ESSAY

An Approach to Educating Residents about Palliative Care and Clinical Ethics

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ABSTRACT

Despite interest in end-of-life educational efforts, attitudinal barriers still thwart the integration of palliative care into medical education. The authors present their experience introducing a graduate medical education program in ethics and palliative care at New York Presbyterian Hospital and Weill Medical College of Cornell University. Through this initiative the authors sought to enhance residents' knowledge, skills, and attitudes needed for effective palliative care. Residents were targeted because they are in a unique stage of their training; while they have mastered many basic clinical skills they remain open to educational experiences that might alter their lifelong practice patterns. Course material was based upon the residents' experiences. Using their case histories interested them as adult learners and validated the importance of the subject matter. Seminar themes included professionalism, the physician facing death, ethical, legal, cross-cultural, and religious issues at the end of life, and pain and symptom management. The program provided a valuable educational forum for residents to give voice to their reflections and receive supportive feedback from peers and faculty. Building upon the residents' own clinical experiences with end-of-life care effectively engaged their interest and provided much-needed instruction in this evolving area of study.

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Medical educators and policymakers are increasingly stressing the need to enhance training in palliative care and the ethical issues encountered at the end of life.[1] Inspired by this mandate to improve the care of dying patients, we orchestrated an educational forum in which residents at our institution shared their clinical experiences with the terminally ill. Using the American Board of Internal Medicine curriculum as a guide,[2] we developed a problem-based learning seminar that fostered professional self-reflection.[3] Our goals were to expand residents' palliative care skills, integrate the study of end-of-life care into the residency program, and provide a responsive forum for a resident-driven yet structured educational agenda. In this paper, we present our experience introducing this program to resident physicians at New York Presbyterian Hospital and Weill Medical College of Cornell University.

BACKGROUND

Despite recent progress and heightened national interest in end-of-life educational efforts, formidable attitudinal barriers still thwart the successful integration of palliative care into general medical education. Medical students and residents are uncomfortable facing death and dying. The prevailing medical culture continues to view death as a medical failure. Palliative care, despite its growing scientific base, is often perceived as low-tech or "soft." Many trainees do not view palliative care skills as core clinical competencies. They learn to prescribe antibiotics but they fail to master the use of opioids. These attitudes coalesce into practice patterns that tend to devalue the provision of palliative care even though the public increasingly asserts the importance of humane medical care at the end of life.

We sought to instill in our residents knowledge, skills, and attitudes they need to effectively provide palliative care; we targeted residents because they

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are in a unique stage of their training. Older physicians may have become entrenched in maladaptive attitudes or practices, while medical students may not have had enough exposure to dying patients and their families to benefit from an intensive palliative care program. In contrast, residents have mastered many basic clinical skills but remain open to educational interventions that may affect lifelong practice patterns. We hypothesized that this mix of experience and open-mindedness would make residents especially receptive to our educational program.

We also focused on residents because they are an especially disenfranchised group when it comes to the provision of end-of-life care. Although they provide the bulk of care to hospitalized dying patients, they often have little standing with patients, families, or their attending supervisors when confronted with difficult ethical issues.[4] Residents watch patients suffer and die yet are often without the power or authority to influence the course of events. Although they are moral agents with their own perspectives on what would constitute proportionate and humane care, they are often compelled to follow treatment plans that they did not devise and with which they might not agree. Residents' inability to influence end-of-life care decisions coupled with their inadequate training in palliative medicine can lead them to avoid outright difficult palliative care issues and can adversely affect their career-long abilities to care for dying patients.

COURSE DESCRIPTION

We outlined a basic structure for the course based on major curricular domains in ethics and palliative care. For each session, we planned to ask residents to present cases from their own clinical experiences that touched on these themes. By using case histories from the residents' own patient rosters we endeavored to interest them as adult learners and reinforce the importance and relevance of the subject matter.[5]

Dividing the course into six seminars, we envisioned a progression of study beginning with the inner self and moving on to the larger institutional, societal, and political influences that affect end-of-life care. Themes included professionalism, the physician facing death, ethical, legal, cross-cultural, and religious issues at the end of life, and pain and symptom management. In addition, we considered family and psychodynamic variables that can influence the provision of palliative care.

The residents who elected to attend this pilot program were from internal medicine, surgery, neurology, and psychiatry. The seminar was team-taught by the authors—a faculty member and assistant chief resident from the Department of Medicine.

Below we present a brief synopsis of each session. These descriptions are based on seminar process notes. Certain characteristics of patients whose cases were presented have been modified to protect confidentiality.

Professionalism and Physicians Facing Death

To help the residents reflect upon their experiences with loss and bereavement, we inaugerated the course by reading Sherwin Nuland's account of his brother's death from colon cancer.[6] Using this poignant narrative as a common text, we considered how a clinician's discomfort with death and dying can adversely influence both the medical care he or she provides and his or her relationships with dying patients and their families.

In advance of this first session we asked a resident to present a relevant case. This resident discussed the situation of a patient who had expressed preferences about end-of-life care and then lost decision-making capacity. Considering this case narrative, we addressed when ethical norms and legal precedents might allow surrogates to override patient preferences. We concluded that the reversal of a patient's previously expressed wishes was seldom justified. Nonetheless, we did acknowledge that this sometimes occurs, creating a moral dilemma for housestaff, who perceive that their ability to be patient advocates is compromised by their subservient position in the medical hierarchy. We discussed how this marginalization may adversely affect residents' emergent professional identities as concerned caregivers, and we then outlined constructive strategies that might allow residents greater participation in end-of-life decisions.

Cross-cultural Issues at the End of Life

In this session we considered the question of truth-telling. The case involved an Orthodox Jewish woman with widely metastatic breast cancer whose family insisted that she not be informed of her dire prognosis. Invoking their interpretation of Jewish law, they forbid discussing a do-not-resuscitate (DNR) order with the patient. Using this case vignette, we discussed DNR orders as a secular issue, its legal origins, and its tension with a theocentric view of death and dying. We discussed the patient's right to be informed and the centrality of truth-telling to the doctrine of informed consent and informed refusal. We addressed the housestaff's frustration with what they viewed as futile care and how negative physician countertransference can undermine dialog and complicate ethical dilemmas.

Pain, Suffering, and the Withdrawal of Life-sustaining Therapy

The case of an elderly man who had end-stage lymphoma with hypoxemic respiratory failure and irreversible anoxic encephalopathy led to a discussion about pain and suffering. Some members of the clinical team had asserted that pain medication was not indicated given the scope of the patient's neurologic deficit. A lone resident on the team disagreed, citing the Hippocratic commitment to nonmaleficence.

We reached a consensus that imminently dying patients should be "empirically medicated" where there is uncertainty about their abilities to perceive pain. In addition, we reviewed our attitudes toward pain management with a specific focus on the doctrine of double effect as it applies to the use of opioids at the end of life.[7] In tandem with this discussion of double effect, which hinged upon the question of physician intent, we reviewed the prevailing ethical and legal norms that would permit the withdrawal of life-sustaining therapy, and addressed the feelings of causality and culpability that often attend a physician's involvement in end-of-life decisions.[8]

Brain Death

In this session, the case the resident presented was that of an elderly woman who was a visiting Chinese national with untreated hypertension who had suffered a large intraventricular bleed.[9] When the staff of the intensive care unit instituted brain-death testing, her son objected. After discussions with the family and efforts to accommodate their religious and cultural beliefs, apnea testing proceeded without objection.

In our discussion, we considered the history of brain death as a clinical and legal construct and its role in the development of organ transplantation. We also reviewed the clinical aspects of evaluating a patient for brain death and a strategy for resolving religious objections to such determinations. We then discussed how notions of disease and illness are socially constructed and may contribute to religious or moral objections to the concept of brain death.

Finally, we discussed how professional attitudes toward brain death are influenced both by the clinician's knowledge of science and by his or her moral intuitions. This aspect of our discussion was triggered by what happened in this case after the second apnea test. As recounted by the resident, after the patient had fulfilled the criteria for a declaration of brain death, she slowly raised both hands toward her face and then returned them to her side. This action prompted several of the physicians at the bedside to reach for their stethoscopes. Although we learned that the patient's actions constituted a cervical reflex associated with brain death, we discussed why physicians would reflexively reach for their stethoscopes to confirm that a patient declared to be brain dead was in fact dead. We concluded that their response suggested that each of us may harbor conflicting moral and scientific notions about brain death. This sentiment was nicely articulated by one of the residents, who observed, "perhaps it [brain death] is a theological position dressed up as a medical position." This remark and other comments led us to acknowledge the importance of being self-reflective about the ambiguity and imprecision inherent in clinical medicine.

Pain and Symptom Management

In this session a resident presented the case of a woman with adenocarcinoma of an unknown primary source who had extensive bony metastases and severe hip pain. We discussed pain assessment in cancer patients and focused on pharmacologic management using adjuvant therapies and opioids as suggested by the WHO "analgesic ladder."[10] We reviewed the pharmacology of these agents, their indications and side effects, dosing information, and conversion strategies.[11] To illustrate the interplay of the clinical and narrative dimensions of care, we created a timeline of the patient's course. Using this teaching aide, we sought to demonstrate the importance of considering both the medical aspects of the patient's illness and concurrent psychosocial and ethical developments.

Institutional Issues and Palliative Care

To place the preceding case vignettes in to a broader context, our final seminar addressed end-of-life care from an institutional perspective. Reviewing data on end-of-life practice patterns at our institution, we considered the difficulty of prognosticating the likely courses of terminal illnesses and the challenge of making the transition from curative interventions to palliative care. Our discussion of the determinants of care within our own institution led residents to suggest organizational reforms to enhance the provision both of palliative care for patients and of palliative care education for residents.

CONCLUSION

As academic medicine becomes more interested in palliative care education it is critical that we develop initiatives to overcome attitudinal barriers toward end-of-life care that may undermine learning—and healing. In this pilot program we provided a valuable forum for residents to reflect on and give voice to their own experiences with end-of-life care and receive supportive feedback from peers and faculty. We found that building upon the residents' own clinical experiences effectively engaged their interest and provided needed instruction in this evolving area of study.

There is perhaps no other field of medicine where the technical and humanistic dimensions of clinical work can be better integrated than in the provision of palliative care. Educational strategies that provide residents with an opportunity for critical self-reflection can help young physicians develop the skills and attitudes necessary for the humane care of the dying.

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