Palliative Care Matters | Building National Consensus

L'importance des soins palliatifs | Forger un consensus national

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Resources for Educating Physicians

November 8th, 2016 – Ottawa, ON, Canada

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Disclosure

- JD has received speaker fees/honoraria from:
  - Boehringer Ingelheim (Canada) Inc.
  - Medtronic Inc.
  - Novartis
- JD is supported by an AMS Phoenix Fellowship (2016-7)

Acknowledgements

- ALL Palliative Care providers who educate, mentor and train physicians in Canada

What resources are required to ensure adequate education, training and mentorship for Physicians providing care for Canadians experiencing a life-limiting illness and their families?

Overview

Introduction

Improving PC education a national priority

- *Palliative Care: CMA National Call to Action*
- Senate reports (2000, 2005, 2010)

Introduction

Stakeholders

- Royal College of Physicians and Surgeons of Canada (RCPSC)
- College of Family Physicians of Canada (CFPC)
- Association of Faculties of Medicine of Canada (AFMC)
- Canadian Society of Palliative Care Physicians (CSPCP)
- Pallium Canada
- Canadian Medical Association

Findings – Core Concepts

Concept #1- Resources

There are many palliative care educational resources already available for Canadian physicians. We don't need any more.

- Courses- LEAP, EPEC
- Intensive courses- Victoria Hospice
- Online resources- Canadian Virtual Hospice, Cancer Care Ontario Palliative Care Tools, Ian Anderson Modules
- …

Concept #1- Resources

Academic system incentivises development of redundant material. Need to adopt 1-2 standardized curricula and use them broadly.

- Impact = Develop new material and get others to use it
- Palliative Care knowledge base doesn't justify new material
- Models- Advanced Cardiac Life Support
- Need to better reward teaching of existing material

Concept #1- Implications

In education there is a need for dissemination and uptake of existing resources, rather than focusing only on generating new resources.

Concept #2- Resources

Canadian MDs not adequately trained in Palliative Care

- Most medical schools teach <10h of Palliative Care in 3-4 years
- Postgraduate trainees uncomfortable with end-of-life care, poorly supervised for end-of-life procedures and family meetings
- Palliative Care rotations not mandatory in most programs, often limited availability in past

Concept #2- Implications

***There is value in recognizing the importance of palliative care teaching at academic institutions*.**

Concept #3- Effectiveness

Some palliative care educational interventions are inexpensive and scalable; others are costly and time-consuming. We know very little about which palliative care educational interventions impact physician behaviour and patient care.

Kirkpatrick Framework

- the reaction of the learner (level 1)
- the knowledge of the learner (level 2)
- the behaviour of the learner in a clinical environment (level 3)
- patient level outcomes (level 4)

Concept #3- Effectiveness

<1% of education-related articles report patient outcomes

Measuring physician behaviour (3) and patient outcomes (4) is costly and logistically challenging- unfeasible for typical educational grants

Educational Investigations = Quality Improvement initiatives

Healthcare Organizations have an interest in collecting performance data- should support infrastructure, would allow routine measurement in studies

- Symptom Management, Advance Care Planning

Concept #3- Implications

There is a need for the routine assessment of the quality of end-of-life care in the clinical environment, including symptom management, Advance Care Planning, etc. to allow better assessment of training effectiveness.

Concept #4- Areas of focus

Teaching Symptom Management

- Palliative Care elective rotation
- Workshops (1-2 days)
- Longitudinal curricula/distance learning
- Web-based modules
- Pocket references/apps

Concept #4- Areas of focus

Teaching Communication

- Learner-centred deliberate practice
- Workshops (>1 day)
- Role playing with simulated/real patients
- Feedback
- Small group discussion

Concept #4- Areas of focus

Teaching Communication - Pitfalls

- Studies show improvement in desired behaviour, but no effect (or possibly harm) in patients/family members.
- No universal endpoint- who judges "improvement"?
- Does patient satisfaction imply good communication?

Concept #4- Implications

***Effective communication training can be time-consuming and costly. It requires support (i.e. time and resources) from all stakeholders*.**

Concept #5- Faculty Development

Educational efforts undermined by "hidden curriculum" in clinical environment.

- Most current faculty have little/no palliative training
- Little supervision/teaching around EOL tasks
- Faculty have little training in giving feedback on EOL tasks

Concept #5- Faculty Development

Need effective faculty development to teach EOL skills, and teach skills in teaching EOL

- Immersive experience for skills
- Experiential learning, feedback
- Peer-to-peer support and mentorship
- Need to incentivise this learning at level of colleges, faculties

Concept #5- Implications

Encouragement, incentivization, and feedback for faculty development in palliative care training is important at academic hospitals and faculties of medicine.

***Professional development activities provided by all stakeholders can support innovative and effective approaches to palliative care*.**

Concept #6- Competency-based education

Transition from time-based to competency-based medical education

- Repetitive formal assessment
- Focused feedback
- Determination of competence/entrustment

Concept #6- Competency-based education

Palliative Care well-positioned for transition

- Validated Entrustable Professional Acts (EPAs)
- Need faculty development to adapt to new framework
- Applicable to practicing physicians

Concept #6- Implications

There is a paradigm shift from time-based training to competency-based training and evaluation. This paradigm shift is supported by faculty development work.

Concept #7- Tailored PC Education

Every MD in Canada should be able to provide basic Palliative Care

- Most Canadians want a specialist PC provider at EOL- probably not necessary and definitely not feasible
- Everyone should have access to anappropriately-skilled provider
- Palliative Care is everyone's responsibility
- Palliative Care is not mandatory in Family Medicine training
- Palliative Care is not mandatory in any specialty or subspecialty except medical oncology and radiation oncology

Concept #7- Tailored PC Education

Specialized practitioners need specialized Palliative Care training

- Most Palliative Care training is based on cancer model
- Some programs offer specialized training (e.g. LEAP-Long-Term-Care, LEAP-nephrology)
- Interprofessional training, but recognize different role of each profession

Concept #7- Implications

Both certifying colleges would benefit from including palliative care competencies in all fields of medicine, and including palliative care rotations in the Subspecialty Training Requirements for subspecialties where palliative care is particularly relevant.

***In this way, palliative care education would be tailored to meet the needs of physicians in specialized areas of practice*.**

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Questions