

Education in palliative care: winning hearts and minds



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Aims

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To:

- Outline the current state of undergraduate education in palliative care in the UK
- Discuss the current issues with putting this education into practice
- Describe some of our approaches to dealing with these issues

Background

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- Five year undergraduate training programme
- Four year graduate entry

Following graduation:

- Two year foundation programme
- Two year core training
- Four to five year specialty training
- Consultant appointment

Background

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- Approximately half of UK population dies in hospital
- 12 % of hospital population prognosis of <3 months
- Up to 86% of patients' deaths can be predicted
- During their first year Foundation Year 1 doctors will care for
 - 40 patients who die
 - 120 who are in the final months of life

Palliative care education University of Bristol

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- Teaching in year 5
- Part of Senior Medicine and Surgery
- Lecture week oncology and palliative care
- Clinical placements
- 1 day hospice
- Radiotherapy and chemotherapy clinics
- Palliative care consults and MDTs
- Cancer site-specific MDTs

Surveys of UK medical undergraduate education

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- 1983, 1994 and 2000
 - Field D and Wee B
- Palliative care teaching ‘fragmented, ad hoc and lacking in co-ordination and consistency’
 - Lloyd-Williams M, MacLeod RD. *Med Teach* 2004
- Mirrored findings elsewhere in the world

2013 survey

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Methods

- Web-based questionnaire
- All course leaders at all medical schools
 - Progress and divergence in palliative care education for medical students

Walker S, Gibbins J, Barclay S et al Palliat Med Feb 2016

2013 survey - results

8

- Mandatory training – teaching around last days of life, death and bereavement
- All other teaching often optional

- 21/30 courses integrated across the curriculum
- 6/30 module within a course
- 3/30 covered in 1 or 2 lectures

2013 survey - results

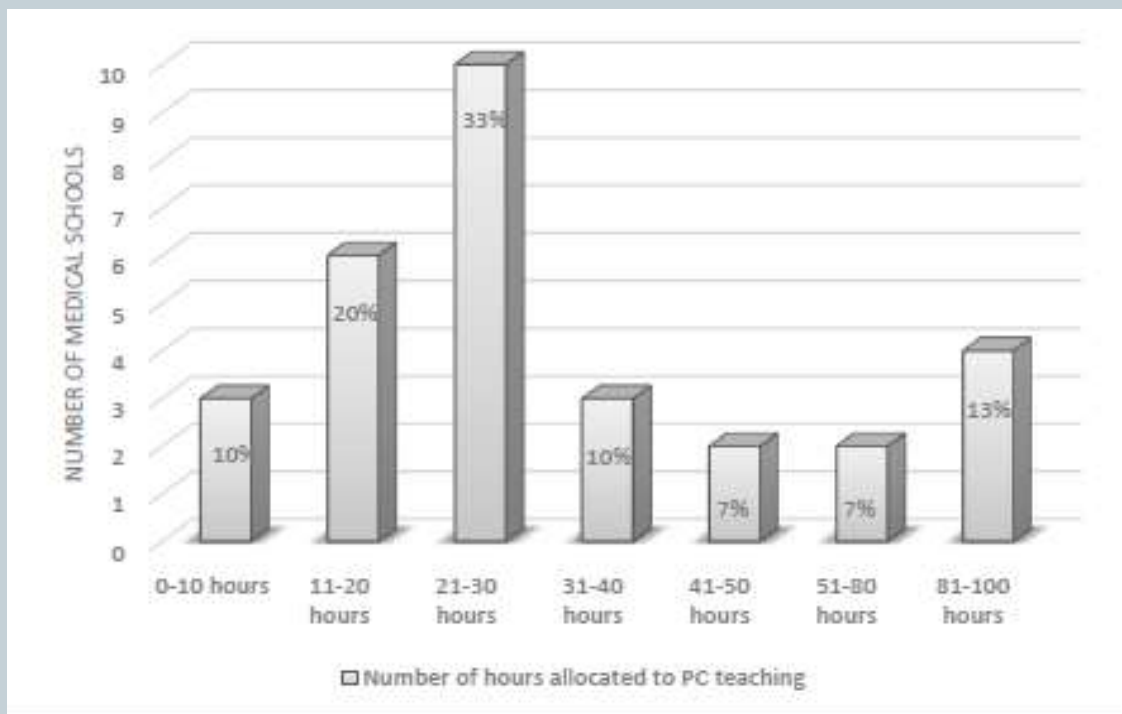
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Time spent in teaching and learning

- 7-98 hours
- Mean 36 hours
- Median 25 hours

2013 survey

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Range of hours of teaching and learning in palliative care UK medical schools

2013 survey – results

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Teaching methods

- Lectures and seminars/small group discussion
- Communication skills courses
- 20/30 direct involvement in clinical areas
- 11/30 patient/carer addressing students
- 12/30 multidisciplinary team meeting attendance

Palliative care (Medical) Education 2015 CSPCP

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- 10/17 Canadian medical schools fewer than 10 hrs palliative care in curriculum – 2011 survey
- Palliative care teaching hours at some medical schools were being reduced
- Residencies & rotations in palliative care limited

2013 survey - results

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14/30 offered e-learning teaching/revision packages

- Pain
- End-of-life care
- Advance care planning
- Patient consultation videos
- Decision tree tutorials
- OSCE revision app

2013 survey - results

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Top three topics

- Pain
- Symptom management
- Certification of death

2013 survey - results

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Teaching topics covered less frequently

- Attitudes towards death and dying
- Communication with family members
- Grief and bereavement
- Psychological aspects of dying
- Religious/cultural perspectives

2013 survey

16

Assessment method	Responses (n=24)	Formative assessment (n)	summative assessment (n=)
No assessment	5 (17%)	–	–
Course work/essay	10 (42%)	6	7
OSCE	21 (88%)	8	16
Long case, multiple/ objective structured long examination record (OSLER/MOSLER)	3 (13%)	3	2
MCQs/single best response	18 (75%)	6	14
Extended matching questions (EMQs)	11 (46%)	3	10
Short-answer questions (SAQs)	2 (8%)	0	2
As part of end-of-year assessment	14 (53%)	4	11
As part of final MB ChB exam	16 (67%)	2	14
Other	2 (8%)	1	1

How/was palliative care assessed?

2013 survey - conclusions

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- All medical schools delivering palliative care teaching
- Teaching increasingly integrated with other specialties
- Mean time close to EAPC recommendations
- Core topics covered
- Most schools now assessing learning

2013 survey - conclusions

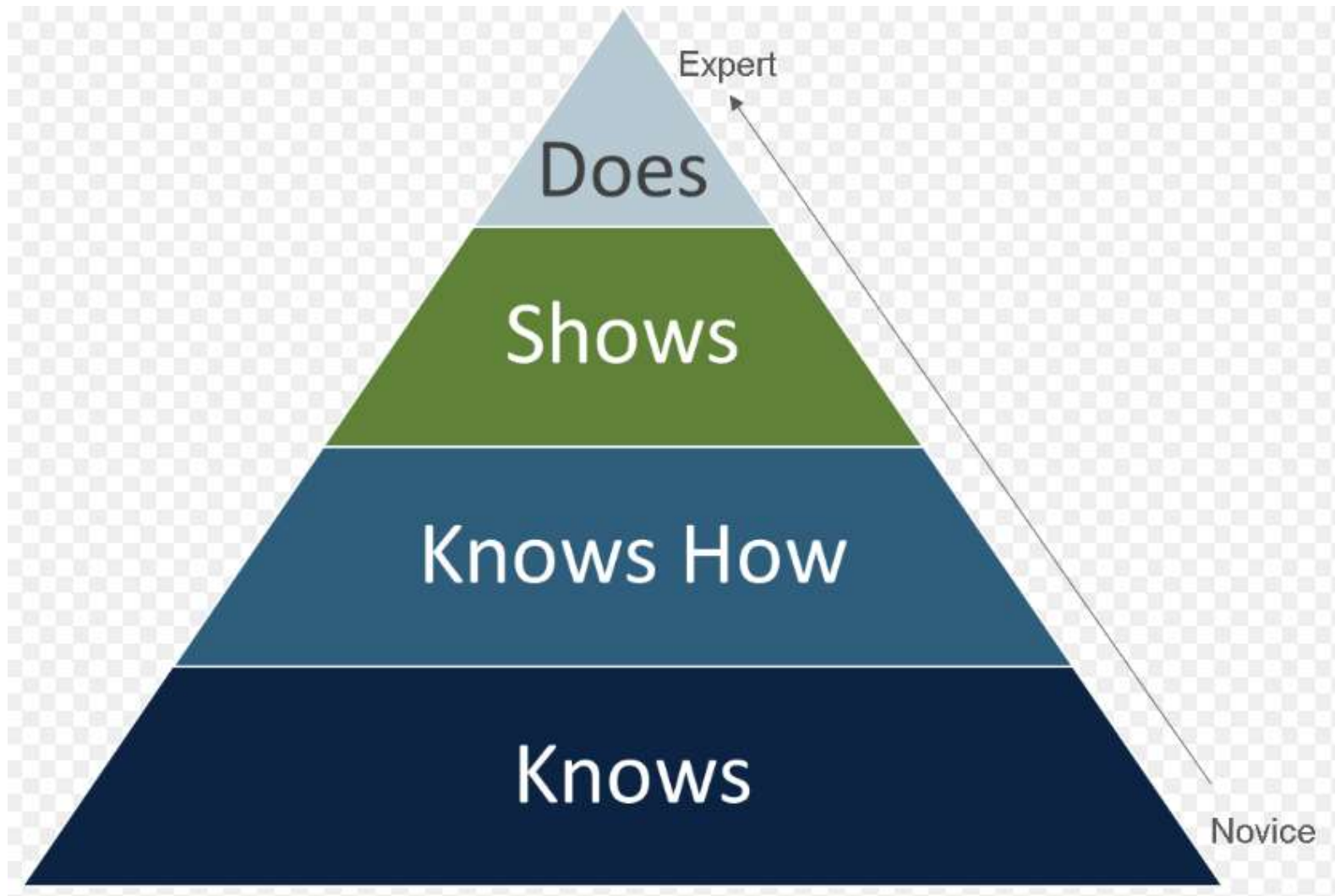
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But

- Time spent variable
- Important topics still not taught uniformly
- Patient content often limited

And

- In some schools possible to graduate without meeting a patient recognised as dying



Adapted from Miller GE, the assessment of clinical skills/competence/performance: Acad Med 1990;65:63-67

Does
Performance integrated into practice Assessed by: <u>Portfolio</u> (YR 3/4), <u>WBA</u>
Shows
Demonstration of learning and clinical skills Assessed by: <u>Portfolio</u> , <u>WBA</u> , <u>OSCE</u>
Knows How
Interpretation / Application of knowledge Assessed by: <u>Portfolio</u> , <u>WBA</u> , <u>OSCE</u> , <u>Written Exams</u>
Knows
Knowledge / Fact gathering Assessed by: <u>Written Exams</u>



Adapted from Miller GE, the assessment of clinical skills/competence/performance:
Acad Med 1990;65:63-67

Simulation

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Palliative care teaching – simulation

- Low fidelity
 - communication skills
 - advance care planning
 - awareness of multidisciplinary roles
 - appreciation of patient/family perspective

Simulation

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Formative assessment using simulation

- Communication skills
- Explanation of patient deterioration
- Prescribing for end of life care
- Explanation around prescribing
- Advance care planning

Simulation

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Palliative care teaching – simulation

- High fidelity (SimMan®) symptom management
active versus comfort care
team working
communication with patient and relatives
etc

Other simulation work

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Patient safety

- Acute care scenarios
- Consultant led
- Consultant makes an error
- Scenario and patient outcome alter accordingly
- How does the team handle the error?

Multidisciplinary simulation work

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Whole ward simulation

- One nurse in charge of ward
- Student ward-based doctor
- Students playing patients and relatives
- Number of scenarios can be run simultaneously
- Multidisciplinary debrief
- Exploration around prioritisation of scenarios

Simulated practice

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Can e-learning simulate practice?

- Usually comprises relatively simple decision processes
- Feedback usually immediate
- Student told only if they were right or wrong

Simulated practice: maze tutorials – background

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- Research indicating students' engagement with palliative care on wards varied
 - a) Students aware of need to learn and got involved
 - b) Students involved themselves if supported
 - c) Students who avoided these patients
- Could we build online tutorials to allow students
 - a) To try out their decision-making?
 - b) To see the consequences of their actions?

Simulated practice – maze tutorials

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- Idea of ‘maze’ tutorial using Quandary
- Initial simple opioid prescribing tutorial
- Developed further into end-of-life care
 - a) as student selected components
 - b) with clinical teaching fellow input
- Evaluated using written feedback and student focus groups

Simulated practice – maze tutorials

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Aims

- To reproduce clinical decision making
- To incorporate the element of time
 - consequences of decisions do not always appear immediately
- Outcomes are the consequences of a combination of decisions
- Intrinsic feedback: the appropriateness of the decision is apparent through a clinical outcome

Simulated practice – maze tutorials

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- Metaphor of a ward round to represent the passing of time
 - the ‘doctor’ may be fast bleeped to attend to omitted aspects of care
- The final outcome for the patient depends on the combination of decisions made over time
- Almost all feedback is presented as outcomes for the patient
 - supported by extrinsic explanations

Restart Back

Written by Professor Karen Forbes - Professorial Teaching Fellow in Palliative Medicine, University of Bristol.

Aim

To improve staff knowledge and skills in caring for patients at the end of life.

Objectives

To help all members of staff to:

- recognise the dying patient
- appreciate their role in caring for the dying patient
- appreciate that care needs change when the patient is diagnosed as dying
- prioritise care needs at the end of life
- be able to explain the role of the UH Bristol End of Life Care Tool in providing individualised care for patients

How to use this material

You may find it helpful to think of this material as a maze. This means that there may be more than way of "solving" it, multiple paths leading to the same place, red herrings and dead ends. It also means that having following a particular path through the material, there will be lots of it that you have not yet seen. Hence we would recommend that you start by choosing what you think is the best path to get to the end, then having done that go back and explore some of the other pathways just to see what will happen.

Start

Exit

Palliative Medicine Decision Tree Tutorial - Copyright United Hospitals Bristol Healthcare Trust 2013 - Learning design and software realisation by [Julian Cook e-Learning Solutions](#)

Restart

Back

Introduction

You are the F1 doctor on call. It is 23:00hrs. The nurses have asked you to see Mrs F because of a deteriorating EWS score.

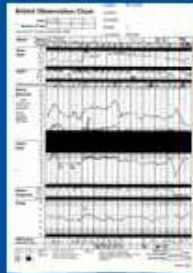
Mrs F is a 73-year-old lady with non-small cell lung cancer. You have not seen Mrs F before.

What do you want to do first?

- Review observations to check pulse, BP, respiratory rate, urine output, temp, oxygen saturation
- Go to see Mrs F
- Look at the drug chart
- Make a judgement about prognosis
- Read the patient notes
- Speak to the nurses
- Talk to other multidisciplinary team members

You check pulse, BP, respiratory rate, urine output, temp, oxygen saturation:
HR 110 BPM
BP 90/60 mmHg
Respiratory rate 25
Urine output 250 mls over last 24 hours
Temperature 37.5°C
Saturations 90% on 20% oxygen

Enlarge the thumbnail to view the obs chart.



What do you want to do next?

- Select Go to see Mrs F
- Select Look at the drug chart
- Select Make a judgement about prognosis
- Select Read the patient notes
- Select Speak to the nurses
- Select Talk to other multidisciplinary team members

You consider you have enough information to make a judgement about prognosis.

Normally you would have spoken to the nurses, read the patient's notes and looked at her drug chart before seeing her. You might also want to talk to other extended team members e.g. Physio, OT in order to make a considered judgement.

Based on the information you have collected, what is your judgement about Mrs F's prognosis?

Select

You believe that this patient is acutely unwell and needs investigations and management

Select

You believe that this patient is deteriorating and probably dying and should be for comfort care

Exit

Caring for Patients with a Poor Prognosis

University Hospitals Bristol 
NHS Foundation Trust

Restart Back

The patient's symptoms were eventually controlled but this could have happened sooner

The patient's symptoms were eventually controlled, but you feel the patient's care would have been improved if the EOL Tool had been implemented fully, or implemented earlier.

See feedback on the right.

Select Continue

What you know so far:

The patient had uncontrolled symptoms: If the doctor had used the EOL Tool earlier or reviewed the patient's drug chart and prescribed appropriate medication in anticipation of end-of-life symptoms the patient's symptom control would have been improved.

You didn't advise the doctor to review the patients' resuscitation status. When the patient died your nursing colleagues were distressed that they had to call the crash team even though the patient's death was expected, since a DNACPR form had not been initiated.

Either the doctor didn't speak to the patient and their family about commencing the EOL Tool, or you recommended commencing the tool before speaking to them. The family contact the ward sister a few days after Mrs F dies, distressed that she may have died more quickly because of the care she received despite reassurances from staff whilst they were on the ward.

Exit

Palliative Medicine Decision Tree Tutorial - Copyright United Hospitals Bristol Healthcare Trust 2013 - Learning design and software realisation by [Julian Cook e-Learning Solutions](#).



Maze tutorial

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Key decision-making points

- The information needed to assess the patient
- Active management versus shift to comfort care
- Making the diagnosis of dying
- Single symptom management vs bigger picture
- Each decision-making point alters the patient's outcome

Maze tutorial - feedback

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- Patient outcome versus right or wrong
- Rarely immediate
- Builds in the background
- Contributes to the quality of the patient's dying process
- Invites reflection and re-exploration

Maze tutorials - evaluation

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Emergent themes – focus groups

- valuable learning experience
- little exposure elsewhere in training
- Consideration of attitudes and beliefs
- making mistakes and dealing with the consequences in a safe environment
- working alongside other learning
- impact on becoming a newly qualified doctor

Maze tutorial - evaluation

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Can we alter attitudes?

- Students asked to complete reflections within the tutorials
- Reflections used as qualitative data set with consent
- Coded into
 - No attitude reflection
 - General reflection on relevant attitude
 - Awareness/surfacing of own attitudes
 - Reflection indicates a change of attitude

Maze tutorial - evaluation

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- 500 responses coded
- 65% included reflection on an attitude
 - 43% a general reflection on an attitude
 - 37% reflected on their own attitudes
 - 19% indicated a change in own attitude

Conclusions – maze tutorials

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- Provides an immersive learning experience
 - Students ‘cared’ about the patient outcome
- Principles eg timelines and feedback worked well

But

- Complex to create; every case has a different structure
- Expensive to create
 - Developed from existing materials
 - 27 hours of meetings; developer cost c £5000

Maze tutorial - evaluation

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Student focus groups

- “This is all very well but you can’t learn this from a computer, you need to be on the wards”

Maze tutorial - evaluation

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Student focus groups

- “I always thought I would know when to stop treating a patient when it was not working, but this tutorial made me realise that I wanted to keep going, just in case there was a chance. What if I stopped and it was the wrong thing to do? It would be my responsibility.”

Maze tutorial - evaluation

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Student focus groups

- “I think one of the most important things I learnt was about the diagnosing dying, and I discovered I was actually really scared of making that decision that this patient would die. And I was really glad that we had a chance to do this in a tutorial format before I was on a ward where I was the one that was having to make that decision.”

Thank you