

Providing Quality End-of-Life Care: A Look at the Essentials of Care and the Adequacy of Instruction in Canadian Medical School Curricula

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ABSTRACT

Most Canadian medical students are interested in learning about end-of-life care. Recent research has explored the key elements involved in providing quality care to terminally ill patients and their families. Despite these new insights, limitations surrounding the provision of end-of-life teaching in medical curricula have left many residents feeling unprepared and uncomfortable in clinical encounters with patients that are near life's end. Various medical programs have effectively augmented their curricula to deal with this issue. We hope that Canadian medical students and educators will reassess the quality of their end-of-life care instruction.

KEYWORDS: *end-of-life care, medical education, terminal illness*

The overwhelming majority of today's medical students will be involved in a patient's end-of-life (EOL) care. Fortunately, both medical students and residents have positive attitudes towards caring for EOL patients and believe that these interactions provide meaningful learning experiences.^{1,2} Medical education deans also consider EOL care education to be "very important" and support its incorporation into undergraduate curricula.³ Since our understanding of what constitutes quality EOL care continues to evolve,⁴⁻⁶ so too should the implementation of these insights into medical school curricula. With this in mind, our objectives are to outline the essentials of quality EOL care, to assess the adequacy of instruction in Canadian medical curricula, and to discuss programs that have made steps towards addressing this vital issue.

A recent study has highlighted key factors for medical professionals to consider when approaching clinical encounters in EOL care.⁴ The most important element identified by doctors, patients, and families in the provision of quality EOL care is being able to trust and have confidence in their doctors. Other factors have also been ranked highly by both parties: patients should not be kept on prolonged and unnecessary life-support, honest communication should occur between doctors, patients, and their families concerning the disease process, and finally, patients should be given adequate time to resolve conflicts, say their goodbyes, and prepare for life's end.

Effective communication techniques can minimize the

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distress experienced by families of terminally ill patients. While prognostic discussions may be uncomfortable, they are necessary to provide a shared understanding among patients and family members regarding the patient's outlook and to guard against the unnecessary grief arising from unrealistic expectations. It is the responsibility of the healthcare professional to create an environment where these discussions can occur in an honest and direct manner.⁵

Finally, the value of having a physician with a kind and caring attitude should not be taken for granted. Informal, everyday conversations with patients and families help create some sense of normalcy and humaneness in an otherwise alien situation. Indeed, patients and families, aware of their vulnerability in such settings, strive to maintain good relationships with their doctors, often fearing that complaints may damage the quality of their care.⁶ It is thus a top priority for doctors to promote and maintain a comforting environment where patients and family members will feel satisfied with the memorable interactions that occur at life's end.

It is unfortunate that many junior physicians find dealing with EOL situations to be the most uncomfortable and unknown area in their medical practice.⁷ Medical residents value learning from terminally ill patients; however, lack of training and supervision can contribute to emotional distress.² Barriers to comprehensive teaching of palliative care in Canadian undergraduate medical education include competition for time, resources, and lack of faculty expertise and leadership.⁸ Students often feel that medical culture is not supportive of EOL education, perhaps because physicians feel unprepared to teach EOL care.⁴ Although EOL-related instruction has increased over the past two decades, its implementation in undergraduate education tends to be fragmented, inconsistent, and rarely formally assessed.⁷ The Educating Future Physicians in Palliative and End-of-Life Care (EFPPEC) Project is a unique initiative undertaken to increase and standardize EOL care instruction in Canadian medical education.⁹ By 2008, this nationwide, interdisciplinary team had developed a complete undergraduate EOL curriculum; however, its effectiveness has not yet been formally assessed.

While we are not in the position to make specific recommendations, there are several examples of medical schools that have implemented successful EOL programs, resulting in increased confidence perceived by their students when caring for patients at the end-of-life.^{10–12}

In New Zealand, medical undergraduate students are required to complete intermittent visits with a hospice patient and his/her caregivers over a period of at least one month.¹⁰ These visits are followed with personal reflection regarding the student's emotional responses, thoughts on spirituality, and self-identified areas of improvement for providing care to terminally ill patients in the future. Many students find the program's emphasis on treating the whole person, instead of individual parts of the disease, to be both personally and professionally enriching.

In contrast, a program in New York has focused on teaching EOL care through multiple small group discussions and interactive lectures.¹¹ The curriculum is split into four main topics: pain alleviation, management of distressing symptoms, communicating bad news, and advanced directives. Students then practice effective communication through videotaped interviews with standardized patients. Co-facilitation of the discussions by physicians and ethicists provides an ideal team-teaching model to address decision-making, legal, and ethical issues related to EOL care. Students appreciated the opportunity to practice delivering difficult news to standardized patients before encountering potentially uncomfortable real-life situations.

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The University of Alberta has received generally positive student feedback by integrating both of the aforementioned techniques into its instruction.¹² It splits palliative care teaching into six classroom sessions, involving both small group discussions and didactic lectures. These are followed by a hospice visit and post-visit discussion led by a palliative care expert. The classroom sessions provide an opportunity to clarify information and ask questions before attending the hospice session while the hospice visit provides reinforcement and integration of lecture content.

It is worthwhile noting that virtually any amount and type of educational intervention, especially those with multiple methods of instruction, can improve students' knowledge and competence when encountering EOL situations.^{2,13} Our hope is that this commentary will provide areas of focus for medical schools to enhance the teaching of EOL care in medical curricula and that graduating students may be adequately prepared to meet the needs of terminally ill patients and their families in our aging population. 

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