Summary of Evaluation Results from the Ian Anderson Sessions on Advance Care Planning for Physicians

Initiative #7: Advance Directives on Care Choices Ontario's Strategy for Alzheimer Disease and Related Dementias

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BACKGROUND

One of the goals of Initiative #7: Advance Directives on Care Choices, of Ontario's Strategy for Alzheimer Disease and Related Dementias, was to provide training on advance directives to physicians. Seven Physician Opinion Leader conferences were held by the Ian Anderson Continuing Education Program in End-of-Life Care in 2001 and 2002. These sessions were held in: Dryden (2), Kingston, Marathon (2), Ottawa, and Toronto.

An evaluation form developed by the Ian Anderson Program was used at the end of each session. Session results were shared with the Alzheimer Strategy Evaluator. The following provides a summary of the results from all of the session evaluation forms.

RESULTS

Response Rate

A total of 223 individuals attended the seven sessions. Of these participants, 148 (66%) completed course evaluation forms (see Table 1).

Table 1: Response Rate

Number of Participants	Number of Completed Evaluation Forms	Response Rate
223	148	66%

Attendance across the sessions ranged from 18 to 48 participants (average = 31 participants). The majority of the participants were physicians and nurses (see Table 2).

Table 2: Discipline of the Participants

Discipline	Percent (Number) of Participants (N=223)
Physician	44.8% (100)
Registered Nurse	29.2% (65)
Other (including Social Workers)	18.4% (41)
Did not specify	7.6 % (17)

* Percentages may not sum to 100% because of missing values.

Course Ratings

Participants were asked to provide an overall rating of the session using a 5 point scale (where 1 = "poor" and 5 = "excellent". The average rating across all sessions was 4.4 or between "above average" and "excellent" (see Table 3).

Table 3: Overall Rating of the Sessions (N = 148)

	Poor 1	Below Average 2	Average 3	Above Average 4	Excellent 5	Mean (SD)
Overall, I would rate this program as…	0	.7% (1)	2.7% (4)	53.4% (79)	37.8% (56)	4.36 (0.58)

* Percentages may not sum to 100% because of missing values.

The majority of participants (94%) indicated that there was sufficient time allowed for audience participation (see Table 4).

Table 4: Time for Audience Participation (N = 148)

Was sufficient time allowed for audience participation?	Percentage (Number) of Participants
Yes	93.9% (139)
No	2.7% (4)
No preference	3.4% (5)

* Percentages may not sum to 100% because of missing values.

Participants were asked to rate the clarity and relevance of the speakers using a using a 5 point scale (where 0 = "poor" and 5 = "outstanding"). The average ratings were 4.6 for clarity and 4.5 for relevance or between "4" and "5 - outstanding" (see Table 5).

Table 5: Clarity and Relevance of Speakers

	Poor 0	1	2	3	4	Outstanding 5	Mean (SD)
Clarity (N = 452)*	0	0	.4% (2)	5.5% (25)	29.9% (135)	64.2% (290)	4.58 (0.62)
Relevance (N = 435)*	0	.2% (1)	.5% (2)	6.4% (28)	33.6% (146)	59.3% (258)	4.51 (0.66)

* Percentages may not sum to 100% because of missing values.
** "N" reflects the number of ratings generated across all speakers and all sessions. Three of the sessions had three speakers; four of the sessions had four speakers.

The participants were then provided with a list of statements and were asked to indicate all of the statements that were applicable to them. Many participants (N=121) indicated that the course information would be relevant to their practice (see Table 6). Very few (N = 22) participants indicated that the course would not alter their practice performance. Fifty-one participants indicated that their practice would be altered.

Table 6: Perceptions of the Sessions

This course ….	Number
will be relevant to my practice	121
met stated objectives	86
will not alter my practice, but confirmed my present approach	22
was under undue commercial influence	0
will alter my practice performance	51
will not be relevant to my practice	0
satisfied my expectations	68
made me wished I had stayed home	0

Those participants who indicated that their practice performance would be altered were invited to comment on the ways in which their practice would be changed. These comments are summarized in Table 7.

Table 7: Ways in Which Practice Will Be Altered As A Result Of the Course.

Improved understanding of cultural issues

- Awareness of culture – I will be more informed
- Providing processes and culture
- Better understanding of native issues
- Alteration of culture – I will be more informed
- Thinking processes re culture
- Approach to cultural issues
- Approach to patients based on culture and considering different personalities

Improved communication

- Listen carefully; improve communication
- Increase empathy, understanding and communication skills
- New ways to get information across
- Better Communication;
- More in office discussion of illness

Change in approach to care

- Alteration of my approach to grief
- I work with chemotherapy patients: this will change how I approach symptom management and how to approach time of aplliative care with the patient.
- Care for palliative patients; also extend to non-palliative care as well.
- Will de-emphasize the push on feeding in palliation
- Approach to "DNR" end of life symptom management
- Helped look at new ways of doing things
- Palliative care conference protocol
- Aid me in patient management; give me more options to manage patients with or offer to patients
- Medical information helpful. Will be more aware of the specified pain of my dying patients

Conflict resolution

- Move from cognitive to affective in conflict resolution immediately (I can see where this have caused me trouble in the past)
- Approach to conflict
- Help in conflict; program development
- Communication and conflict resolution+
- I will (hopefully!) step back and prevent conflict more effectively
- Better understanding of conflict resolution; will use it with a family meeting in 2 days
- Conflict resolution skills, sensitivity to patients needs/feelings

Education
- Build a case method; I will use this
- Enhance educational programs
- Use a "Build a Case" in teaching
- Gave me tools for future use for education
- I particularly appreciated the "Create a case" scenario
- Celebrating differences of opinions and using these as drivers to teaching

Increased comfort/confidence
- Increased comfort in addressing EOL issues with patients
- More confident in attempts at recruiting other MD.

Awareness of EOL issues
- More aware of issues around death and terminal illness especially of family issues

Team approach
- Improve teamwork
- Work more with a team approach with family environment
- Increased information re: team functioning
- Involvement with other team members

Participants were invited to make any other comments about the course. These comments were generally positive and are summarized in Table 8.

Table 8: Other Comments about the Course

- Great – lots of information
- I found the information and exercises very informative and helpful
- Very informative, interesting – enjoyed it greatly
- You are excellent resources. Thank you
- Re-affirmed the importance of grief issues/EOL care
- I am delighted. I was wondering if I was coming to a basically medical conference. It has been great. Thank you
- Excellent topic discussion re spirituality/indigenous perspectives on dying; very moving speakers (all)
- The course provided a high level of view of key and significant issues
- Not as much participation
- Have taken home pearls to apply
- Loved the "So Simple ……"
- Validated my belief in opinion leaders
- I didn't find the building case scenario especially helpful
- I was very disappointed with this program, it was mostly for doctors, not for hands on care givers or palliative care teachers
- Might be relevant to my practice in new initiatives in palliative care, help team building. Wasn't quite sure of objectives before, what was purpose of course. Not quite sure how will use but interesting insights into group dynamics.
- Better understanding of barriers/process for change
- More specific discussion as to how to overcome obstructions posed by one's colleagues re using the expertise of others, etc.
- Good idea, great sharing, different setting/forum for networking.
- Not in clinical practice (participant is retired). Committees & community involvement only.
- Need to target family medicine residency programs.

Participants were asked whether the course should be offered again. The majority (89%) of participants indicated that it should be offered again (see Table 9).

Table 9: Offering the Program Again (N = 148)

Should this course be offered again?	Percentage (Number) of Participants
Yes	89.2% (132)
No	1.4% (2)
No preference	3.4% (5)

* Percentages may not sum to 100% because of missing values.

When asked how often the course should be offered, 43% reported annually (see Table 10).

Table 10: Frequency of Course Offering (N = 148)

How often?	Percentage (Number) of Participants
Annually	43.2% (64)
Biannually	28.4% (42)
Other • Possibly over3 years • 3-5 years • 2-3 years • Every 3-5 years • Day with focus on different aspects of palliative care • Not to the same people • As often as possible • Biennially • As needed in community areas • As needed • Every 2 years • Once only • Not with this particular group • Would depend on who is interested. • As needed by interest.	11.5% (17)

* Percentages may not sum to 100% because of missing values.

Finally, participants were invited to comment on what modifications to the course they would suggest. These suggestions are summarized in Table 11.

Table 11: Suggestions for Modifying the Course.

Target Audience

- Make it known, this is for more than just doctors.
- Better advertising to stress not just medical related; more reference to clergy, Alzheimer support groups, etc.
- More oriented towards nurses, social workers, less physician oriented.

Format/Strategies

- At first I was disappointed you weren't following the hand out material more closely, but now I've appreciated the route you followed.
- Perhaps combination and combined presentations mixed with sessions specially geared to interests of individual groups.
- Depending on the audience, more pragmatic focus.
- For this particular version (opinion leaders) it may have been a bit of preaching to the converted. But I thought the emphasis on teaching how to teach, etc. was a great idea.
- The afternoon session on "Build a Case" and [So Simple] Game was problematic and I would not use the last exercise at all.
- Participants to bring examples of current teaching on subject; Liaise with undergrad medicine to ensure consistency.
- Short lectures or 10-minute break.
- Show family video at public forum.
- I know this is not possible but one day and one half and then some time for follow-up.
- Two days is good.
- More case study work, show us how to get it started.
- As directed by SCO – Elizabeth Bruyere – do a lot of community initiatives/outreach.
- Increase number & variety of topics/short sessions. I felt that we talked through the cases for too long. I would have appreciate more/different challenges.
- Similar sessions – additional focus areas.
- Trying to get participants who are otherwise not involved in EOL to try to recruit and interest others in this

Content

- The issue of dementia and EOL could have been adressed more.
- Focused objectives – were we there to learn how to teach EOL care or there to learn about EOL care.
- More on teaching health care providers, especially doctors, to change practice re: EOL care.
- More modular content.
- Deal with conflict/mediation issue for the whole day.
- More practical.
- More problem oriented.
- Increase Aboriginal content.
- Updates to information.
- I understand why it took a medical approach; however, much of the content (drugs, physical symptoms, etc.) is not really appropriate to me.
- Evolve with the specific needs of the palliation community.
- Update and present recent topics as they arise
- Aboriginal component – longer conference to include role plays, psychosocial/spiritual, etc.

Miscellaneous

- More healthy breakfast.
- This is a very useful conference for our area (all areas in Canada). Offering the conference either yearly or every second year at different communities in Northwestern Ontario would be very useful and well attended.
- Different location within north-Western Ontario.
- Dilemma arises health care dollars in oncology care are reflected with the actualtask (physical) such as the # or Rx's, the number of times you start an IV, which is the easy part. The time and hard work is during the interpretive/pt/caregiver relationship which is hard to quantify.

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