Innovations in Family Medicine Education

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Enhancing the Hospice Curriculum Within the Family Medicine Clerkship

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Background: *Medical schools are improving end-of-life (EOL) care curricula; however, students rarely practice EOL communication skills in a safe learning environment.* Objective: *Our objective was to study which curriculum improves students' ability to discuss hospice care.* Methods: *We conducted a study of six family medicine clerkship blocks; three taught with a didactic curriculum (A) and three with an interactive curriculum (B).* Results: *Students reported improvement in their skill and comfort in discussing hospice care in both groups. Subjectively more students commented on the instructiveness of curriculum B due to role-plays.* Conclusion: *A variety of curricular methods helped students' confidence and self-reflection around hospice discussions in a comfortable environment.*

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End-of-life (EOL) training in US medical education has been incomplete.[1] Some schools have implemented complex curricula to address this deficit[2] using group discussions, lectures, and clinical cases. One study found that graduating students preferred non-lecture educational opportunities such as role-plays and hospice visits;[3] another study found that few patients were choosing hospice and believed this to be secondary to few health care professionals being well trained about hospice care.[4]

A decade ago, "The Project on Death in America Report" indicated that communication and self-reflection were two of five essential EOL educational domains.[5] Therefore, students must be given opportunities to witness faculty or residents discussing hospice care with patients and to perform the skill themselves. We compared a didactic approach with an interactive, hands-on approach to evaluate improvement in students' skills and comfort level with hospice discussions. In both approaches, we tried to create an environment that students would find safe for participation and learning and would provide opportunity for self-reflection.

Methods

In 1996, the Department of Family Medicine at our institution began to have students in the family medicine clerkship spend a half day conducting home visits with a hospice nurse and encouraged students to attend a hospice team meeting. Elsewhere in the 4-year medical school curriculum, students have approximately 15

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hours of palliative care education, but nowhere in the curriculum were students specifically taught to introduce patients to the idea of entering into hospice care. Students received little exposure to hospice learning elsewhere in the other third-year clerkships.

Curriculum A

Our hospice module takes place over two sessions in the clerkship. The first session begins with a video of hospice founder Dame Cicely Saunders discussing the history and philosophy of hospice care,[6] followed by a 40-minute lecture and brief question-and-answer session about hospice care by a hospice nurse from a Visiting Nurses Association. Students are assigned to spend 1 half day with a hospice nurse, including attending a hospice team meeting. The second session consists of a 1-hour discussion to debrief and reflect on the hospice experience, followed by students observing a demonstration of a hospice referral by two faculty members.

Curriculum B

To attempt to make the hospice curriculum more interactive, using the findings of previous studies,[7,8] we changed the 40-minute lecture-based session to a question-and-answer-based session led by a hospice nurse, substituted a video demonstrating a simulated hospice discussion for the live faculty enactment, and added three role-play scenarios, of increasing complexity, for the students to practice during a 30-minute session (Table 1). Students performed the task in small groups and then received feedback from each other and from circulating faculty.

We surveyed students at the beginning and end of each 6-week clerkship block to assess the effectiveness of the hospice curricula. Surveys included questions on students' experience observing and participating in hospice referrals, their attitudes regarding physician responsibility in making a referral, and their self-reported preparation, comfort, and skill in discussing a patient referral for hospice care. This study was approved as exempt from review by the Institutional Review Board (IRB) of the University of Connecticut School of Medicine, and students were informed that participation was voluntary, would not affect evaluation of their performance during the clerkship, and responses would be anonymous.

Results

Students in the first three family medicine blocks of the year (January–December 2006) were taught using Curriculum A and in the last three blocks of the year using Curriculum B. There were 37 students in each cohort. All students attended the hospice curricula, and all voluntarily participated in both surveys. Students reported comparable skill levels in both groups.

Following the hospice module, students exposed to both curricula showed a statistically significant improvement in skill (chi-square: 34.2 (A) versus 33.7 (B), $P \leq .000$), self-assessment of preparation (chi-square: 41.3, 51.4, $P \leq .000$), and self-reported comfort (chi-square: 41.3, 51.4, $P \leq .000$), but there was little difference between the two curricular groups on any of these post-clerkship questions.

Table 1

Hospice Curriculum Schedule Comparisons

Time Allocated	*Curriculum A*	*Curriculum B*
Session 1 (total time: 1:00)	(total time: 1:00)	(total time: 1:00)
0:00–0:05	Introduction	Introduction
0:05–0:12	EPEC Video: Dame Cicely Saunders	EPEC Video: Dame Cicely Saunders
0:12–0:55	VNA nurse presentation (40 min) VNA nurse Q&A (3 min)	VNA nurse Q&A (43 min)
0:55–1:00	Wrap-up and hospice assignments	Wrap-up and hospice assignments
Interim week (total time: 4:00)		
0:00–4:00	Home hospice visit and hospice team meeting	Home hospice visit and hospice team meeting
Session 2 (total time: 2:30)	(total time: 1:30)	(total time: 2:30)
0:00–0:30	Discussion of hospice visit	Discussion of hospice visit
0:30–0:40	Introduction to video	Faculty demonstration of hospice discussion
0:40–1:15	Video/discussion	Answer questions
1:15–2:15	Wrap-up	Students practice role plays/discussion
2:15–2:30		Wrap-up

EPEC—Education for physicians on end-of-life care
VNA—Visiting Nurses Association

Students were able to make anonymous open-ended comments about the hospice component of the clerkship. Few students in curriculum A commented on what was most instructive; eight stated that the post-hospice home visit discussion and viewing the live demonstration by the faculty was most informative; four stated the lecture by the hospice nurse was helpful. For curriculum B, 31 students commented that the combination of the role-plays and video demonstration were the most instructive component of the experience. Representative comments give us a window into the metacognitive learning that took place: "The hospice visits are nice but don't teach you how to communicate about entry into hospice care;" "It was really helpful to see how it feels to actually tell someone they need to consider hospice care; it was harder to talk about than I thought it would be."

Discussion

This study assessed students' attitudes, experiences, and ability in discussing entry into hospice with patients, before and after implementing changes in the hospice curriculum within the family medicine clerkship. The results indicate that both curricula were effective in increasing students' self-reported skill and preparation to lead discussions about hospice. Students in the interactive curriculum (B) indicated subjectively that the video and role-plays were an important tool for their learning. From a faculty standpoint, the video example of discussing hospice was easier since skilled faculty did not have to be present.

This study was limited in its assessment due to the small number of students in each rotation block but suggests that simply having a curriculum for hospice care discussions improves students' skills and comfort. Administration of the survey to future family medicine students would allow for a larger sample and thus greater power to determine any differences in the effects of the two types of instruction.

While many of our curricular components are not new, they permit students to practice the undertaught skill of discussing entry into hospice in a safe environment with immediate feedback and ample time for self-reflection on their home visit experiences.

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