete as possible and understood by all relevant parties.

2. Explore the pt's goals while making sure the goals are achievable.

3. Explain the options.

4. Show empathy as the pt and the family adjust to changing expectations.

5. Make a plan with realistic goals.

6. Follow through with the plan.

7. Review and revise the plan periodically as the pt's situation changes.

After the diagnosis: How to communicate with terminally ill patients

One of physicians' most difficult duties is to give patients bad news about their health or prognosis. Even with significant advances in medical education on communication in end-of-life discussions, many doctors do not always feel sufficiently prepared for this daunting task. The unease of the situation may cause physicians to avoid having meaningful discussions or communicating adequately with patients diagnosed with a terminal illness and with their families (when appropriate). Failing to communicate effectively can sometimes lead to unwanted consequences such as invasive procedures, rather than focusing on comfort and support for the patient. This, in turn, may precipitate otherwise avoidable complaints and legal actions against physicians.

A recent study identified 11 key elements of end-of-life care discussions with seriously ill patients in hospital. These include, for example, disclosing the prognosis and asking about the

patient's values in the context of healthcare decisions. They also include providing information about expected outcomes, and the risks of life-sustaining treatments and comfort measures. Patients reported that on average only 1.4 of the 11 elements had been discussed during the first few days of being admitted to hospital, and 10% of patients were not told their prognosis.

By preparing for a discussion of bad news, considering how to deal with patients' reactions, and dealing with their own emotional health, physicians can communicate effectively with patients and their families when a patient's prognosis is terminal. This can help patients make informed choices that are consistent with their values and that contribute to quality end-of-life care.

Preparing to share the news

Starting a dialogue early — when definitive test results are known and the physician has made a final diagnosis — is important for helping patients face a terminal illness.

- Rehearse how you will deliver the information. If your experience in delivering bad news is limited, consider observing a more experienced colleague or use role play to practise different scenarios.
- Schedule the discussion in a private, comfortable location. Allow sufficient time, free of interruptions. When possible, and with the patient's permission, have a family member, caregiver, or substitute decision-maker attend.
- Have the patient's medical record, including diagnostic results, on hand.
- Be prepared to provide as much information as a reasonable patient would want and need to know.

Dealing with patient reactions

Doctors may want to prepare the patient and family for the news by saying, "I have received the test results and we need to talk. I'm sorry, but I have bad news." Physicians need to be candid but compassionate, and the information should be presented in a well-organized

manner using plain, non-technical language. The literature offers suggestions for language that may be employed. At all times, it is important to be sensitive to patients' personal and cultural values, and spiritual or religious beliefs.

Most patients need time to process difficult news, and physicians should be prepared for emotional reactions including shock and distress. The discussion should proceed at the patient's pace and according to the patient's emotions. It is also important to listen and to give patients and their family opportunities to ask questions. Supplying written material such as patient aids may help patients better understand their clinical situation.

After having time to absorb the news from the initial discussion, patients and families may request follow-up discussions. During these subsequent discussions, patients should be given the opportunity to ask additional questions, and physicians should be ready to repeat the information or provide more details. At such follow-up meetings, the goals of care, treatment options, and end-of-life preferences should be discussed. The goals of care should be routinely assessed over time and remain focused on compassion and the needs of the patient. The patient's emotional state should be closely monitored. In addition to communicating with the patient and family, when appropriate, the most-responsible physician should also communicate relevant information to the care team. These discussions and actions should be documented in the medical record.

Maintaining hope is crucial for many patients. When a cure is not a likely outcome, hope may be focused on achieving comfort and quality of life. Patients will want to know about their options for palliative care, and families may want to seek available community-based support. This may also be a good time to talk with the patient about whether they want spiritual support and to direct them to resources, as appropriate. The patient needs to know that the physician cares and will provide the necessary support or find resources to do so.

Physicians need support, too

Physicians should be attentive to their own emotions during and after difficult discussions with patients and families. Physicians who feel overwhelmed or stressed may benefit from speaking with a sympathetic colleague, or contacting their provincial physician health program, which can offer individual counselling and support. As physicians' emotional

response continues after work, sharing their feelings with their loved ones, without divulging personal patient information, can also help.

The bottom line

Physicians' attitudes and ability to communicate are essential in helping patients cope with difficult news.

- Remain sensitive to the patient's cultural values and spiritual beliefs, which may help guide how much information a patient wants about their condition. Nevertheless, patients should have sufficient information to enable them to assess their options and make informed decisions about their care and plan the end of life.
- Determine patient understanding of the information being provided, and answer questions honestly and openly. Address any language, cultural, or cognitive barriers to effective communication.
- Demonstrate empathy and support to the patient and family.
- Document the consultations and communication in the medical record.

Annexure II

Bharath Institute of Higher Education and Research

Sri Lakshmi Narayana Institute of Medical Sciences

Participant list with signatures

Value added course: **EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS (dated 04/01/2019)**

Sl.No	Reg.No	Name of the candidate	Signature
1.	U16MB261	ANANYA SHARMA	
2.	U16MB262	ANGALAKUDURU DEEPCHAND	
3.	U16MB263	ANJAN BANERJEE	
4.	U16MB264	ANWESHA CHATTERJEE	
5.	U16MB265	ARCHANA .A	
6.	U16MB266	ARCHITHA.A	
7.	U16MB267	ARIVUMATHI .R	
8.	U16MB268	ARJUN.S	
9.	U16MB269	ASHVANTH KUMAR .A	
10.	U16MB270	ASMITHA S.V	
11.	U16MB282	DEBARPITA NATH	
12.	U16MB283	DEEBAK .I	
13.	U16MB284	DEEKSHITH D.R	
14.	U16MB285	DEEPIKAA D.V	
15.	U16MB286	DELFI MARY .E	
16.	U16MB287	DEVIKA.U.M	
17.	U16MB288	DHAKSHANA .M	
18.	U16MB289	EDA SAI VENKATA TEJA	

19.	U16MB290	GAURAV KUMAR	Gaurav kumar
20.	U16MB277	BLESSY AMALA RISHA .J	Blessy. A. J

ANNEXURE - III

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

EXPLAINING PROGNOSIS FOR A PATIENT WITH TERMINAL ILLNESS

SHORT NOTES

Course Code: IM10

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to prepare oneself before breaking the news to the patient and family?
2. How to help the family take in the news
3. Pain relief in terminal illness
4. Providing options to the patient and family

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - III

EXPLAINING PROGNOSIS FOR A PATIENT WITH TERMINAL ILLNESS

SHORT NOTES

Student Name:

ARJUN.S

Course Code: IM10

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to prepare oneself before breaking the news to the patient and family?
2. How to help the family takein the news
3. Pain relief in terminal illness
4. Providing options to the patient and family

9/10 Good Management

1) Discussing the prognosis and asking about the patients values in context for healthcare decisions. Consider how to deal with patients reactions and dealing with the values and that contributes to quality and end of life care.

2) Reserving time to determine the information schedule to discuss in patients comfortable location. Allocate sufficient time to process the information be prepared to provide as much information as possible a reasonable patient would want and need to know.

3) Patient relief in terminal illness is given through palliative care. pain relief in end of care is crucial because patient should be made comfortable.

4) Additional follow up discussions to provide more information and details, the goals of care, treatment options and end of life preferences should be discussed communication with the family is crucial

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Annexure - III

EXPLAINING PROGNOSIS FOR A PATIENT WITH TERMINAL ILLNESS

SHORT NOTES

Student Name:

ASMITHA . S. V

Course Code: IM10

WRITE SHORT NOTES ON THE FOLLOWING:

1. How to prepare oneself before breaking the news to the patient and family?
2. How to help the family takein the news
3. Pain relief in terminal illness
4. Providing options to the patient and family

6

(1) First initiate the pros of the patient and start with explaining the positive outcome of the illness and explain about the maximum best management done by doctor.

(2) Explain about the proportion of the disease prevalence in the community. Compare the patient with the prevalence of patient in community. Of disease with one patient in community.

(3) Pain relief. (1) Palliative care & counselling (2) Analgesics (morphine)

(4) Explain about organ transplant & other forms, kind of care to patient & family.

ANNEXURE-IV

Sri Lakshmi Narayana Institute of Medical Sciences

CERTIFICATE OF MERIT

This is to certify that _____ARCHANA .A_____ has actively participated in the Value Added Course on **Explaining prognosis to a patient with terminal illness,** conducted between Jan 2019 - April 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. Arul Murugan
RESOURCE PERSON

Dr. C. Aravind
COORDINATOR

ANNEXURE - IV

Sri Lakshmi Narayana Institute of Medical Sciences

CERTIFICATE OF MERIT

This is to certify that _____ANJAN BANERJEE_____

has actively participated in the Value Added Course on **Explaining prognosis to a patient with terminal illness,** conducted between Jan 2019 - April 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

Dr. Arul Murugan
RESOURCE PERSON

Dr. C. Aravind
COORDINATOR

ANNEXURE V

Student Feedback Form

Course Name:**EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS**

Subject Code: **IM10**

Name of Student: Ananya Sharma Roll No.: 216MB261

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear				✓	
2	Course contents met with your expectations				✓	
3	Lecturer sequence was well planned					✓
4	Lectures were clear and easy to understand					✓
5	Teaching aids were effective					✓
6	Instructors encourage interaction and were helpful					✓
7	The level of the course				✓	
8	Overall rating of the course	1	2	3	4	5 ✓

** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory*

Suggestions if any:

Signature

Date: 19/1/2019

ANNEXURE V

Student Feedback Form

Course Name:**EXPLAINING PROGNOSIS TO A PATIENT WITH TERMINAL ILLNESS**

Subject Code: **IM10**

Name of Student: Asmitha .S.V Roll No.: U16 MD 270

We are constantly looking to improve our classes and deliver the best training to you. Your evaluations, comments and suggestions will help us to improve our performance

Sl. NO	Particulars	1	2	3	4	5
1	Objective of the course is clear					✓
2	Course contents met with your expectations					✓
3	Lecturer sequence was well planned					✓
4	Lectures were clear and easy to understand					✓
5	Teaching aids were effective					✓
6	Instructors encourage interaction and were helpful					✓
7	The level of the course					✓
8	Overall rating of the course	1	2	3	4	5 ✓

**** Rating: 5 – Outstanding; 4 - Excellent; 3 – Good; 2– Satisfactory; 1 - Not-Satisfactory***

Suggestions if any:

Date: 10/12/2019

Signature Asmitha S V

Date: 22/04/2019

From
Dr. C. Aravind
Professor and Head,
Department of General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

To
The Dean,
Sri Lakshmi Narayana Institute of Medical Sciences
Bharath Institute of Higher Education and Research
Chennai

Sub: Completion of value-added course: Explaining prognosis to a patient with terminal illness

Respected Madam,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **"Explaining prognosis to a patient with terminal illness"** on 19/04/2019. We solicit your kind action to send certificates for the participants. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards

Dr. C. Aravind

Reg.No:038432
Professor & HOD, General Medicine
Sri Lakshmi Narayana Institute of Medical Sciences
Oragadam, Kadapakkam, Puducherry 606 603.

Encl: Photographs