Educating Toward Attitudes in End-of-Life Care: Opportunities and Constraints in Program Development

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Abstract

With the intent of integrating educational activities into the existing medical school curriculum that prepares the attitudes of medical students to care for the terminally ill, this study seeks to determine the opportunities and constraints that could potentiate or prevent its fruition. This requires a survey of governing agencies, accrediting bodies, the extent of current end-of-life (EOL) program support, and time constraints that ultimately impact program development. We must also understand the core competencies that the physician seeking certification in Hospice and Palliative Medicine (HPM) is required to know (refer to www.ahrq.gov/patients/WH/EOL_competencies2_3.pdf). Imogene King’s dynamic interacting systems framework illuminates the relationships between the factors impacting the development of an EOL program and attitudes conducive to quality EOL care.

Background

The concept of hospice was modernized by London physician Dame Cicely Saunders who believed that care of the dying should be holistic, relieve suffering, and family-centered. The mobility of society disseminated the concept so that at one time supported families through significant life events. Exposing death with dignity, Elizabeth Kubler-Ross and Saunders spread the hospice movement to the US in the 1960’s. EOL care encompasses both palliative and hospice care. Palliation may include life-sustaining treatments, differentiating it from hospice care that begins once the patient no longer seems curative care.

The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. It affirms life and regards dying as a normal process. It intends neither to hasten or postpone death.

The Problem

Traditionally, modern medicine has been curative. However, with death being an inevitability of life, physicians should be provided to prepare a good death to the terminally ill. Caring curative care can be very challenging for the physician whose professional success has depended upon making patients well. Only within the past 20 years have medical schools begun to address the specialized needs of the dying. All schools must include a minimum of EOL content to remain accredited, but research indicates that EOL education is often deficient.

Searching the websites of accredited medical schools, I was able to determine the relative extent of coursework on EOL care using the site search engine, searching departments, courses, content and clinical opportunities as available for each.

<table>
<thead>
<tr>
<th>Inclusion of EOL content</th>
<th># of MD schools</th>
<th># of DO schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusive</td>
<td>6.3%</td>
<td>3%</td>
</tr>
<tr>
<td>Integrated</td>
<td>125</td>
<td>18</td>
</tr>
<tr>
<td>Extensive</td>
<td>45</td>
<td>11.8%</td>
</tr>
</tbody>
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Inclusion = EOL content is offered. Extensive = EOL, though through multiple modalities, special programs. 
Inclusive = EOL content offered as seminar, elective, part of electives.

Opportunities

Opportunities guide and support the development of a quality educational program because they establish standards and propel progress.

- Selecting introductory yet critical EOL concepts from the HPM core competencies can form the foundation for an EOL program.
- National governance
  - The US Secretary of Education – approves agencies that accredit all medical schools as part of the code of federal regulations 34 CFR 602.
  - State medical licensure is overseen by the federal medical boards.
- Patient Self-Determinant Act (1990) – requires that healthcare institutions provide written information about a patient’s rights to make their own decisions, write advance directives, and without or without health care. This law poses an opportunity for EOL education because physicians need to be prepared to grant the expressed wishes of the patient.
- State governance
  - State Medical Boards: require that medical students graduate from an accredited school to obtain licensure.
  - State Medical Boards set such requirements for licensing physicians but all students must take a national exam with EOL content which is submitted to the Boards as part of the process to license physicians.
- Accreditation – the accrediting bodies for both allopathic and osteopathic medical schools state requirements for the inclusion of EOL teaching for the school to remain accredited. The extent of participation varies widely.
- If a school fails its accreditation, its students cannot enter residency or sit for licensure exams.
- Opportunities within the individual medical schools include:
  - Grants, philanthropy, or other funding to develop EOL programs/courses
  - Respected program champions and strong administrative support.

Constraints

Constraints can create barriers to program implementation. If we can anticipate hurdles, we can then prepare to respond to them and work with the resources available to us.

- Funding can present a challenge, particularly in a program that is not profitable, but is the right thing to do.
- Physician education and death among health care professionals continue to resist program support.
- Finding faculty, who are adequately trained in pain management and skills specific to end of life care can be challenging. Recruiting their participation in professional development to learn about EOL care can present an even greater challenge.
- Requirements of substantial time, planning, and persistence within medical schools already overburdened with content and mandates, a history of being resistant to change, and other special interest groups vying for limited resources.

- Retaining the leadership championing the cause long enough to get the program on firm footing.
- Decentralized administration can create difficulties for expedient decision making. Can be counteracted with high level support and diligent communication.
- Diversity presents more of a challenge than a constraint. Must be mindful of student and faculty cultural values concerning death and how to work with the values in the context of patient needs.

Plan

Dedicating a course of study in the undergraduate medical years would be redundant since fellowship training for board certification in HPM already exists. Instead, integrating EOL teaching into the existing curriculum hosts the greatest potential for program viability. Selecting introductory yet critical topics from the HPM core competencies then appropriately timing their placement in the curriculum is an approach that has been used successfully. The inclusion of EOL content is relevant to all areas of medicine. For example:

- Students learn early on that physiologic changes at the EOL are taught as natural phenomena rather than equated with medical failure.
- While learning about Alzheimer’s, students are asked what-if questions such as, “What will be the patient’s quality of life if I place a feeding tube in a patient with late stage Alzheimer’s who can no longer swallow?”
- Teaching students to appreciate the family sacrifice of caregivers’ donation helps them approach anatomy from a different perspective.

Attitudes can affect behaviors and receptivity to patient needs; therefore, educating toward attitudes is requisite in EOL care. The core competencies require that attitudes toward the dying be addressed. Raw play, vignettes, clinical exposure and self-reflection are powerful tools for teaching students to understand their own attitudes.

References


Cicely Saunders

King’s dynamic interacting systems framework: Opportunities and constraints of developing an end-of-life medical educational program that improves medical student attitudes toward care of the dying.