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Supplementary Data

Discussion Guide

Discussion guide explored 3 areas: (a) ACP real-life tasks (eg, sub-tasks, variability of practice) in the linguistic and cultural context; (b) ACP competencies needed by residents (eg, recurrent communication skills, clinical reasoning non-recurrent skills, attitudes); and (c) training needs (eg, current formats used, perceived gaps)

Introduction

Reminder of the aim of the study + reminder of anonymity

(a) ACP real-life tasks in the HUG context

Are you familiar with the advance care planning?
In the HUG, here in Switzerland, how do you talk about advance care planning?
What do you mean by NTBR code status and GOC?
- If participant trained at another institution / in another country: what are the differences here?

Please reflect on a recent experience with ACP: can you tell us what happened?
- If needed: Where did it happen? Who was involved?
- In this example: what was simple / what was difficult?
- Do you have examples of patient safety issues related to ACP?

What tasks are expected of residents regarding ACP?

(b) Competencies needed

To perform these tasks, what are the competencies needed by residents?
- What kind of knowledge do they need?
- What kind of skills?
- What about their attitudes?

Could you sketch a diagram illustrating how you would organize the skills needed during ACP? (Tentative skills decomposition, individually or collaboratively on a paper board)
- If needed: When do you use this skill automatically, or reflexively?
- When performing this task, what do you have in mind?

(c) Training needs in ACP

Please reflect now on training residents in ACP:
- How have you been trained yourself?
- How is the training currently organized here?

How would you suggest improving this training for residents?

Conclusion

Acknowledgments and perspectives (member-checking meeting and future training)

Abbreviations: ACP, Advance care planning; GOC, goals of care; NTBR, Not to be resuscitated (at the time of the study, this acronym was used instead of DNACPR in the Geneva University Hospitals)

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ACP Training for Residents: Suggestions Using a 4C/ID Framework

(1) Learning tasks
Could be gathered in three task classes, based upon local needs analysis. E.g.:
- Preparing ACP
- Discussing ACP
- Recording ACP

Tasks classes should capture the variability of practice, eg, discussing ACP with patient's relatives and with other healthcare professionals.

(2) Supportive information
Should start at the beginning and is available throughout the training. It aims to help residents developing mental models and cognitive strategies to cope with the non-recurrent aspects of the ACP-related tasks.
eg, videotaped worked examples, residents' supervision with cognitive feedback focusing on non-recurrent skills requiring adaptation to every single situation (such as clinical-reasoning and decision-making skills) while encouraging situational awareness and reflexivity.

(3) Procedural information
Should be provided during each learning task to support residents in developing their recurrent skills.
eg, GOC pocket-sized information sheet; residents' supervision with corrective feedback on their use of structured discussion frames during GOC discussions.
Of note, feedback should be ideally embedded within residents' workplace-based assessment with the tools already used in practice (eg, Entrustable Professional Activity, Multiple-Source Feedback)

(4) Part-task deliberate practice
Could be proposed to improve the level of automaticity of some recurrent skills needed for ACP.
eg, Role plays or simulation to improve the structure of GOC discussions, screen-based simulation to improve the documentation of ACP in electronic health record.