UNDERGRADUATE MEDICAL EDUCATION IN PALLIATIVE MEDICINE
The First Step in Promoting Palliative Care in Lebanon

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ABSTRACT : Effective delivery of high-quality palliative care requires effective interprofessional team working by skilled healthcare professionals. Palliative care is therefore highly suitable for sowing the seeds of interprofessional team working in early professional undergraduate medical education. Integrating palliative medicine in undergraduate medical education curricula seems to be a must. In this review, we present as an example the Palliative and End-of-Life Care Curriculum (PEOLC) used in Canada for undergraduate medical education and underlinethe need for such a national curriculum in Lebanon. One must keep in mind that medical education does not stop at the end of the medical school, ongoing learning needs exist. Continuous medical education in palliative care should also be emphasized ; the overall goal is promoting palliative medicine. Respecting and protecting human dignity is the right of every patient.

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RÉSUMÉ : La mise en œuvre efficace de soins palliatifs de qualité nécessite un travail en équipe interdisciplinaire par des professionnels de santé qualifiés. De ce fait, les soins palliatifs peuvent encourager la collaboration interdisciplinaire dès le début de la formation professionnelle. L'intégration des soins palliatifs dans les cursus en vigueur dans les facultés de médecine devient une nécessité. Dans cette revue, nous présentons comme exemple le curriculum des soins palliatifs et de fin de vie en vigueur au Canada dans le cadre de la formation médicale prédoctorale. Nous soulignons l'importance de promouvoir la médecine palliative en l'intégrant dans la formation médicale continue. Nous insistons surla nécessité d'adapter et d'inclure un tel curriculum dans la formation médicale à l'échelle nationale libanaise, le respect et la protection de la dignité humaine étant un droit pour chaque patient.

ORIGIN AND DEVELOPMENTOF PALLIATIVE MEDICINE : THE INCREASING NEED FOR UNDERGRADUATE MEDICAL EDUCATION

Presumably, man has attempted to relieve the suffering of his fellow creatures since he first appeared on earth. The history of hospices is well documented from the Middle Ages through their modern developments toward the end of the nineteenth century up to our days, with their worldwide proliferation. The origins of palliative medicine as a discipline worthy of practicing, study and research are more recent, and to trace them we have only to look back 35 years. In the first decades of the twentieth century, what else could doctors do but palliate ? Much as they must have wanted to be able to do so, there were few conditions they could cure.

Then things began to change. With new medical discoveries (Anesthetic advances, antibiotics, etc.) doctors began to change their goal from palliative caring to absolute curing. Hospitals have not been regarded as welcome havens for patients in the last days of their lives [1]. For example, cancer chemotherapy prolongs lives to only a modest extent in adults with most forms of metastatic cancer, but until very recently assessment of such treatment has concentrated on outcomes such as patient survival, change in tumor size and the toxic effects of the drugs. Trivial but statistically significant improvements in survival have been enthusiastically heralded, whereas the effects of therapy on patients' symptoms and quality of life have been ignored. Formal studies of consumer experiences and views confirmed that pain control was inadequate, symptoms were often left uneased, fears were not answered, spiritual needs were left unrecognized, and doctor's home visits were becoming fewer. Study after study in hospital and community in many different countries produced the same type of report – the dying are a neglected and disadvantaged group in modern health care systems.

Those best able to bring about change were the doctors, already aware and troubled and now conscious of nursing unease and consumer dissatisfaction. Doctors saw clearly that better care for the mortally ill did not mean a return to the "old days", nor any rejection of scientific medical advances, but rather a healthy marrying of both of them :

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"Science and compassion are not antagonistic – they are symbiotic'". Thus palliative medicine was born. Modern palliative care dates back to 1967, when Dame Cicely Saunders responded to what she perceived to be a deficit in the care of dying patients by opening St. Christopher's Hospice in London, England [2]. She based her model of humane care for the dying on a sound educational and research base. Since then, thousands of palliative care programs have been established in many communities in the Western world, particularly Great Britain, Canada, the United States, Australasia and Scandinavia. Other developed countries have been slow to establish formal palliative care programs, but most Western European nations are now introducing palliative care into their health care systems.

Thus it would be outrageous to cast all blame on the clinicians and not look at the parallel changes in medical education. The already packed curriculum was pruned here and added to there to accommodate details of new advances in medicine and ever-increasing scientific details and data. "Softer" subjects, such as communication skills, ethics, psychological aspects of medicine, etc., were given less time, relegated to low priority slots, or omitted completely. Therefore, possession of good palliative care skills is essential for every doctor – indeed, the UK General Medical Council (GMC) document *Tomorrow's Doctors* identifies palliative care as one of the core content areas for undergraduate medical education [3]. In the UK, death is the final taboo [4] and many patients and families still find that we fall far short of providing palliative care that is delivered in an effective yet caring manner [5]. All medical schools in the UK now include some teaching on palliative care within the undergraduate curriculum [6], but palliative care is still seen as being synonymous with the care of patients dying of advanced cancer. The requirement to extend the boundaries of palliative care for all patients is acknowledged, and many believe this is a natural progression for a specialty that has proven its efficacy and benefits for patients with advanced cancer.

We tend to believe that the concept of palliative care for all patients is new, but 40 years ago a study found that patients dying of renal failure and heart failure had greater distress than those dying of cancer [7]. More recently, research has highlighted the needs of non-cancer patients with chronic life-threatening disease, emphasizing not only their physical distress in their last year of life but also the great psychological distress many of these patients suffer [8-9]. On the other hand, in 1999, the Council of Europe stipulated that : *"The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life. This respect and protection find their expression in the provision of an appropriate environment, enabling a human being to die with dignity."* [10]

This is to remind us that palliative care is the right of every patient and its provision the responsibility of every doctor.

So how can we provide palliative care for all patients who require it and what is it that we are trying to provide ?

The key skills of palliative care are of caring holistically within a multidisciplinary team ; the knowledge of how and when to use drugs appropriately ; the wisdom of knowing that just because something can be done it does not mean it should be done and that at times the best treatment is no treatment. Palliative care teams are not afraid of facing the challenges of difficult ethical and often highly emotional decisions.

These skills and knowledge can only be achieved by integrating palliative medicine in undergraduate medical education ; the overall goal is having every medical student and resident graduate with knowledge, skills and appropriate attitudes in palliative care.

PALLIATIVE AND END-OF-LIFE CARE CURRICULUM UNDERGRADUATE MEDICALEDUCATION (PEOLC) : THE CANADIAN EXAMPLE

[This section is adapted from The Educating Future Physicians in Palliative and End-of-Life Care (EFPPEC) Project accessible for complete reference at *www.efppec.ca*]

- ➢ The goal of this palliative and end-of-life care undergraduate curriculum is not to usurp curriculum but to integrate end-of-life care competencies, their enabling competencies and specific objectives into each medical school's curriculum and build on currently existing curriculum. The end point is not to create a single course or clinical rotation. Rather it is known and expected that some of the competencies may be handled within established courses such as bioethics, communications and other courses and clinical rotations within each faculty.
- ➢ The PEOLC curriculum enabling competencies and specific objectives will :
  - Cover pre-clerkship and clerkship years.
  - Have the students on graduation being competent to contribute effectively to discussions on the interdisciplinary management of terminally-ill patients and their families.
  - Students are not expected to be able to "do" everything but to contribute at an appropriate level to address all the competencies.
- ➢ This curriculum should not be seen as a curriculum taught by palliative medicine specialists only. It is critical that other opinion leaders and teachers in other specialties and professions be involved.
- ➢ The curriculum must be taught both in pre-clerkship and clerkship parts of the medical school curriculum.
- ➢ It is important that medical students are exposed to role models in all specialties who practice quality end-of-life care.
- ➢ The curriculum in many areas provides opportunity for interprofessional education.
- ➢ This curriculum discusses which teaching methods

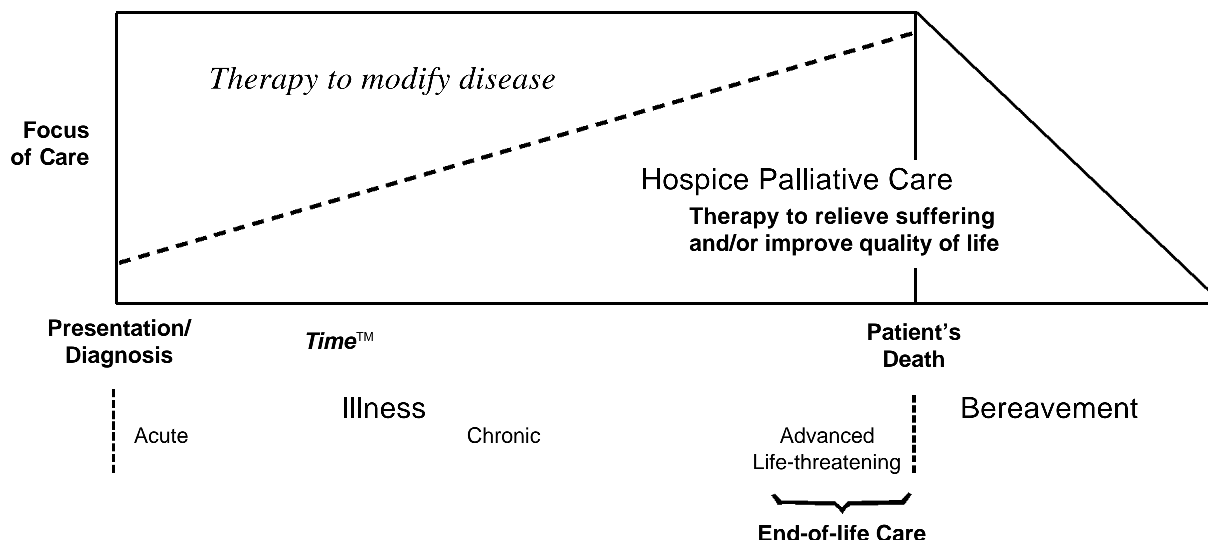

FIGURE 1. The model of palliative care

and evaluation methods may be most effective.

- The undergraduate curriculum will be complemented by the development of postgraduate competencies for all clinical residents.
- The definition of palliative care and the model of palliative care follow the model developed by the Canadian Hospice Palliative Care Association presented in Figure 1 [11].

The PEOLC

This curriculum consists of enabling competencies in five skills :

I. Medical Expert/Skilled Clinical Decision-Maker
II. Manager
III. Communicator
IV. Collaborator
V. Health Advocate

Every competency required is divided into subcompetencies that must be acquired in order to accomplish learning.

I. Medical Expert/Skilled Clinical Decision-Maker

1. When graduating from medical school, students will be able to address and manage pain and symptoms.

1.1. Assess pain and symptoms effectively via a pain history, appropriate physical exam and relevant investigations.

1.2. Propose evidence-based opioid therapies, including effective prescribing, titration, breakthrough dosing and prevention of side effects.

1.3. List and justify adjuvant modalities and medications for pain in palliative care patients.

1.4. Recommend evidenced-based plans for other symptoms including fatigue, anorexia and cachexia, constipation, dyspnea, nausea and vomiting, delirium, anxiety and depression.

1.5. Assist in monitoring the efficacy of treatment plans for pain and symptoms.

1.6. Contribute to recording a holistic management plan.

2. When graduating from medical school, students will be able to address psychosocial and spiritual needs.

2.1. Assess psychosocial and spiritual issues in end-of-life care including grief.

2.2. Develop and propose a care plan in collaboration with other disciplines.

2.3. Self-assess one's own attitudes and beliefs in caring for the dying.

2.4. Demonstrate cultural, religious and aboriginal sensitivity in addressing end-of-life care.

II. Manager

3. When graduating from medical school, students will be able to address end-of-life decision-making and planning using basic bioethical and legal framework.

3.1. Assist in determining, recording and implementing goals of care through effective communication with patients, families and other caregivers.

3.2. Propose advance care plans, including developing and discussing advance directives with patients and families.

3.3. Describe models of end-of-life care.

3.4. Distinguish between physicians assisted suicide and euthanasia and terminal sedation, and withholding and withdrawing therapy.

III. Communicator

4. When graduating from medical school, students will be able to communicate effectively with patients, families, and other caregivers.

4.1. Communicate information about the illness effec-

tively including bad news.

4.2. Participate effectively in patient and family meetings.

4.3. Assist in the education of patients and family about end-of-life care issues and pain and symptom management.

4.4. Keep adequate medical records.

IV. Collaborator

5. When graduating from medical school, students will be able to collaborate as members of an interdisciplinary team.

5.1. Describe the complementary roles of physicians and other formal caregivers in end-of-life care.

5.2. Demonstrate an interdisciplinary case approach with formal and informal teams.

V. Health Advocate

6. When graduating from medical school, students will be able to attend to suffering.

6.1. Describe the elements of suffering in end-of-life care for patients, families and caregivers.

6.2. Describe a supportive approach to suffering.

6.3. Demonstrate self-awareness and self-care in caring for terminally ill patients.

Teaching competencies in PEOLC

1. Some of the specific objectives listed in the document can be introduced through interactive lectures with medical students.
2. However, in pre-clerkship years, many of the objectives are best served by small group case-based teaching that allows development of self-awareness, the expression of feelings and the development of skills and attitudes that are important in achieving the best quality end-of-life care. This case-based teaching can include the use of standardized patients.
3. Similarly small group case-based teaching is appropriate for clerkship but the preferred method of teaching is to integrate teaching into ward rounds, case report rounds and clinical observation and evaluation of students.
4. Suitable role models are invaluable in guiding students through distressing experiences with dying patients.

Evaluating competencies in PEOLC : Evaluation drives learning

1. Multiple choice questions are probably the best and most reliable way to assess knowledge acquisition in the competencies.
2. However, skills and attitudes are best assessed through the use of OSCEs (Objective and Structured Clinical skills Examination), standardized patients and families, and observation and evaluation of clinical performance in rotations such as general medicine where the exposure to dying patients is the greatest.

This was about the Canadian Curriculum but what is about the **Lebanese** one?

Unfortunately, only one medical school among the six schools teaching medicine in Lebanon has dedicated an eight hours module for palliative care and pain management. This module covers the definition and interest of palliative care medicine, its purpose and the communication skills needed in patients and families accompaniment. A more developed palliative medicine curriculum needs to be implemented on a national level among the six existing medical schools.

But because other countries may look to the palliative medicine curricula established in the UK, Canada and the US for models, it is important to point out that lack of agreement on the curriculum content remain an issue. There is a consensus that essential elements of a palliative medicine curriculum should include pain management and clinical pharmacology, psychosocial support, symptom control and communication skills. Still, training in palliative medicine is challenging because the limits, objectives and nature of palliative medicine are not clearly agreed upon by practitioners [12]. In the US, psychosocial issues such as bereavement among relatives dying of cancer are not addressed in the curriculum. In the UK, there is a little emphasis on problem-based learning – a survey of medical palliative care teaching found that 66% of the topics were taught in lecture format [13] – and a concern that the growing popularity of modular courses in palliative medicine may make palliative education a series of unrelated chunks of content [14].

ONGOING LEARNING NEEDS

While experience and research has suggested that opportunities for better undergraduate education in palliative care exist, there are also ongoing learning needs – medical education does not stop when medical school ends. It is necessary to provide differing levels of education for healthcare professionals according to their specific needs. The level of education should be adapted to the degree of palliative care involvement in their everyday practice since *“All professionals do not need to receive the same level of training. Roles with both the patient and team may differ, as does the type and overall number of patients whom they come into contact with.”* [15]

This is reflected in Table I which describes three different levels of palliative education, considering the fact that in some countries, specialist academic knowledge may be at this time unattainable and therefore practice knowledge may be equally valuable.

But one must keep in mind that opportunities for direct experience in palliative care at postgraduate or post-training level for doctors are limited. In palliative medicine in the UK, there are only 38 approved Senior House Officer posts and competition for these posts is very intense and learning opportunities are largely limited to the management of inpatients [16]. There are

TABLE I
LEVELS OF PALLIATIVE EDUCATION

Level A	BASIC (Undergraduate)	Future healthcare professionals during their initial training
	BASIC (Postgraduate)	Qualified healthcare professionals working in a general health care setting who may be confronted with situations requiring a palliative care approach
Level B	ADVANCED (Postgraduate)	Qualified healthcare professionals who either work in specialist palliative care or in a general setting where they fulfill the role of resource person. Qualified healthcare professionals who are frequently confronted by palliative care situations (*e.g. oncology, community care, pediatrics and elderly care*)
Level C	SPECIALIST (Postgraduate)	Qualified healthcare professionals who are responsible for palliative care units, or who offer a consultancy service and/or who actively contribute to palliative education and research

many diplomas and degrees available in palliative care, but these tend to be taken by those specializing in this area and rarely by those working in other specialties. Palliative care includes not only control of physical symptoms but also addresses the many psychological, social and spiritual issues that affect patients as the end of life approaches. GPs recognize the need for provision of palliative care for all patients [17], but a survey of UK vocational training schemes for those wishing to specialize in primary care revealed that palliative care teaching is very variable, focuses predominantly on cancer related palliative care and that nine schemes did not offer any teaching in this subject [18].

So the remaining question is how can palliative care be extended ? How can we extend boundaries?

There are hundreds of postgraduate study days held each year on various aspects of palliative care but no studies of their effectiveness. We would suggest that all study days require defined learner centered objectives and should include a variety of teaching methods and where possible be multidisciplinary in nature. The complexities presented by patients with multiple clinical problems require effective organization, communication and teamwork, which require professionals, patients and carers to work together for the benefit of the patient. This is especially true of palliative care where these complexities are often intensified by the patient's diminishing stamina and rapid deterioration as well as relatives'physical and emotional exhaustion. In consequence, education in palliative care is not only the aim of medical curricula but other healthcare professionals (nurses, pharmacist, physical therapist, etc.), social workers and even clergy need to address palliative care in their education ; palliative care being a suitable setting for multidisciplinary interprofessional teamwork. There is a need to develop partnerships in care, and to look critically at the skills and knowledge required to enable palliative care to be provided within all settings.

The key to providing effective palliative care for all is the provision of a generic evaluated and assessed undergraduate curriculum for medical, nursing and other healthcare professionals undergraduates coupled with appropriate postgraduate and continuing professional education. Only then can we begin to truly extend the boundaries of palliative care and ensure that all patients are enabled to have access to appropriate and effective care at all times and in all settings.

THE LEBANESE COLLEGE FOR PALLIATIVE MEDICINE : IS IT THE WAY ?

There is no doubt that undergraduate medical education may be the first step to promote palliative medicine in Lebanon. In this perspective, creating a Lebanese national college for palliative medicine will be of great interest.

This national college will group active members from the educational committees of all the Lebanese medical schools ; doctors, nurses and psychologists will be included. Such a multidisciplinary composition will facilitate this college mission in promoting Lebanese palliative medicine.

Actions can thus be undertaken to integrate palliative care in :

1. Undergraduate medical education.
2. Residency programs of specialties dealing with palliative care such as : internal medicine, oncology, anesthesiology, pain medicine, etc.
3. Continuing medical education.

This national college may also have a role in educating pharmacists, psychologists, physical therapist and social workers.

A more ambitious action will be the development of a national training program for future teachers in palliative care medicine. This program can be based on interactive educational methods.

Finally we must emphasize, that every action or program elaborated by this college must be supported by the Lebanese Order of Physicians and adopted by all the Lebanese medical schools ; in the hope that one day palliative care brings its way to the Lebanese medicine.

CONCLUSION

Modern palliative care should be viewed as the prevention and relief of suffering by identifying, assessing and treating both physical and psychosocial symptoms as early as possible in patients with incurable medical problems [2]. Key literature within palliative care would suggest that as a specialty, palliative care is developing a body of substantive knowledge on which to base practice. Therefore the potential development of palliative care is based on education and research as the core component to practice [19]. According to the World Health Organization *"Education is a priority for ensuring the effective implementation of a cancer pain relief program,"* in accordance with these recommendations governments, professional organizations and institutions in many countries have taken steps to improve physician training in cancer pain control and palliative care. Examples of initiatives which are changing the culture of pain management and palliative care can be identified in the United Kingdom, Canada and the USA ; we highlighted the Canadian curriculum.

Nongovernmental organizations including the European Association for Palliative Care have also issued recommendations to improve education for physicians-in-training.

Clearly, the existence of curricula and training programs alone is not enough to insure improvements in the delivery of palliative care. Although physicians can be tested on curriculum-based questions, cancer pain management and palliative medicine include a set of attitudes and approaches to care which may or may not be taught [20].

The challenge for leaders in academic palliative medicine is to share their expertise and skills in cancer pain management and end-of-life care with primary care physicians and fellows, using training formats that have been shown effective to improve clinical practice.

In summary, those training formats must take into consideration the following points :

➢ Palliative care should be available for all patients regardless of diagnosis.
➢ A core undergraduate curriculum is essential for medical and nursing undergraduates.
➢ Palliative care should be assessed within the undergraduate curriculum.
➢ Postgraduate teaching should be experiential and learner-centered utilizing patients or bereaved carers as teachers.

All that being said, our final aim is that, one day, we will integrate more and more these principles in our medical education and practice.

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