The Role of Palliative Care in Medical Education

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More than a decade ago in medical school, I learned the basic skills of managing pain, breaking bad news, and exploring the psychosocial effect of advanced illness in an elective course called “Living With Life-Threatening Illness.” The experience laid the foundation for my advanced training and clinical practice. Unfortunately, most clinicians have not received such training, and palliative care continues to have a limited role in the overall schema of medical education (1). I argue here that palliative care teaches good medical practice and the art of medicine and therefore should be an essential and longitudinal component of medical education and training.

Palliative care is “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering” and by “addressing physical, intellectual, emotional, social, and spiritual needs” through the continuum of illness (2). It echoes medicine’s traditions of altruism, empathy, trust, and service. Palliative care—with judicious use of advanced technology, surgical procedures, or expansive therapeutics—requires skills of bedside diagnosis, empathetic communication, and psychosocial support. For example, trainees may refine history-taking skills (such as characteristics of pain, spiritual and religious history, loss, and coping mechanism). They may improve physical examination skills (such as neurologic and musculoskeletal examination for pain and oral, abdominal, and rectal examination for nausea, vomiting, and constipation). They will learn that the family meeting, which includes finding appropriate settings, understanding patient and family perceptions, inviting the sharing of information, diagnosing the diagnosis and prognosis, acknowledging emotion, and summarizing action plans, is the most important procedure in palliative care. In palliation, the goals are to diagnose and treat symptoms at the bedside and communicate effectively and compassionately with patients and families. Moreover, the interdisciplinary nature of palliative care puts it ahead of the curve for elements envisioned for the “medical home.” Caring for patients with advanced, serious illness requires expertise of medicine, nursing, social work, nutrition, pharmacy, rehabilitation, and chaplaincy. Although physicians often take on leadership roles in interdisciplinary teams, this is not a given, and the unique contribution of each team member is valued. In this era of relationship-centered, team-based care and increasing demands of chronic illnesses, palliative care thus may be the ideal platform on which to build and expand interprofessional collaboration.

Palliative care also exemplifies the high-quality and cost-conscious care that is increasingly requested. Many studies have shown that palliative care improves the patient’s quality of life and family satisfaction, reduces costs, and even prolongs survival (3). It strives to match the intensity of treatment to appropriate goals of care for patients with advanced, chronic illness or those at the end of life. As the U.S. health care system increasingly shifts to managing chronic illness, palliative care should be integrated into chronic care models for debilitating illnesses with high symptom burden, such as neurodegenerative disorders (4). Most important, the field of palliative care is deeply rooted in humanism and the medical humanities. Caring for patients with life-limiting illnesses is extremely rewarding for trainees and critical to their career development. A typical palliative care encounter teaches personhood, life review, hope, grief, and shared decision making. Palliative care’s overlapping themes with branches of medical humanities may expose trainees to diverse perspectives. These include medical ethics (decision making at the end of life); narrative medicine and reflective practice (illness narrative and life review); history and philosophy (cultural evolution of death and dying); and arts, literature, and music (attentive observation and active listening). Finally, because palliative care is emotionally stressful, effective strategies for self-care have been developed through cultivation of emotional resilience, reflective capacity, and attentive mindfulness (5). Trainees in any career path can learn and adopt these techniques to avoid professional burnout, moral distress, and compassion fatigue.

There are many models of teaching palliative care, from early medical school to subspecialty fellowship training (1). Components of palliative care, such as pain and symptom control, prognostication, and transitions of care, can be taught in different clerkships and residency rotations, whereas communication skills are best taught using role playing and workshops. However, innovative teaching methods are needed because dedicated curriculum time is likely limited in both undergraduate and graduate medical education. For example, given the increasing penetration of palliative care into many specialties and subspecialties, it may make sense to teach formulating prognosis, managing end-stage complications, and addressing symptoms of chronic diseases (such as congestive heart failure, pulmonary fibrosis, and end-stage renal disease) explicitly along with their pathophysiology, diagnosis, and treatment. Training in palliative care may be delivered during basic, clinical, and postgraduate training because spaced repetition and longitudinal integration likely provide the highest retention yield. These millennial learners will also benefit from technology-enhanced curriculum in the forms of flipped classrooms (reading before classes and collaborative problem solving during classes), online modules, interactive multimedia, and social networking (6). In addition, even without mandatory experiential training in an interdisciplinary team setting, palliative care can lend itself to innovative interprofessional educational strategies, includ-
ing interdisciplinary team-based case simulation, collaborative online learning, and scheduled debriefings (such as grief rounds and narrative journaling) (7). Finally, effective dissemination of palliative care knowledge, skill, and attitude requires a train-the-trainer approach for the diverse specialty clinical faculty. These palliative care champions can then serve as role models for trainees and resources to their specialty colleagues (8).

In “The Nature of Suffering and the Goals of Medicine,” Cassel (9) states that the relief of suffering and the cure of disease must be seen as twin obligations of the medical profession. In this regard, the teaching of palliative care illustrates the essence of bedside evaluation and the delivery of high-value, patient-centered care. Along with the necessity of learning biomedical sciences for comprehension of diagnoses and treatment of human diseases, it is now time for the medical education community to embrace palliative care as the prerequisite for mastering the art of medicine. Most important, the lifelong learning ritual of every physician must include periodically revisiting both biomedical sciences and palliative care relevant to his or her specialty.

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