



Getting an Education in Palliative Care

Increased training can make for better doctors – in any situation

Last year, the College hosted a forum of experts in the end-of-life care field. We asked them what needed to change to meaningfully improve the last months, weeks and days of patients' lives.

The experts describe a current environment where assumptions and misunderstandings – between physician and patient, among specialists and within families – replace informed discussion.

Given that lack of communication appears to be one of the biggest barriers to optimal end-of-life care, we've decided to launch a conversation. What is optimal care and what can be done to achieve it?

Over the next several issues, *Dialogue* will bring you the views of experts in palliative and end-of-life care, as well as lessons learned from patients' experiences.

We are also taking the conversation online.



Please visit us at www.cpso.on.ca/endoflife and share your thoughts and experiences.

By Stuart Foxman

In medical school, Dr. James Downar was asked to list the specialties that he was drawn to and those that held little interest. “The only thing I wrote down was ‘Don’t put me in palliative care,’” he recalls. He had gone into medicine to cure people, not to watch them die.

Today, Dr. Downar is a palliative care physician and intensivist at the University Health Network in Toronto. He explains that as he came to understand palliative care, he learned that it was more about life than death.

In fact, he suggests that every doctor, regardless of specialty, can benefit from more grounding in palliative care: “We all need a basic level of competency.”

Are physicians getting the training to provide quality end-of-life care? What methods are educating physicians on the nuances of palliative medicine? And how can this education help any physician to become more effective overall?

In this first of a five-part *Dialogue* series on palliative care, we'll explore education and professional development.

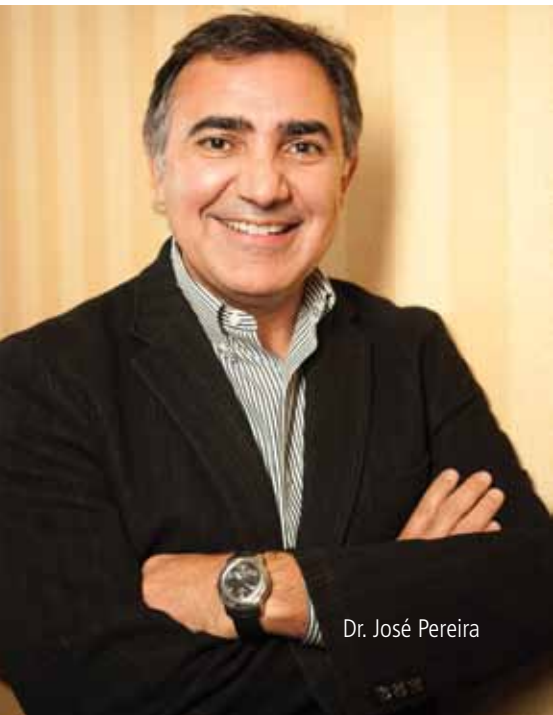
The need for palliative care is growing. This care is no longer restricted to cancer patients; it now applies to



Dr. James Downar

people with other chronic conditions and illnesses. Canada needs more palliative care experts, especially given the aging population.

Some medical schools offer a one-year fellowship with added competence in palliative medicine, accredited by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. The Royal College has also proposed a two-year subspecialty in palliative medicine, with adult and pediatric training streams. ►►



Dr. José Pereira

There has also been a move to incorporate palliative concepts in medical curricula as central to every discipline. As a recent article in the *Canadian Medical Association Journal* noted, “End-of-life care should be as important to us as quality birthing care or quality care in the emergency department.”

Palliative care training in medical schools varies, but the curriculum generally focuses on managing pain and symptoms; responding to psychosocial and spiritual needs; assisting in end-of-life planning/decisions; effective communication with patients and families; interdisciplinary collaboration; and easing the suffering of terminally ill patients.

The issue isn't just what's taught but when. Often, palliative care education is confined to years one and

two of medical school. Dr. Downar notes the stark contrast between what's learned in the classroom and at the bedside. He'd like to see palliative care ingrained in later years of training, into residencies and fellowships.

“The clinical years should have exposure to palliative care as an obligatory rotation,” agrees Dr. José Pereira, head of the Division of Palliative Care, University of Ottawa.

To understand the gaps in palliative care training, consider this. All physicians will be expected to have training in CPR. However, how many will need to apply those skills? In contrast, hospital policies suggest that doctors routinely ask all patients about their care goal. “Yet, there is no standard training on how to talk about it, and in most cases no training at all,” says Dr. Downar.

Dr. Pereira, who is also Medical Chief, Palliative Medicine at Bruyère Continuing Care and The Ottawa Hospital, believes that palliative care training must be more robust. “It's not just about end-of-life care, but a foundation of learning other competencies, like a patient-centred or holistic approach, bringing together the science and the humanism.”

A need to broaden exposure

Not every patient ends up seeing a palliative care specialist. Yet doctors in all fields see patients who can benefit from advance care planning and other palliative support. “How we manage end-of-life care is everyone's responsibility,” says Dr. Downar.

Dr. Pereira is alarmed by some specialists who say “I don't do palliative care,” even though they'll see patients with incurable illnesses. “It behooves all clinicians to look in the mirror and ask if they have these skills or should get some fine tuning.”

Medical school faculty need to model the desired palliative care qualities and skills, Dr. Pereira adds: “If residents don't see it, they won't follow it.” He says that many faculty members should look at upgrading their own skills, with a program like LEAP (Learning Essential Approaches to Palliative and End-of-Life Care) a 13-hour educational program designed for physicians, nurses and pharmacists, across all sectors of care.

The medical literature identifies one big barrier to increased palliative care training – the culture of curative medicine. Dr. Downar mentions a survey of 600 oncologists, who were asked about their

most difficult conversation. It wasn't telling someone they had cancer, but telling them their treatment wasn't working.

"You're aligning care with the goals of the patient."

Hoping for the best and planning for the worst should always be an operating principle, Dr. Downar says. Why might doctors avoid conversations about end-of-life or use indirect terms? "Because they feel they're taking away hope – but they're really taking away truth," he says.

Education must address some of the myths around palliative care, namely that palliative means death. As Dr. Pereira says, "It's really about living as best as you can, as long as you can."

He cites evidence regarding lung cancer patients who saw a palliative care team earlier in their illness (while receiving chemo or radiation). Says Dr. Pereira, "Not only did these patients have a better quality of life – less depression, less anxiety – but they lived on average three months longer than those who received palliative care only at end-of-life."

Dr. Downar's greatest education in palliative care came during his medical training in the ICU. He was "in love with technology and advanced procedures." But meeting families of terminal patients had a dramatic impact on his career.

"We knew the patient wasn't going to get better but didn't know how to talk about it," Dr. Downar says. "Everything was about the cure, so making this transition was difficult. But when family meetings went well, it was the best I ever felt, far better than doing a procedure successfully or resuscitating someone. You realize the non-curative route is often what people want. You're aligning care with the goals of the patient."

To make that hit home, Dr. Downar has designed a novel program at Toronto General Hospital. Actors play family members of critically ill patients. Doctors who are in the last years of their sub-specialty training are then placed in these scenarios. The program aims to improve how these doctors interact with a family – with compassion and understanding – and help them make informed end-of-life decisions.

Conversations are difficult

Any training that makes these discussions more real is welcome. End-

of-life conversations can be hard for all involved. That's why Dr. Deanna Mercer feels strongly about broadening education on palliative care. Last year, the Ottawa psychiatrist had three family members die within two weeks, including her father and grandmother.

Each case had issues regarding end-of-life care, not so much around quality of care but around the difficulty of having the needed discussions. Dr. Mercer says "the challenges families face in making ►►

Join the conversation



We want to hear from you about your opinions, your experiences.

- Should palliative care training be a part of every medical student's experience, regardless of discipline?
- How did palliative care training make you a better doctor to your healthy patients?
- Did a lack of palliative care training lead to some difficult experiences at patients' bedsides?

Join the conversation and let us know what you think:
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reasonable end-of-life decisions are compounded by physician unwillingness to have the conversations and beliefs about what is good care.”

Watching her loved ones struggle, she found it difficult to initiate those conversations even though she’s a physician. Dr. Mercer believes that all doctors – not just palliative care physicians – should learn how to confidently and competently broach sensitive issues with patients and their families, like withdrawing care and the value of comfort measures.

“I suspect that helping physicians address [these topics] will have a much larger overall impact on improving people’s experiences at the end of their lives,” says Dr. Mercer.


Dr. Erin O’Connor agrees that palliative care training is helping to round out her medical education. She didn’t receive any such training while studying medicine at Queen’s University, and chose this, her

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fourth year in a five-year emergency medicine residency, to do a one-year program in palliative care.

“In emergency, we see lots of people at end-of-life, whether suddenly due to a major trauma or because of something like end-stage cancer,” says Dr. O’Connor, who works at Ottawa Hospital and Elizabeth Bruyère Hospital. “Most of us choose medicine because we want to fix people. We feel that when we can’t we’ve failed the patient and their family. It’s not a failure. Even if you can’t make a person live longer, there’s still much more you can do. You can fix their pain, you can fix their suffering.”

While her special one-year program will serve her well in emergency medicine, Dr. O’Connor echoes the feeling that palliative care training can improve any doctor’s ability to deal with any patient. “Palliative care is very patient-focused,” she says. “It’s not focused on the disease or symptoms, but on what the patient wants and what’s best for them.”

Sometimes, that can get lost in solely treating an illness or condition. “I think that palliative care training is making me a more effective listener,” says Dr. O’Connor. “I’m better able to ask the right questions, and I’m more sensitive to patient symptoms and needs. And that’s making me a better doctor.” 

COMING UP:

A recent national poll found that 86% of Canadians haven’t heard of advance care planning. In the next issue of *Dialogue*, we’ll continue our series on end-of-life care with a look at this important planning. What tools are needed for physicians, patients and their families to actively engage in this process at an earlier stage, prior to the onset of serious illness? We invite our readers to share their thoughts on the series at: www.cpsso.on.ca/endoflife.