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Training Committee in Palliative Medicine

Clinical Foundation in Palliative Medicine Logbook

SIX SATISFACTORY EXAMPLE CASES

TRAINEE DETAILS

Trainee full name	Dr Enda Lyfe

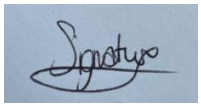
SUPERVISOR DETAILS

Supervisor full name	Dr Sue Pervisor

☒ I have viewed the details of each case with the trainee, and they are of true and accurate information.

☒ I have sighted and discussed this logbook with the trainee and make the following comments:

Dr Lyfe has seen a diverse group of palliative care patients in the consult setting. This is an accurate record of selected patients with a range of symptoms and management challenges. The logbook is supported by guideline and literature sources.

Supervisor's signature (required):		Date:	DD/MM/YY

IMPORTANT INFORMATION

The Clinical Foundation Logbook consists of two sections:

1) Record of cases.
2) Record of courses and educational meetings attended.

The record of 30 cases should demonstrate:

- Experience with a wide variety of clinical scenarios.
- Managing a range of issues in palliative care in the physical, social, psychological and/or spiritual domains.
- Experience interacting with patients' families and/or carers.
- Recognition of when to refer patients to other disciplines and services.
- Personal reflection on the case.

- The learnings gained from each case with appropriate reference to evidence-based practise i.e. journal article, guideline.

Please note:

- The logbook is to be discussed with the supervisor to enhance learning experience.
- The length of each case record must not exceed one page.
- The logbook must be submitted within one month of completing the training rotation.
- The logbook will be reviewed by the Training Committee in Palliative Medicine and the trainee may be asked to resubmit if the logbook does not meet the expected standard.
- The reflection statement for each case should include comparison with similar cases where applicable.

LOGBOOK SUBMISSION

Please submit your logbook via email to: PallMedFoundation@racp.edu.au

If you are scanning this document, please make sure the scan is clear. Please do not send faxes.

Case Number:	**1**	**Date First Reviewed:**	03/02/2025
Patient Details			
Sex:	F	**Age:**	53y
CALD (Culturally and Linguistically Diverse):	☒ Yes ☐ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☐ Yes ☒ No

Domain(s) of Care:

☒ Physical ☒ Psychological ☒ Social ☐ Spiritual

Diagnosis:

Non-small cell lung cancer IV and advanced COPD.
Progressed on palliative chemotherapy with liver, bone and brain metastases.

Main Presenting Symptoms:
(Main symptoms/issues)

Breathlessness, functional decline with weight loss.
Challenges with accepting deteriorating state with little reversibility and refusing community services.
Solo parent of three teenage sons with concern regarding their needs.

Management:

Patient was investigated for infection and pulmonary emboli – negative. Symptoms due to pre – existing COPD now worsened with increasing lung metastases. Assistance from occupational therapist and physiotherapist with non-drug measures including a handheld fan which she liked and energy conserving measures (shower seat, bath robe). Found oral morphine helpful but only wanted as needed dosing.
Social worker input for adjustment to progression and assistance with future planning for children.

Outcomes:

Family “friend” conference held to enable discharge home where the patient wanted to be with her children. Friends developed a roster to provide care and help to maintain a normal routine for the children.

Challenges:

Initially the pt would not accept that more chemotherapy would make her worse.
Needed to demonstrate the use of the handheld fan and persuade trying morphine before exertion. Reassured that there are options to manage side effects, particularly constipation.

Learning Issues:
(Reflection on the case = what did you learn from managing this patient?)

Confronting case, particularly as the patient had tried to “protect” her sons (aged 13y, 15y and 17y) who were not aware how sick their mother was. MDT involved, particularly the SW and OT. Role of “chosen family”.
European Respiratory Society guidelines advise against opioids, however their data did not include patients at the end of life.

Evidence-based safe practise reviewed:

(References i.e. evidence-based guidelines, journal article)

Holland AE et al. ERJ 2024 63(6) European Respiratory Society clinical practice guideline on symptom management for adults with serious respiratory illness.
Cancer Council Talking to Kids About Cancer https://www.cancer.org.au/assets/pdf/talking-to-kids-about-cancer-a-guide-for-people-with-cancer-their-families-and-friends Accessed February 2025

Case Number:	**2**	**Date First Reviewed:**	05/03/2025
Patient Details			
Sex:	M	**Age:**	75y
CALD (Culturally and Linguistically Diverse):	☐ Yes ☒ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☐ Yes ☒ No

Domain(s) of Care:

☒ Physical ☒ Psychological ☒ Social ☐ Spiritual

Diagnosis:

Metastatic pancreas adenocarcinoma – biliary obstruction.

Main Presenting Symptoms:
(Main symptoms/issues)

Severe abdominal, back pain, nausea, anorexia and weight loss.
Existential distress and denial, insisting on ongoing chemotherapy despite progressive disease. Carer fatigue, wife unable to cope with husband's symptoms, poor sleep and "demanding" behaviour.

Management:

Patient was admitted under the surgical team with biliary obstruction. Biliary drains inserted but ongoing obstruction with high bilirubin. Patient cachectic and poor functional status requiring assistance with toileting and bathing. Subcutaneous morphine titrated - drowsy and confused. Switched to methadone and pregabalin added with moderate effect. Patient blamed wife for side-effects of medications. Underwent interventional radiology splanchnic nerve block with improvement in pain. Wife disclosed to nursing staff that her husband had been abusive to her for many years, and she did not know if she could care for him at home.

Outcomes:

Pain eventually improved but the patient continued to lose weight and deteriorate functionally.
Extensive involvement by the social worker to support the patient and his wife.
Patient had another episode of biliary sepsis with shock – all agreed for terminal care.

Challenges:

Balance of analgesia and side-effects.
Meeting the needs of the patient in wanting to go home and concern for his wife's safety.
Repeated explanations of why chemotherapy could not be given.

Learning Issues:
(Reflection on the case = what did you learn from managing this patient?)

I was not familiar with nerve blocks and their indication which was educational. I was educated by the social worker on domestic violence and intimate partner violence which can get worse at the end of life. I found it hard to support the patient when his wife was obviously scared of him but did not want to report him.

Evidence-based safe practise reviewed:
(References i.e. evidence-based guidelines, journal article)

Dong et al. Neurolytic Splanchnic Nerve Block and Pain Relief, Survival, and Quality of Life in Unresectable Pancreatic Cancer: A Randomized Controlled Trial Anaesthesia 2021 35 (4)
Myall et al. Domestic Abuse in the Context of Life-Limiting Illness: A Systematic Scoping Review Health & Soc Care 2023

Case Number:	**3**	**Date First Reviewed:**	24/03/2025
Patient Details			
Sex:	M	**Age:**	49y
CALD (Culturally and Linguistically Diverse):	☐ Yes ☒ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☐ Yes ☒ No

Domain(s) of Care:

☒ Physical ☒ Psychological ☒ Social ☐ Spiritual

Diagnosis:

Glioblastoma multiforme

Main Presenting Symptoms:
(Main symptoms/issues)

Behavioural and personality changes with agitation.
Severe functional decline with dense L hemiparesis and poor sitting balance

Management:

Initial contact with PC in late stages of disease. Patient and wife needed multiple discussions to process disease progression and limits of care. Patient and family worried about effects of medication particularly after the first seizure when midazolam caused prolonged drowsiness. Deterioration in swallowing with family asking for feeding tube.

Outcomes:

Patient deteriorating irreversibly and wanting “everything done”. Patient and wife insisted on discharge home before the MDT could assess and provide equipment only to be readmitted within 24h. Continuous negotiation with patient and wife regarding medications for nausea, agitation and seizures.

Challenges:

The patient’s and wife’s distress was hard to witness and support. I found it challenging to see that he was heading to the final part of his life when he and his wife were focused on “cure”.

Learning Issues:
(Reflection on the case = what did you learn from managing this patient?)

Patient-centred care and setting goals of care when the patient and wife's view was at odds with the medical assessment.
Neuropsychiatric symptoms due to disease and due to medications.

Evidence-based safe practise reviewed:
(References i.e. evidence-based guidelines, journal article)

Patel et al. Palliative Care Issues in Glioblastoma and Weissman et al The Family Meeting Part 6 – Goal Setting and Future Planning. University of Wisconsin Fast Facts Coronatto et al., Palliative care in glioblastoma patients: A systematic review Rev Assoc Med Bras 2024 Jun

Case Number:	**4**	**Date First Reviewed:**	01/05/2025
Patient Details			
Sex:	F	**Age:**	67y
CALD (Culturally and Linguistically Diverse):	☒ Yes ☐ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☒ Yes ☐ No

Domain(s) of Care:

☒ Physical ☒ Psychological ☐ Social ☒ Spiritual

Diagnosis:

Metastatic lung cancer, severe COPD, continued to smoke

Main Presenting Symptoms:
(Main symptoms/issues)

Shortness of breath, functional decline

Management:

Patient was managed with morphine and oxygen. She was very anxious and admitted to being frightened of dying and "choking" to death. She had a traumatic childhood and done everything to protect her children and grandchildren. Patient did not want to die so she could protect her family.

Outcomes:

There was intensive involvement form the social worker. Our service did not have access to a psychologist. The Aboriginal Liaison Officer supported the patient and her family who were coming to terms with the poor prognosis.

Challenges:

Trying to reduce the patients fear and anxiety, managing her distress in the face of deterioration.

Learning Issues:
(Reflection on the case = what did you learn from managing this patient?)

I had to think about a trauma-informed approach particularly with the information the Aboriginal Liaison Officer shared. It is not just the events of the illness that impacted on this lady but life events since childhood and what had happened to her elders. It was distressing to see her distress and learning about compassionate boundaries was very useful.

Evidence-based safe practise reviewed:
(References i.e. evidence-based guidelines, journal article)

Lo A et al. Demoralisation and death anxiety in cancer. Psycho-oncology 2018
https://thephn.com.au/what-we-do/palliative-end-of-life-care/palliative-care-resources-for-aboriginal-and-torres-strait-islander-patients-and-carers
https://palliativecare.org.au/story/palliative-matters-supportive-care-into-the-dreaming/

Case Number:	**5**	**Date First Reviewed:**	02/04/2025
Patient Details			
Sex:	M	**Age:**	72y
CALD (Culturally and Linguistically Diverse):	☒ Yes ☐ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☐ Yes ☒ No

Domain(s) of Care:

☒ Physical ☒ Psychological ☒ Social ☐ Spiritual

Diagnosis:

Progressive diffuse large B cell lymphoma – relapse after CAR T therapy

Main Presenting Symptoms:
(Main symptoms/issues)

Sepsis, recurrent respiratory infection, severe cough.

Management:

Patient had relentless cough.
Excluded and/or treated potential contributors – bronchospasm, GORD.
Started on regular morphine with some effect, added gabapentin with improved sleep.

Outcomes:

Patient had a PET scan that showed significant worsening of his disease. He wanted voluntary assisted dying which his family supported though his wife was unsettled (because of her religious beliefs).

Challenges:

Treating refractory cough and avoiding sedation in order to undergo the VAD process.

Learning Issues:
(Reflection on the case = what did you learn from managing this patient?)

Cough hypersensitivity syndrome.

Evidence-based safe practise reviewed:

(References i.e. evidence-based guidelines, journal article)			
Irwin RS, Madison JM. Unexplained or Refractory Chronic Cough in Adults. N Engl J Med. 2025			
Case Number:	**6**	**Date First Reviewed:**	01/08/2025
Patient Details			
Sex:	F	**Age:**	98y
CALD (Culturally and Linguistically Diverse):	☐ Yes ☐ No	**Aboriginal/Torres Strait Islander or Māori Origin:**	☐ Yes ☒ No
Domain(s) of Care: ☒ Physical ☐ Psychological ☐ Social ☐ Spiritual			
Diagnosis:			
Advanced dementia – probable Alzheimer's disease			
Main Presenting Symptoms: *(Main symptoms/issues)*			
Presented pre-terminal from aspiration pneumonia. Had a clear advance care directive to remain in the nursing home. Only family was a nephew interstate.			
Management:			
Implemented Last Days of Life toolkit with Comfort Observation and Symptom Assessment Chart. Syringe driver with morphine for dyspnoea and midazolam for restlessness. Nursing home could not take back due to infection outbreak.			
Outcomes:			
Patient died 3 days later.			
Challenges:			
Detecting distress and discomfort in a non-verbal patient.			
Learning Issues: *(Reflection on the case = what did you learn from managing this patient?)*			
I did not know there was a Clinical Excellence Commission Last Days of Life Toolkit including a way to monitor patients in the terminal phase.			
Evidence-based safe practise reviewed: *(References i.e. evidence-based guidelines, journal article)*			
https://www.cec.health.nsw.gov.au/improve-quality/system-safety-culture/person-centred-care/end-of-life/last-days-of-life Gupta, Elena, and Pragnesh Patel. Palliative care in dementia Annals of palliative medicine 13, no. 4 (2024)			