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Hospice and the subspecialties in dermatology and death

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DESCRIPTION

Doctors see hospice as the most ideal finish of-life (EOL) care. Early hospice referrals and improved quality of life near death are reported by patients who have EOL discussions. Sadly, this awareness has not resulted in consistent, reassuring, and self-assured discussions about end-of-life care and the admission of patients to hospice. During EOL discussions, patients and their families may not receive important information, even in the intensive care unit. Palliative care specialists are frequently consulted to fill these gaps in the inpatient setting; however, in the outpatient setting, this support may not be available locally. Even though dermatology and other subspecialties are not discussed much in the hospice discussion, this does not mean that they should be ignored. We argue that any doctor who may be involved in the care of a patient near the end of their life needs to be trained not only in how to care for that patient but also in how to have a dignified conversation about the transition into hospice. A single encounter with a patient is all it takes for a doctor to realize how unprepared [1].

Our male patient, who was 69 years old, had had a cardiac transplant 10 years before, and tacrolimus and cellcept were used to suppress his immune system. We examined him numerous times over the years, diagnosing a number of cutaneous squamous cell carcinomas, one of which was a left helix tumor that spread quickly and was treated with Mohs micrographic surgery. He presented with a painful mass in his left neck six months after resection. In his postauricular lymph nodes, a biopsy revealed poorly differentiated squamous cell carcinoma. Multifocal, unresectable disease was discovered during the subsequent radiographic examination. He was referred for evaluation to the head and neck tumor board and pain management [2].

He experienced multiple metastatic cutaneous lesions on his trunk, arms, and nasal tip within two months. Ulceration added to the unusual nature of the eruptive metastatic nasal lesion. Our patient requested relief from a 1.5-cm tumor on his nose that was "bleeding on [his] newspaper in the morning" and, due to its prominent location, psychologically distressing. The patient and his family were aware that resecting this tumor would not prolong his life, but it would improve his symptoms and give him the dignity he desired. Fruitful resection was acted in a short term setting with nearby sedation. At each subsequent visit, the patient and family expressed gratitude for the resolution of the bleeding and disfigurement. A few months later, the patient's family began discussing hospice

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care due to additional metastasis and clinical deterioration. I advised them to contact his "doctor," but the patient and his family responded with "you are his doctor" in a confused manner. The patient's family requested that dermatology coordinate care because the patient did not consistently see a primary care physician. We contacted hospice services after recognizing my grave error, and we continued to see him for the remaining months of his life. Finding appropriate care took less time than with a typical preauthorization [3].

The decision about whether or not to continue with treatment is the most difficult one for a patient and a doctor to make together. Subspecialists rarely face this problem, despite the fact that it occurs frequently in hospitals, oncology, and critical care settings. Nonetheless, it might turn out to be progressively significant as quiet consideration shifts from the long term domain to short term subject matter experts. We believe that all doctors, including subspecialists, should be ready to help patients transition into hospice care.

Physicians need additional training during residency to feel prepared for EOL discussions, despite the increase in hospice exposure during undergraduate training. Implementation ought to occur throughout all residencies, including subspecialties, including oncology and critical care. a good investment because, after just a few sessions using simulated patient encounters, doctors feel more at ease with EOL discussions [4].

Hospice care focuses primarily on psychological and physical comfort and pain management. Our case, in which a metastatic facial tumor was removed, highlights other dignified ways to treat terminal patients. It's likely that each specialty brings something unique to the table. Although hospice is not difficult, many physicians are unaware of the full range of services offered. A brief look at a website like the American Cancer Society can help you get used to the many options. We were pleased to learn about respite care, which relieves caregivers, as well as support for family meetings.

If the training is done in a meaningful and purposeful way, it doesn't have to take a lot of time for doctors to engage in EOL discussions and transition patients into hospice care. However, the impact on our patients' well-being may be significant. Residents should be trained to care for patients with compassion in all stages of life, including their final days, in all residency programs, including subspecialties. Positive feedback analysis revealed that self-pacing and greater accessibility were more effective than traditional learning methods at allowing participants to revisit lessons. The course's high audio/video quality and numerous self-assessment opportunities, according to other participants, led to higher levels of engagement and active learning.

The need for additional images in the course presentations themselves rather than in a supplementary course atlas received the most criticism. Important general characteristics of dermatology education and learning preferences are highlighted by this finding and the demand for more interactive course components. Students wanted more interaction and visual learning, despite being pleased with the course's overall content and delivery. This result is consistent with the fact that dermatology is primarily an observational field. Additionally, it is consistent with data indicating that approximately 80% of medical students prefer visual learning4,5. Additionally, the high percentage of participants who reported network issues (10%) suggests that locally hosted (offline) content may be beneficial to virtual educational tools [5].

CONCLUSION

There are limitations to this qualitative study. Because the virtual curriculum was used at just one school, it didn't cover as many different points of view. Despite this, it adds to the limited body of literature on global dermatology education delivered online. By maximizing images and interactive features and limiting bandwidth requirements, virtual dermatology courses can be improved in light of the advantages of self-pacing and increased accessibility.

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CONFLICT OF INTEREST

None.

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