

Preparing future doctors for palliative care: views of course organisers

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ABSTRACT

Background Effective training at medical school is essential to prepare new doctors to safely manage patients with palliative care (PC) and end of life care (EOLC) needs. The contribution of undergraduate PC course organisers is central but their collective views regarding role are unknown.

Objective To survey attitudes of PC course organisers regarding their course, organisation, the adequacy of training provided and level of personal satisfaction.

Methods An anonymised, multifactorial, web-based questionnaire was devised, tested, modified and then sent to lead PC course organisers at all UK medical schools.

Results Data were obtained from all 30 UK medical schools. Organisers agreed/strongly agreed (=agreed) that their PC course was highly rated by students (26, 87%). 25 (83%) agreed their course 'enabled misconceptions and fears about PC, death, dying and bereavement to be addressed', 'delivered quality PC training' (23, 77%), 'fulfilled General Medical Council requirements' (19, 63%), 'prepared students well to care for patients with PC/EOLC needs' (18, 60%) and 'enabled students to visit a hospice and see the role of doctors in caring for the dying' (17, 57%). Concerns were limited capacity to accommodate students (agreed 20, 66%) and variability in teaching according to location (15, 50%). Most agreed their institution recognised PC training as important (22, 73%), they felt supported by colleagues (21, 70%) and experienced cooperation between stakeholders (20, 67%). All agreed that PC training was essential for undergraduates, while 29 (97%) supported inclusion of a hospice visit in the curriculum. 27 agreed that their role was satisfying (90%), 3 disagreed (10%).

Conclusions Approximately two-thirds of organisers were generally positive about their PC

course, institution and role. A minority expressed concerns; these may reflect suboptimal PC training at their medical school and poor preparation of new doctors.

INTRODUCTION

The importance of strengthening palliative care (PC) and end of life (EOL) care training for all staff in England was highlighted by the Leadership Alliance for the Care of Dying People.¹ The views of foundation years 1 and 2 doctors (FY1&2) regarding their readiness to care for patients with PC and EOL needs has previously been investigated.² In comparison, little is known about how PC course organisers responsible for medical student training regard their course, how well they think it prepares future doctors, the degree of institutional support they receive and views on their own role.

A degree of insight was provided by Gibbins *et al.*^{3 4} The researchers undertook a mixed-method study of 14 course organisers purposefully selected from UK medical schools (ie, around half of UK institutions) seeking their views on a range of training issues. A questionnaire based on the work of Field and Wee⁵ was followed up by a face-to-face interview and transcript analysis using a grounded theory approach. Participants described difficulties in establishing a subspecialty in the face of time pressures, limited information and coordination, a rigid curriculum and powerful interests.^{3 4} The importance of university support along with adequate funding and strong leadership were identified as crucial. Other problems were insufficient PC teachers, specialist units and student placements. The researchers concluded that course



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organisers are following the General Medical Council (GMC) recommendations to limit factual knowledge, in contrast to previous research which suggested that the focus was on gaining knowledge.^{6,7}

How does this compare with experience elsewhere? Sullivan *et al*⁸ conducted a survey of 51 associate deans for medical education (or equivalent) across US medical schools. The researchers found that while there was strong support for EOL care education many considered that it was less valued by faculty and students, with one respondent describing it as an ‘important but somewhat peripheral topic’. There was general opposition to the introduction of courses specific to EOL care. All respondents considered that effective EOL teaching is best achieved by integration within the existing curriculum. Barriers to teaching were similar to those identified by Gibbins *et al*,³ namely, lack of curricular time, faculty, funding, leadership and clinical exposure.⁸

Since then, there has been additional guidance from the GMC and a number of local initiatives to improve PC teaching.^{9–11} The previous studies provide only a limited impression of the positive and negative aspects of being a PC course organiser. Our aim was to seek this group’s in-depth views as to their current role. Parallel research looking at course evolution, organisation, funding, faculty, content and assessment is reported elsewhere.^{12,13}

METHODS

A 40-point web-based questionnaire was developed using SurveyMonkey. This is described in more detail elsewhere together with inclusion and exclusion criteria.¹² The document was adapted from a survey employed by Field and Wee.⁵ The survey was piloted by a group of senior PC physicians and educators and subsequently modified. A link to the survey was sent electronically to PC course organisers at UK medical schools, together with an invitation letter, information sheet and supplementary data request form.

Targeted PC course organisers were either known to the collaborators on this project or were identified through multiple emails and phone calls. Where there was no formal course organiser, a senior figure involved in PC education agreed to be the respondent. In situations where the information received was unclear or incomplete, the respondent was contacted by email or telephone. Information from more than one source was combined or a consensus sought.

The data analysis function of the SurveyMonkey package was used to obtain an overview of the responses. This was then refined by a manual search of related questions, text-box answers and information from the supplementary forms.

Data were stored securely and presented in an anonymised, descriptive format. This study received

approval from the University of Dundee Research Ethical Committee (UREC 12073).

RESULTS

Results were obtained from PC organisers at all 30 UK medical schools included in this study.

Preferred course structure

Nineteen of 30 (63%) respondents considered that PC training should be a separate course partially integrated within the curriculum, 10 (33%) preferred full integration while only 1 (3%) expressed the wish for a completely separate course.

PC course organisers’ views about delivery of PC teaching at their medical school

Most PC course organisers were positive about their own course (figure 1). Altogether, 26 (87%) agreed/strongly agreed that theirs was highly rated by students (neutral: 4, 13%). A high percentage agreed/strongly agreed with the following statements about their course (figure 1):

- ▶ Enabled students’ misconceptions and fears about PC, death, dying and bereavement to be addressed: 25 (83%);
- ▶ Delivered quality PC training: 23 (77%);
- ▶ Enthusiastic colleagues deliver training: 27 (90%);
- ▶ Fulfilled GMC requirements: 19 (63%);
- ▶ Prepared students well in caring for patients with PC needs and those who are dying: 18 (60%);
- ▶ Enabled students to visit a hospice and see the role of doctors in caring for the dying: 17 (57%).

The most frequent concerns were capacity for placements and variability in teaching:

- ▶ Twenty (66%) agreed/strongly agreed that PC training was limited by local services’ capacity to accommodate enough students;
- ▶ Fifteen (50%) agreed/strongly agreed that teaching varied depending on where students were sent.

Respondents provided a number of insightful quotes:

- ▶ “Devolved responsibility, so variation in amount of PC teaching.”
- ▶ “When the students attend the hospice it evaluates well, but there is great variation in teaching.”
- ▶ “Lack of clinical placements locally limits the ability of students to actually spend clinical time on the wards seeing PC patients.”

PC course organisers’ views about their institution

Again, our findings were generally positive (figure 2). The number (%) agreeing/strongly agree with the following statements were:

- ▶ PC training is recognised as an important part of the curriculum: 22 (73%);
- ▶ PC training and efforts to advance teaching are well supported by university colleagues: 21 (70%);
- ▶ There is good cooperation between university, hospitals, hospices and community in delivering PC training: 20 (67%).

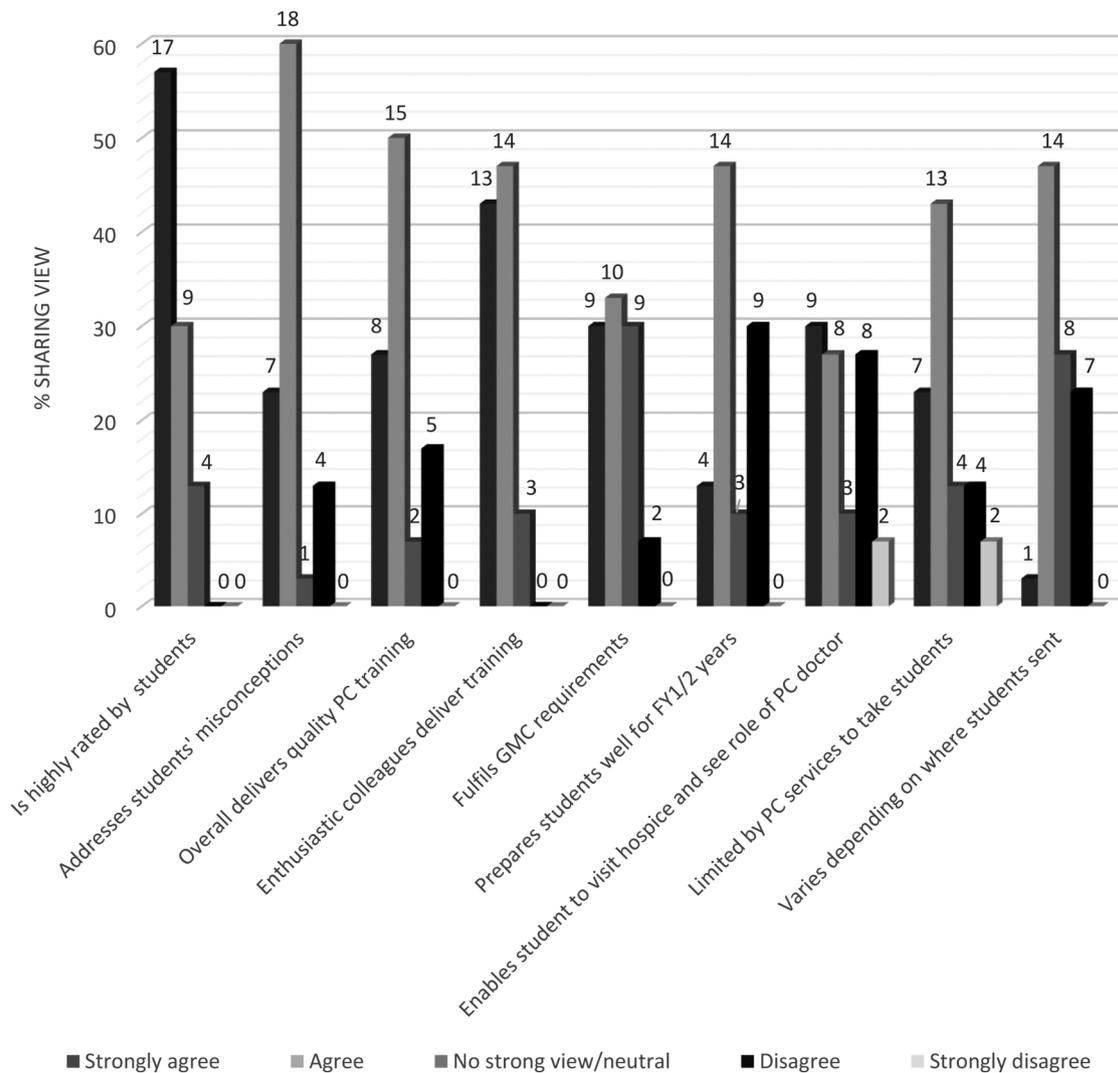


Figure 1 PC course organisers' views about teaching at their medical school. Percentage of respondents sharing that view are along the y-axis and actual numbers are given above each column (N=30). FY, foundation year; GMC, General Medical Council; PC, palliative care.

The most frequent negative responses were in respect of PC teacher numbers and placements:

- ▶ 22 (73%) agreed/strongly agreed that there was a need for more PC teachers.
- ▶ 25 (83%) agreed/strongly agreed that more PC teaching placements were required.

A small minority were concerned about the limited time dedicated to PC training within the curriculum, organisational funding and funding provided for teaching (figure 2). Several comments suggested that attitudinal barriers to PC training may still exist within institutions: 'Specialist PC and care of dying is of little importance within [our] medical school', 'Lack of recognition for PC as core aspect' and 'The culture of hospitals, that is, death-denying'. Also, students themselves may be negatively disposed to PC training: "Students rate the teaching highly, but [we do get] comments like 'we are here to learn how to save lives' and 'specialist PC is irrelevant, as I want to save lives'."

Personal views on PC training and their own role

Almost universally, course organisers were positive about PC training, hospice visits and their own role (figure 3). The number (%) agreeing or strongly agreeing with the following statements (N=30) were:

- ▶ PC is an essential part of undergraduate training: 30 (100%).
- ▶ All students should visit a hospice: 29 (97%). One respondent had no strong views on this point (3%).
- ▶ My role in PC training is satisfying: 27 (90%). Three respondents disagreed with this statement (10%).

External advice to optimise undergraduate PC training is now available from a number of sources: 17 (57%) agreed/strongly agreed that the GMC has provided good guidance, while 20 (67%) held similar views in respect of material provided by organisations such as the Association for Palliative Medicine of Great Britain and Ireland (APM) and the European Association for Palliative Care (EAPC), etc. With regard to their own educational needs as teachers, 17

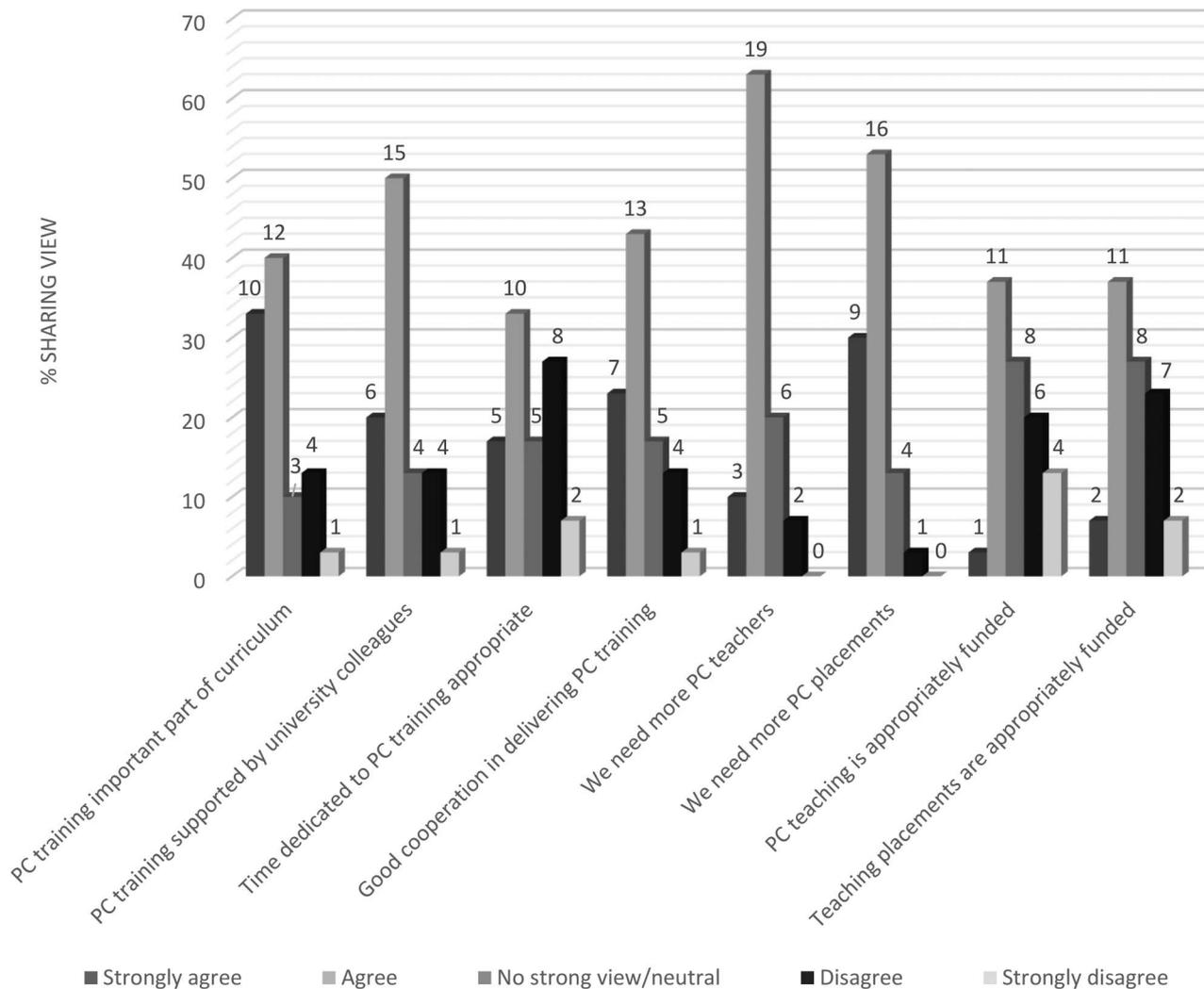


Figure 2 PC course organisers' views about their institution and its approach to PC training. Percentage of respondents sharing that view are along the y-axis and actual numbers are given above each column (N=30). PC, palliative care.

(57%) agreed/strongly agreed that those delivering courses would benefit from better training.

Barriers to PC education for medical students

Participants were asked to list in free text perceived barriers to PC education at their institution. The commonest responses in descending order were:

- ▶ Pressure on curriculum time;
- ▶ Lack of placements;
- ▶ Availability of teachers;
- ▶ Absence of leadership;
- ▶ Funding issues;
- ▶ Lack of support from their university or hospital.

Exploration of individual results

A range of responses were received which appeared to fall into two broad categories: 20 (66%) were generally positive about their course and institution and agreed that their role was satisfying/very satisfying. The remaining 10 (33%) expressed a number of negative views. These included all nine responders

who did not agree that their course prepared students well for their FY1&2 and the five who held similar views as to the quality of their PC training. Three responders had multiple concerns, for example, poor preparation, quality of PC training, limited institutional support and lack of cooperation. We have also added one respondent who found his role unsatisfying.

An exploration of the free-text answers suggests that some negative responses may in part be due to a lack of oversight across large student numbers receiving PC training at different locations: "Given I have found it impossible to try and get to the bottom of what [our medical students] actually get (as opposed to what the curriculum says they get), in all honesty I am not sure if we are fulfilling GMC." Another factor may be insufficient opportunities to visit a hospice and see the role of doctors in caring for the dying, a deficit which may not be compensated for in other settings: "Clearly many of the patients that they will see in the hospital or GP setting will have palliative

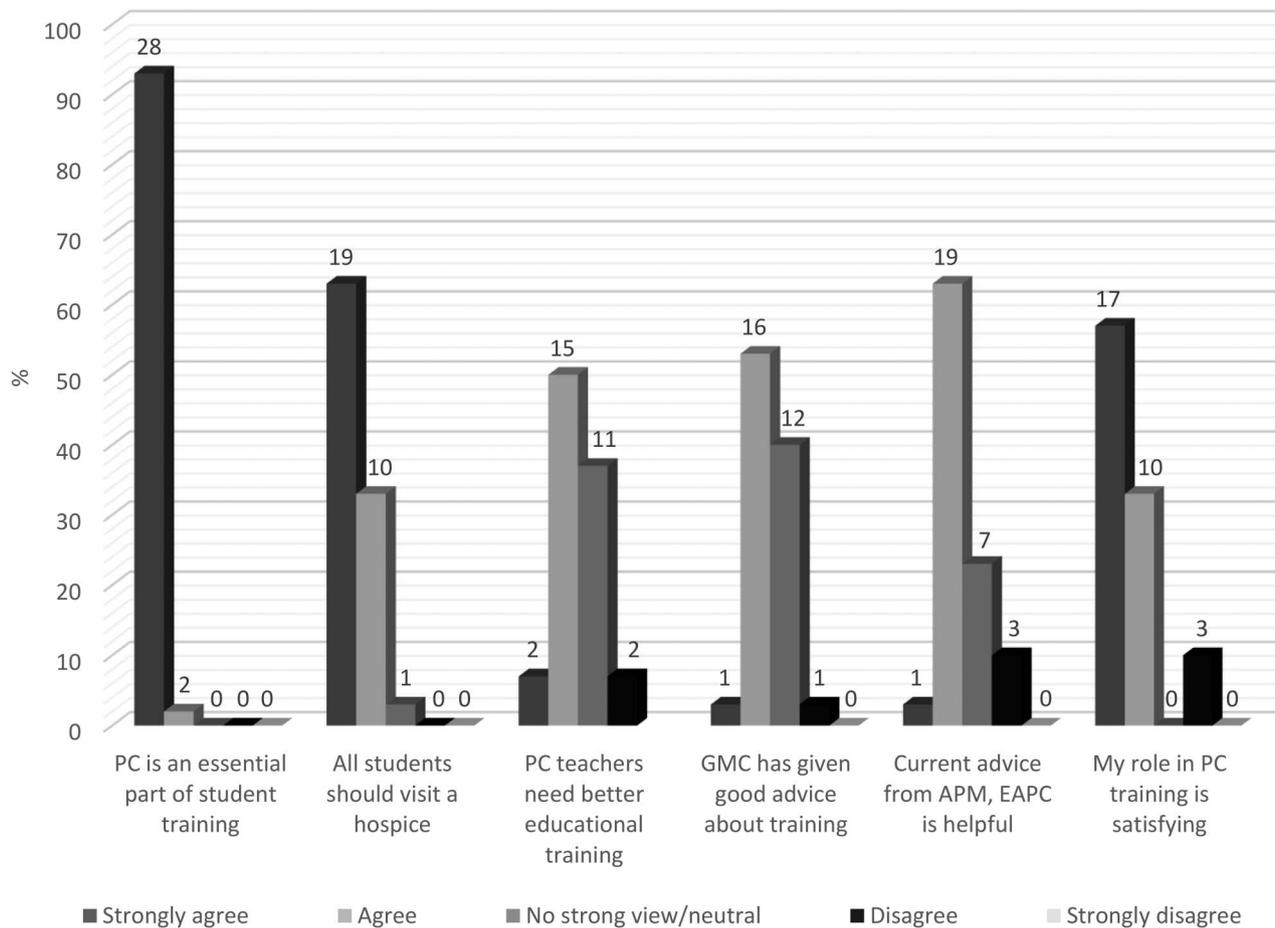


Figure 3 PC course organisers' personal view on PC training at institution and their role. Percentage of respondents sharing that view are along the y-axis and actual numbers are given above each column (N=30). APM, Association for Palliative Medicine; EAPC, European Association for Palliative Care; GMC, General Medical Council; PC, palliative care.

needs, but outside of the 'palliative care course' I think students find it difficult to recognise this."

DISCUSSION

This multifactorial study built on previous work which highlighted some of the difficulties faced by individuals trying to incorporate PC in the medical student curriculum.³ The generally positive responses from around two-thirds of medical schools are encouraging, but individual answers suggested that some institutions were failing to deliver optimum PC training for their students, promote cooperation among stakeholders or to provide teaching staff with adequate resources to ensure a quality learning experience.

In general, students were reported to rate highly the PC training they received. Most course organisers also considered that they are doing a good job in, for example, addressing misconceptions and fears about PC, death, dying and bereavement, and preparing students well to care for patients with PC needs. This was despite respondents from two-thirds of medical schools agreeing/strongly agreeing that training was limited by availability of local services; and that in half of schools teaching varied depending on where

students were sent. Providing a similar educational opportunity for all in a real-life environment is challenging. Illeris¹⁴ postulates that what students experience occurs as result of a complex interaction between learning content, learning dynamics and environment, all of which are difficult to reproduce.

Quality of PC training and preparedness

Twenty-three (77%) course organisers agreed/strongly agreed that their course was delivering quality PC training. This was usually associated with positive responses in other areas of the survey. It is disappointing that 5 (17%) disagreed. Examination of individual results suggests that this may be related to course and/or institutional issues, for example, inability to 'visit a hospice and see the role of PC doctors' and 'address students' misconceptions. Gibbins *et al*³ highlight that a lack of meaningful contact with patients having PC needs, or who are dying, was a feature across the medical schools included in their study. This could be seen as a 'failure' to prepare junior doctors for a key aspect of their hospital role. Further, patient contact was often limited or absent regardless of the amount of EOL teaching time. Ellershaw and Ward¹⁵ reported

that the focus of care was frequently on ‘curing people’. This was sometimes at the expense of the patient’s comfort; and when it was belatedly recognised that a patient was dying, they were often ‘protected from students’.^{2 15} How can students be expected to recognise when someone is dying and manage them appropriately if there is no provision for experiential learning and the subject is avoided by their trainers?³ It is perhaps not surprising that the majority of newly qualified doctors in Gibbins *et al*’s³ study were surprised when patients did die, and apparently lacked awareness that looking after the dying, as well as the sick, was an integral part of their role.

Gibbins *et al*³ acknowledged the challenge of providing patient contact in the face of large student numbers, limited teaching time and few specialist units. They proposed that this could be addressed by students being routinely exposed to dying patients on general wards or in the community. Many teachers chose to ignore this resource, possibly because such patients were considered to provide few learning opportunities, were too complex or there was reluctance on the part of medical and nursing staff cause distress.¹⁶ One current respondent points out that students in a non-specialist environment may not recognise that a particular patient is dying and could therefore provide an experiential learning opportunity. Patients themselves may view things differently: Harris *et al*¹⁷ found that the majority with PC and EOL needs welcomed interaction with medical students.

Eighteen course organisers (60%) agreed/strongly agreed that their course prepared students well for PC activities as FY1&2 doctors. Again, an examination of the responses from the 9 (30%) who disagreed showed that while this may be related to quality, other contributory factors existed such as poor institutional support and cooperation. This finding must be put into context. In a multimethod study, Illing *et al*¹⁸ found a widespread lack of preparedness across many areas of medicine—such as prescribing, managing acutely ill patients, coping with the workload and being on call—though once on the wards, student doctors quickly gained competence. The study identified many potential contributing factors, concluding that clinical placements need to be more structured and consistent in what they deliver, and the requirement for greater exposure to experiential learning. Gibbins *et al*² noted that medical students’ theoretical understanding of PC may not equip them to engage with much of what they see unless it fits the culture of clerking, recognising signs or passing examinations, or is not highlighted to them by senior staff. Furthermore, where the focus of study is resolutely on cure, care for acute illness and use of technology, undergraduate medical students cannot easily identify their own EOL care learning needs.²

Institutional support and cooperation

Around 70% of course organisers reported that PC training is considered an important part of the curriculum, well supported by university colleagues and facilitated by good cooperation between the various organisations involved. In contrast, in the USA, Sullivan *et al*^{8 16} found a lack of interest among faculty members and suggested that some university deans were paying ‘lip service’ at their institution by incorporating a few token elements of this ‘peripheral topic’. This echoes the findings of Gibbins *et al*,³ who reported that the discipline must fight for acceptance. Gaining support from those with influence is crucial; some course organisers had to resort to lobbying, armed with needs assessments and comparative data. The most frequent concerns in this study were insufficient teachers (73%) and placements (83%)—something also noted by Gibbins *et al*^{3 4} in the UK and Sullivan *et al*^{8 16} in the USA.

Views on personal role, guidance and barriers to training

Most course organisers were positive about their role, with only 3 (10%) suggesting that what they were doing was not satisfying. In two cases, issues were apparent with the course and institution, while in the third providing generally positive responses, no clear reason was identifiable. By comparison, other respondents were ‘satisfied’ with their role despite a range of challenges.

Might further guidance and training help? While 17 (57%) agreed that the GMC has provided good advice about PC training for medical students, 12 (40%) were neutral on this point. Results were similar in respect of better training for teachers. By comparison, a larger number (20, 67%) agreed that the current advice from bodies such as APM and EAPC were helpful. Gibbins *et al*³ had previously found that many respondents considered the earlier APM undergraduate curriculum to be unachievable. It should be pointed out that the current survey predates the latest curricular guidance from the APM Special Interest Forum.¹⁹

Respondents were given the opportunity to list barriers to PC training using free text. While this did not result in any new issues, it is interesting that the top four were all related to course delivery, for example, pressure on curriculum time, insufficient placements and teachers, absence of a forceful leader and insufficient funding with ‘lack of support from their university or hospital’ coming last.

Implications for clinical practice

“The incorporation of PC into the medical undergraduate curriculum has involved a complex process of individual, institutional, clinical, patient and curricular factors.”³ Though clinical experience with dying patients is clearly vital, this is not easy to achieve for multiple reasons related to medical

schools and PC services. Considerable progress has been made in most medical schools but there remain a significant minority where PC education is considered inadequate. More creative solutions are needed. It may be that more could be done at an earlier stage in the curriculum away from the bedside by means of multidisciplinary group teaching. In the later stages there may be further opportunities, especially when students are based on general wards and in primary care. Gibbins *et al*³ hypothesise that better collaborative working (eg, shared teaching tools, assessments/examinations, training of future educators and development of a research base) will result in better and more consistent outcomes—a theme echoed by Linklater *et al*.¹¹ We suggest that the one-third of medical schools who struggle to deliver PC education should collaborate with successful institution to optimise training and patient care.

Limitations of study

Our focus was on just one heterogeneous group (course organisers) and one method of data gathering (questionnaire). Some respondents may be less clear in their roles and have significant blind spots. It is likely that a fuller picture could have been achieved by detailed interviews. Also, we have not explored the link between ‘strong’ or ‘weak’ training and what effect this has on preparedness. These limitations have been discussed in greater depth elsewhere.¹²

CONCLUSION

The views of PC organisers were generally positive across UK medical schools regarding teaching, the training they provide and support received from their institution. A number of barriers have been identified. A small minority expressed concerns about their role and whether they were delivering quality training that would adequately prepare students to look after patient with PC and EOL needs during their FY1&2.

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Contributors SW was responsible for the original concept which was subsequently combined with a similar proposal from BW, JG, SB, PP and AA. SW developed the questionnaire, sent it to respondents, collected and analysed the data and developed the first draft of the manuscript. JG, PP, AA, SB, MC and BW gave advice on methodology, trialled the questionnaire, helped with data analysis and interpretation, contributed modifications to the final manuscript and approved its contents. MC provided general advice and support at all points along this journey. PL and FG gave advice on methodology and undergraduate PC training, trialled the questionnaire, gave advice about data interpretation and contributed modifications to the final manuscript and approved its contents.

Competing interests None declared.

Ethics approval University of Dundee Research Ethical Committee (UREC 12073).

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