



TEAM BUILDING: WORKING EFFECTIVELY WITH LOCAL PHYSICIANS

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¹ A companion kit entitled *Conversations on Caring – Volume 1* is available through the CHPCA Marketplace (www.chpca.net) for use in Canada in staff development, continuing professional development (CPD) and health sciences education.

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Suggested Process and Learning Objectives for Problem-based, Small Group Learning and Local Staff/Professional Development Learning Circles

INTRODUCTION AND SUGGESTED LEARNING OBJECTIVES

INTRODUCTION

This transcript is a web-based version for use with a companion MP3 professional development podcast. This MP3 session is also part of a larger set of digital audio recordings forming a resource entitled *Conversations on Caring, Volume 1* (CoC). CoC is a learning resource which has been prepared from previous Pallium Project professional development events. These events are the *Monthly Continuing Professional Development (CPD) Audio-conference Program* series. The *Monthly CPD Audio-conference Program* series was supported in 2005 and 2006 through a contribution from Health Canada's, Primary Health Care Transition Fund (PHCTF) as part of Primary Health Care Renewal in Canada. The views expressed in these sessions do not necessarily reflect the official policies of Health Canada or the employing organizations of members of the Pallium Project's, Community of Practice. These materials have been prepared as "reminder resources" for participants of the original CPD sessions and as learning resources to help support improved access and enhanced quality for provision of Hospice Palliative Care in Canada.

The MP3 audio files and this PDF of the written transcript have been post-produced from the original event in order to provide essential information and enable use, generally within 1 hour time blocks. Each of the sessions has been based on topics which practicing Registered Nurses have identified as important to improving practice and service locally as part of a 2005-2006 audio-conference series entitled *Improving Care in Our Communities*. While program-developed and organized principally from a nursing process and case-management perspective, sessions reflect the inter-professional and trans-disciplinary perspectives of both the Guest Resources/Invited Panelists and the local participants, many whom reflect a diversity of perspectives of social workers, spiritual care providers, primary-care physicians, hospice/palliative program volunteers and others.

SUGGESTED LEARNING OBJECTIVES FOR THIS SESSION

By the end of the session the participant should be able to discuss all or part of the following:

- A functional, working definition of team as applied to palliative service provision in primary-care settings.
- The importance of intentionally including patients and family caregivers within a definition of team.
- Key characteristics of effective teams in hospice palliative care settings.
- The importance of a team approach in provision of hospice palliative care.
- Strategies for ensuring patients and families are included as part of the care team.
- Common challenges in providing hospice palliative care within team-based models.
- Common strategies to support effective inter-professional collaboration among RNs and community-based, primary-care physicians in effective and timely case/medical management of the patient experiencing advanced, end-stage illness.

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Guest Resource
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Moderator
Jacque Peden, RN, MN

Original Air Date – June 23, 2005

JACQUIE PEDEN

It is great having you speak with us today Romayne. Can you define a team? What is a team?

ROMAYNE GALLAGHER

I have a specific definition that I can give to you. It is a group with a specific task or tasks. The accomplishment which requires the interdependent and collaborating efforts of its members. It sounds like a mission statement I suppose. In palliative care, we don't really have a specific team and of course, you who come from smaller sites will say we will never have a palliative care team. We have to form teams around the patient and family when we need them. It is not as though we can have a dedicated team for palliative care at every centre.

In really small centres it could be you and the physician are it – you are the team for everything. The team focuses around the patient and around the family. I think one of the things we can do is really make a difference to patients and families by thinking of ourselves as teams because really end of life care often has a lot of major discontinuities in clinical relationships so particularly when people have cancer and the oncologist says well “I don't have any more to offer to you” or the cardiologist says “I don't need to see you anymore” and people often feel abandoned and let down and having a team that is there to catch them and to pick up the pieces is extremely important.

JACQUIE PEDEN

Do you consider the patient and family part of the team?

ROMAYNE GALLAGHER

Very much so... In fact, they are the reason for the team, but I also think they should be considered as team members. I think we are going to discuss how to include them later.

JACQUIE PEDEN

I just wanted to clarify that. I think that it was very insightful that you said that in some of the smaller communities you won't have access to a multidisciplinary team which often the literature says is important in palliative care. You mentioned very much about the patient and family and I just wanted to clarify that. Can you tell me what the role of the team is?

ROMAYNE GALLAGHER

The role of the team I would say is to care for and support the patient and family through the illness. The team is about the family and about the patient and not about the health care

providers which we will discuss later on. The other purpose of the team is to coordinate care and help navigate the patient and family through the health care system and I think this is a major problem for people today – trying to figure out how to negotiate this thing.

The other thing which I think is a key part of the team is to support each other. The health care providers need to support each other in the difficult work of caring for people and family at the end of life. This is where we help each other. I mentioned before that the team is not about health care providers but in this sense we do support each other and help each other deal with issues. Can I talk about some characteristics of an effective team?

JACQUIE PEDEN

Sure, go ahead.

ROMAYNE GALLAGHER

This is from an article written by Ina Cummings I believe, who is from Nova Scotia which dates back to 1998 from the Oxford Textbook of Palliative Medicine. She was talking about characteristics of effective teams. Her point was that a whole the team than the sum of the individual members. In other words, shared minds work better than individual minds. The leadership role is shared. We kind of know this sometimes that someone will take the role on an issue or patient where other times they might not be the leader.

We need to be flexible in our professional roles because some people have a lot of problem in saying, well, I am the physician and I am the one who is ultimately responsible for this and how can I share my professional responsibility. A confident team knows and trusts each other and does have flexible professional roles. The team is interdependent so the whole team succeeds or the whole team fails. Again it is not about a single individual.

There also should be a sense of fun and belonging and I know in health care, a lot of these days people would say that it is very difficult to find a sense of fun and belonging. I think that it is in teams when you have good relationships that you actually help each other survive through increasing workloads, fewer resources, more stress, etc. and I think it is very important. It also key that members of the team share their vulnerabilities or strengths, so if someone is upset or they failed on a particular issue, then they can talk about that. If I can digress and tell a story – having a group of physicians there and being so pleased that one of them could stand up

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and say, “I am going to lead the discussion by talking about a time when I feel I really failed to look after a patient” and was able to discuss how he felt he had failed to control the patient’s symptoms. Well, actually I think he succeeded because he never abandoned the patient. . The other is the ability to deal with disagreements and anger in a constructive manner and we will talk about that a bit later. Most importantly the team helps each other to grow professionally – we share learning. So, that’s it and that is her thoughts on effective teams.

JACQUIE PEDEN

I liked what she said about shared minds. It really fits. I know I was fortunate that when I worked in hospice palliative care there was at the bedside –probably 10 years ago – I worked in Edmonton on the palliative care team in home care and we had a team and that was all we did (to provide palliative care). We did go out of our way to make sure that we supported one another. Fridays were always popcorn days and we would share bringing in popcorn. I think I ate more than anything at the team meetings. I just remember a really good sense of team cohesiveness and support and that was what helped get through doing the work that I did.

ROMAYNE GALLAGHER

Yes, I know we found often that the ward I worked on, if we had a series of difficult deaths that we declared a coffee afternoon and someone would bake some cake and stuff like that. Often times, and I so well remember a nurse who came to one of these things and she was a new nurse and saying oh, I felt kind of bad because I was crying with Mrs. H when she was telling me about how difficult her illness was – was that unprofessional? We were able to express the fact to her that we thought that she was behaving in a real human way and probably gave a huge amount of comfort to Mrs. H. I think if we had not had that opportunity to talk about that, would that perhaps shut down someone who could grow as a person and share the journey with people.

JACQUIE PEDEN

Why is a team approach to care important?

ROMAYNE GALLAGHER

Well, if you look at the research evidence from the ICU – the degree of coordination of care, in other words, how the team functions is a key predictor of the survival of patients. In palliative care, I think team function is a key predictor of quality of life of the patient and family and also the quality of the death experience for loved ones. I think we have all heard that figure that they quote that the death of one person dramatically affects five people. I don’t know where that came from. It is probably a rural/urban myth or whatever, but we are very mindful of the fact that other people will live their lives remembering this experience and I think the team is a key determinant of how that goes.

The other reason for team approach is some people will have a different rapport with a patient and family and I always remember a lady who was dying of cancer and she was a

nurse. Some people say health care professionals can make the worst patients. This lady was very interesting because she could talk really well with the nurse but wouldn’t really speak to me or the chaplain. We found it was great because if we felt that things weren’t going well, we would just say that she will talk to you and you just go ahead and that was great because that way we were able to provide her with a good death and be helpful to her family.

The other thing is that we do learn from each other and I have learned a tremendous amount working with other health care professionals and working and learning with the patient and family as well.

The other thing is that we share successes and failures. I think we probably don’t think as much about the successes as we do about our difficult families. I wouldn’t call them failures, but you know what I mean. Sometimes other team members are able to see things that we can’t. I hope you don’t mind, but I want to tell another story. I remember this fascinating, elderly lady who had her middle-aged son living with her and I think in fact that this fellow had a degree of mental handicap that we didn’t quite appreciate and he was meeting with the social worker and was behaving a little strangely and he pulled out his gun registration card and showed it to the social worker and said, “See, see what I can do?”. He showed her this and of course she came back to us saying, “Oh my God, this guy is threatening us with showing us his gun card”. She was quite concerned that this might get out of hand. We tried to not keep that in mind too much and didn’t request any bullet proof vests be sent to the ward or anything like that. We talked to him a little but more and realized eventually that what he was trying to show us was not that he was threatening us but that he was such a responsible person that the government trusted him to have a gun and then we were able to figure this out that it was not a threat. It was his way of showing us that he is responsible.

The other thing that I think is so key about team approach is that we are trying to provide whole person care – in other words, we are trying to see someone as a physical, psychological and spiritual being. As Balfour Mount, one of our founders of palliative care in Canada, said to give whole person care, it takes the whole person to do this. I think all of us realize that we bring our own problems, issues, experiences and judgments into the situation and, therefore it is not really possible for us to meet all of the needs of a person who is dying and their family.

We cannot be all things to a patient and family. Sometimes others can help us out with that. I am thinking particularly of I have worked with colleagues who have experienced substance abuse in their family and whether they realize it or not, sometimes they bring some resentment towards that. So when you are trying to work with someone with substance abuse, things might come out that they don’t even realize and it is about what happened to them. The team can help out with that and not only buffer that but help that

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person to understand. I think this is where together we, as a team, can provide whole person care. I also think that if you try to do it alone, it is a recipe for burnout – professional burnout and I think that is why a team helps us survive longer.

JACQUIE PEDEN

Yes, that makes sense to me. Let's talk now about the patient and the family. How can you ensure that they are part of the team?

ROMAYNE GALLAGHER

I, first, think it is an attitude. You first have to see that you are there to meet the needs of the patient and family and I think this really gets put to the test when you have a family who say has different needs other than most families. For example, I am thinking of a lady who was in her thirties and she had a 5 year old boy and she was dying of bowel cancer. She wanted to live until Christmas. This was in August. She wanted us to do absolutely everything and wanted TPN (total parenteral nutrition). Some people would say, "Woah!, wait a minute, that's inappropriate to give to a person who is dying". But it was a challenge for us to say, well, wait a minute and if we are trying to meet her needs – she would desperately like to live as long as possible to spend more time with her little boy and her husband and how can we help her meet those needs? She was going back to a small community and we were able to set up TPN through the local hospital and she was able to live longer. We also knew that medically she could tolerate it. It wasn't as if we had someone who was 90 asking for TPN and we knew that it wouldn't help them to live longer. We knew in this case that it would actually help her to live longer and she could spend more time with her son. That was an example of where we had to say that this is appropriate for this person.

Another example of that that comes up often is those patients who appear to be denying that they are dying. I just recently dealt with an older lady who was a physician and who appeared to be denying that she was dying. She kept saying, "I must find more treatment. I am sure I can live. I am sure I can get a cure" and this was really worrying the homecare nurses because they felt that her death was not going to go well. How could we meet her needs? What we ended up working out with her, was saying we know it is possible to drive down two roads at once. Let's hope for the best but prepare for the worst. I wouldn't have called worst, but preparing for the worst was making arrangements like where did you want to die, who did she want to be there, talking about DNR, things like that and then hoping for the best was her ongoing belief. Looking for a cure worked out quite well for her.

I think we also need to include the patient and family in the meetings and particularly I have seen some meetings where health care providers get the family in there and then they give a monologue of the health care providers reporting on the progress and the discharge plans. I think it is much better

if we start out and say to the patient and family what do you feel is happening, how are things going, and what are your concerns? I think that first helps you find out the language that the family understands. I don't mean language in the sense of French vs. Cantonese – I mean the slang terms they refer about bodily functions and do they call it cancer or do they not call it cancer, do they really understand that their heart is failing, these kind of things.

I also think that if we want to make a patient and family part of the team, we need to be culturally competent in the way we deal with a patient and family. For example, they have a Filipino patient who designates the eldest son as major decision maker and wishes all information to be given to the son. If we don't respect that, we are not really including them as part of the team.

I find that some people still say that we have to let the patient know. When we are learning about different cultures and learning in fact that the patient wishes not to know and wishes their son to make all of the decisions. It is very important that we respect that as a way of including the family. I wanted to add one more thing, Jacquie, because I am thinking that when I say the needs of the patient and family are number one – yes, but the needs of the team members also need to be respected. For example, I had a patient who wanted a surgeon to fix him. He had a bone destroyed by cancer and the cancer was in his arm. He just wanted the surgeon to fix it even if it killed him and the surgeon refused. He was very angry at the surgeon and I had to explain to him that the surgeon has some rights and some concerns. He doesn't want to be part of his death. He doesn't want to do something that he knows is going to kill that person. The team also has feelings and has responsibilities.

JACQUIE PEDEN

Can you talk about some of the challenges of working within a team?

ROMAYNE GALLAGHER

Right... This is where we get to the issue of different personalities and I think that different personalities can enhance a team if we use the energy cooperatively. If it becomes uncooperative it can really can poison a team and make life miserable. Thinking back on all the jobs I have had, you know, it has never been the work, it has always been the people. If the job turns out to be a disaster, it is always the people, never the work. The other thing we need to realize is that disagreement doesn't equal conflict. Disagreement is a difference in ideas, but we don't get emotional about it.

Conflict is when the disagreement is elevated to the level of emotional involvement and that is where it really undermines the team. Now if you have fun on the internet you can look up things like the Myers-Briggs personality type indicators and check yourself out. It is interesting in that you can see what kind of a person am I and it looks at people in terms of attention and energy focus. You know, are you an extrovert

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or an introvert? An extrovert is a person who is spontaneous, is talkative, etc. An introvert is generally a person who sits through meetings and doesn't say anything very much, but then after has a heck of a lot to say. How do you make decisions? Do you base it on logical, analytical things? Do you base it on feeling emotional? Are you a structured and ordered person or a flexible, go with the flow type of person? These kind of things make a huge difference and I think that sometimes understanding how each other works can be helpful.

For example, if you have got someone who is very quiet and does not say very much, they might have some very good things to contribute but they probably need some warning. They can't spontaneously have a meeting and sit down and talk it all out. They need to think a little bit first. The people who tend to shoot from the hip and be intuitive - the ready fire, fire; those who are detail people who evaluate and ponder everything are called the ready aim, aim people. Those people can work well together because they can save the person from starting off in the wrong direction - the go get it person without thinking, whereas, the person who tends to be intuitive and go for it, help the person who is stuck with making decisions. We can work with personalities that way.

The other challenge is to realize that the team leader doesn't equal the decision maker. Although a team may need a leader who is one who takes the initiative, who schedules and plans meetings, this person isn't always the person making the decisions and we need to distribute the decisions amongst the teams or make a team decision together.

The other problem that does tend to come up is that sometimes individuals can use the team to take responsibility for individual things that they should have done. A health care provider must not use the team to avoid responsibilities. We have our individual responsibilities, but we also have team responsibilities as well. I think that we want to move on and talk here. I think we were going to talk around the issues of physicians.

JACQUIE PEDEN

I think that is what everybody is sort of waiting for. What are some strategies the nurses can use effectively with physicians?

ROMAYNE GALLAGHER

I really thought a lot about this one because it is difficult and I think that there is no denying that the way our health care was structured, there was a definite power differential and this makes it really difficult. I think also there are different personality types and I think that physicians used to be chosen to be sort of individual decision makers that had to make a decision and get on with it. In a way this has backfired. I think that things are changing now - the newer medical students and graduating physicians I see are taught that they are part of a team, but I think that we need to

acknowledge that we can't immediately walk away from that power differential, that is, with older physicians that maybe don't understand that. I want to talk about the issue of when particularly a nurse is phoning a physician for an order. I think that this tends to be an area of frustration for nurses?

JACQUIE PEDEN

Yes, definitely.

ROMAYNE GALLAGHER

Say a home care nurse is phoning for an order. A physician gives an order to a nurse and that physician must take responsibility for that order. Really, they are accepting liability for another discipline's work. In order to do this, the physician must trust the nurse's professional skills at assessing the patient.

I think that some physicians take this responsibility more serious than others. In other words, some physicians say, "Sure, do whatever you want" or say to the nurse, "What do you think I should do?" Others say, "I will have to come and see the patient myself" and how to get around those issues. I think that one of the best ways though is in a relationship that is going to be based on trust, if you can demonstrate that you have done the proper assessment of the patient, you will show the physician that they are able to trust your professional work.

For example, a phone call where you might say, well Mrs. B is having a lot more pain over the last few days and I think that we need to increase her morphine. Can we increase to 50 mg sub-q q4? That gives an opinion and some information, but that doesn't show that you have assessed it. So, if you said here is an example of what you think might work a bit better. Mrs. B has neuropathic pain radiating down her left leg. Earlier this week, the pain was 3 out of 10 and she was comfortable with that. Now the same pain is escalated to 7 out of 10. She is currently using 35 mg sub-q q4 hours and 4 breakthroughs of 10 mg yesterday and that still didn't seem to reduce her pain. It was still 7 out of 10. I can't think of any other reasons and there doesn't seem to be anything else responsible for the increase in pain. She has not changed any medications and she is very concerned that the pain is getting unbearable. Can we increase the dose to 50 mg q4 hour with a breakthrough of 32 one hour PRN?

See, you are providing information that backs up your assessment and you're showing the physician that you've kind of done your work and the first example where you just sort of skip the assessment and the information part, you still have done your work, it's just that the physician was not aware of it. Often when the physician gets to know you they will say okay and they will go with it. I think to have that assessment down is quite key. I think that if you are assessing a pain - if you know where the pain is and how the patient describes it.

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I take calls on a 1-800 line in BC and in the Yukon and I find that thing that is often missed when I am speaking with health care providers is what is the pain like for the patient and that is very helpful in deciding whether this is nerve pain or non-nerve pain or whatever so it's very helpful to know that.

I also think that using the scale to measure pain is very helpful to me, to know the medications and to know how many PRN doses have been used. I also think that it is helpful to know how much that the pain is affecting the patient because I think this will give weight to the need for medication because if you say, Mrs. B's pain is 7 out of 10 and she can't get out of bed anymore, then that adds a lot more extra weight to it. I think some suggestions for what to do and I know many nurses will phone me on the 1-800 line before they phone the doctors saying, "Here is the situation, have you got any suggestions?" Some health care authorities in BC (Interior Health Authority) has this and they are online and I think they have some symptom management guidelines and what they will do often is send/fax these symptom management guidelines to the physicians. Let's go back to that issue of impact of symptoms and they fax the guidelines, but they also can fax the symptom assessment sheet. I have seen these sheets and they sort of provide a template for assessments – like where is the pain, what is the level of it, and what are they currently taking. Some nurses find that as they fill out the assessment sheet and fax it and then say to call you in a couple of hours to get a new order. I know it is a couple of hours, but it is a couple of minutes work or maybe more but often times, then the physician says, "Wow, they have really done their stuff, and they have a record of it" and by the time you call they are ready to give you the order that you need. Many people will do that and this same health authority with the symptom assessment sheet will also fax the guidelines, too, as sort of a backup. How about we talk about if you phone in and give the physician an order and they say no.

JACQUIE PEDEN

That was what I was thinking or you phone in and they give you an order like Demerol because they don't have a good understanding of how medications are used or analgesics. What do you do then?

ROMAYNE GALLAGHER

Well, I think I was looking in the nursing literature yesterday and looking about dealing with conflict and a lot of these articles said that as a group nurses tend to be conflict avoidant. What happens is they kind of say, "Oh, okay", hang up and feel really frustrated right and say, "Now what the hell am I going to do because I have a patient that is suffering and I feel that the doctor just hasn't recognized the problem".

I have some strategies that I hope will help with it. What about if the physician says, "No, I don't think we should increase the dose". How about trying something like, "Well I am concerned that Mrs. B. will be in more pain and will be calling you later today if we don't get this under control. Can you suggest a solution to this?" You know to say that, "I am

concerned or I am concerned about Mrs. B. because she cannot get out of bed because of the pain and you may find that she may want to be admitted to the hospital. Can you suggest a solution?"

The other thing that you can do is sort of say both this physician and I want this patient to be comfortable and so what you could do is say, "Dr. so and so, I know we both want her to be comfortable and she is telling me that she is not comfortable currently with this level of pain medication. Can you suggest a way to improve her comfort if we don't increase her medication?"

The other thing to do is – because I find a lot of physicians as you say don't know what to do or aren't comfortable increasing medication. Suppose you give a suggested dose and the doctor says no and gives you a different dose. Say you want a 50 mg dose for your patient and he says well let's raise it from 35 mg to 40 mg. You think, oh damn, that is not going to do any good, so you could say, "Dr. so and so, do you have concerns about raising her morphine dose" or "I am not sure that that would make a difference - studies say that you are supposed to raise the dose by at least 25% to have a positive effect on pain that is out of control". Strategies like that might help and I think that you are gently reminding the physician that they are not solving the problem and that this is a significant problem for the patient. Now you mentioned what to do if they say Demerol or something.

JACQUIE PEDEN

They give you another medication that you know is not appropriate.

ROMAYNE GALLAGHER

Would that be because they are afraid of raising the dose?

JACQUIE PEDEN

It could be because they have no knowledge about palliative care and about the use of Demerol. I have had that happen. Where a doctor said Demerol and not an opioid (morphine or Dilaudid).

ROMAYNE GALLAGHER

Yes, and that is where I say symptom management guidelines come in extremely handy because you can say, "Well I have heard that medication is not the best used in pain management. Can I send some guidelines to you?" I think that would be ok. I don't think physicians would get their knickers in a knot over that but sending them guidelines and sending them papers can be very helpful because I think doctors have to face medical literature when it is presented to them because you are speaking their language. I think that any physician that doesn't know about evidence based medicine now, must have been in a time warp for the past ten years so I think that can be helpful.

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JACQUIE PEDEN

I think that we probably need to move on so that we can get questions from the participants. Did you have anything else to add before we do that?

ROMAYNE GALLAGHER

No, except that I have got two articles that I often find are useful for nurses to present to physicians. One is about the use of opioids and sedatives at the end of life. It is an article about reviewing the literature that shows that morphine doesn't shorten people's lives and that you need to use the right amount to get people comfortable. I don't know Jacquie if there is a way of making these available?

JACQUIE PEDEN

Yes, I think that what we could do is we could send the reference to the Pallium office to Sharman and she could send them out to participants.

ROMAYNE GALLAGHER

Great. One is online and one is in Lancet Oncology. The other article is on the use of opioids for shortness of breath. I find that a lot of physicians seem to avoid the use of opioids for the shortness of breath, when really they are becoming the treatment of first choice for shortness of breath in people with advanced disease.

JACQUIE PEDEN

Ok, first of all I wanted to mention the questions that were actually written on the registration forms. The first one is from Andrea Hoyer from Vernon. She says what do you do when physicians refuse to order appropriate medications and the patient is suffering and there is no palliative physician consultation in the area of the home or free standing hospice? I think that we might have addressed that.

ROMAYNE GALLAGHER

Yes, I think so. With using symptom management guidelines and actually Vernon is in Interior Health so they have their guidelines. I also think to say to the physician that, "You know Mrs. so and so is really suffering and I know that we both want her to be comfortable. What can we do?" I think the physician will then be put on the spot and challenged in a nice way that they have to do something about this. You can always suggest that if you're in BC you can call our 1-800 line. If you are outside of BC, you know suggest that they may call a palliative care unit in one of the cities and ask for some help.

JACQUIE PEDEN

I think we still need to move on here. How can home care nurses empower palliative care patients in relationships with GPs who tell them they will only deal with one problem/issue/need per appointment, therefore, forcing multiple appointments. This is coming from Elaine Klimes from Parksville, BC

ROMAYNE GALLAGHER

Right... The way around that I would say is that most physicians will have times of day in which they can make longer appointments and what may be happening is that the patient says, "I won't be very long but I just really need to see them today" and then they come in and they have about five problems instead of one. I think the thing is to phone up and say, "I need to spend some time with Dr. so and so and I would like to book a longer appointment because I have a number of issues to discuss. Can Dr. so and so make me an appointment when he or she has got the time to spend with me?" Giving the doctor a few days notice is at least helpful. I know I used to schedule end of the day appointments with people where we could sit down and discuss the difficult things and if they gave me advance warning, I can do that.

JACQUIE PEDEN

We have only ten minutes left so I want to move this along because I want to be able to open it up for discussion.

ROWNA NEUFELD - BRANDON, MANITOBA

Hi. Dr. Gallagher had referred to a 1-800 number in which staff could call for advice and suggestions around pain management or other issues. I am just wondering if that 1-800 would be available to us in Manitoba?

ROMAYNE GALLAGHER

If you paid us, yes (*Editorial note: intonation as semi-sarcastic dry humour*). No, this is only available in BC. We did have it available in the Yukon as well. What I understand happens in Manitoba is that you call the Winnipeg Regional Health Authority Palliative Care Team there. They would encourage your phone calls because I think that is what you should do because then you can say, "I spoke with Dr. so and so" when you are dealing with a difficult physician and tell them that they suggested it. What the nurses have told me in BC is that often they say, "I have spoken with Dr. so and so on the 1-800 line and they suggested this" and the doctors will often just go with that.

ROWNA NEUFELD - BRANDON, MANITOBA

Thank you.

JACQUIE PEDEN

Thank you.

FLORENCE LANG – LACOMBE, ALBERTA

Dr. Gallagher, you had said something about a template for assessment and that it was on the website?

ROMAYNE GALLAGHER

It is not on the website, but I think I could pass this on to Jacquie because I have this and it was passed on to me from Fraser Health Authority and I am sure they wouldn't mind me sharing it so, Jacquie, I will pass it on to you and you will pass it on to the Pallium office?

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JACQUIE PEDEN

Yes, I will do that.

FLORENCE LANG – LACOMBE, ALBERTA

Thank you very much.

SHARON GLOVER - SASKATOON, SASKATCHEWAN

I think our question was the same as to how we could get the symptom management guidelines.

ROMAYNE GALLAGHER

Yes, there are symptom management guidelines from Interior Health that are on the web. There are actually and you make a good point that when Pallium gets our Learning Commons Website going we should have some symptom management guidelines up there. There is right now, access to the Alberta White Manual. Are you familiar with that one? It is on the web and it is from the Edmonton Palliative Care Program.

SHARON GLOVER - SASKATOON, SASKATCHEWAN

I see some heads nodding but maybe you could share the information about it?

ROMAYNE GALLAGHER

Yes, Jacquie, do you have the website for it?

JACQUIE PEDEN

No, I don't but it is going to be going national and will be available on the Pallium website.

ROMAYNE GALLAGHER

Yes, but in the meantime, what I will do is also email Jacquie the current area where you can access that because there are some guidelines there which can be helpful. There are a number of online manuals that have that actually and I think that they can be extremely useful in referring physicians to that. Hopefully most physicians are becoming internet savvy and would use that. I think a lot of them do.

ELAINE KLIMES - PARKSVILLE, BRITISH COLUMBIA

Hello Romaine. I really liked your comment about nurses developing trust with physicians in terms of getting orders. The other point I would like to make with that is that it goes both ways. I think that physicians need to earn nurses' trust as well in terms of knowing the drugs and being responsive to the requests for orders.

ROMAYNE GALLAGHER

Yes, you mean physicians need to learn to trust nurses?

ELAINE KLIMES - PARKSVILLE, BRITISH COLUMBIA

I think that physicians need to earn nurses' trust as well. There are a lot of very proficient nurses out there who really know what they are doing and certainly they have a list of doctors who are more responsive than others. It really makes for good team work when everyone can work together and trust each other.

ROMAYNE GALLAGHER

I know and I always considered the home care nurse to be a wonderful help to me and I only wish that I could convince some physicians that that is the case. I think that it is some physicians who take this responsibility of being responsible for another professional and they take it to the nth degree and it is ridiculous. I think it ends up having a negative impact on their patient and that is where I think the nurse says, "Here is the impact this is having on the patient. What would you suggest we do about it?"

ELAINE KLIME - PARKSVILLE, BRITISH COLUMBIA

Absolutely, I agree and that certainly works.

TAMMY M^cCLUSKEY - TRAIL, BRITISH COLUMBIA

Hi Romaine. I just wanted to mention the Canadian Virtual Hospice Website for people, not only patients and family but professionals. There are spots on the bulletin board where you can ask questions about a variety of topics and get very professional answers back.

ROMAYNE GALLAGHER

Thanks Tammy. That is great. I forgot about that. As I hope you have all tried out Canadian Virtual Hospice and it is www.virtualhospice.ca and you can even post questions there that will be answered by the folks in Winnipeg and that can be extremely helpful for people. Can I make one more comment about what to do when you really cannot stand the physician and you are so bloody frustrated with him/her? I think this was on a good conflict website. When you are phoning up and thinking I have really been frustrated with this doctor before, is to separate the people from the problem and when you're making the phone call, to think of something good about that physician. Something like they are committed to their practice and they are willing to go and see their patients and keep that in mind because your voice will be friendlier, you will be more relaxed and you will be more likely to succeed. That is how you start to build trust with people who just frustrate the hell out of you. I only wish I could learn that as well as I could say it.

JACQUIE PEDEN

Well, thank you Romaine. I'd like to thank you for joining us and sharing with us the importance of team and strategies for working within a team effectively.