Palliative Medicine 1997; **11**: 375–380

Improving the effectiveness of palliative care education

RD MacLeod Mary Potter Hospice, Wellington and **CR James** Business School, University of Glamorgan, Pontypridd

Key words: education, medical; evaluation studies; models, educational; palliative care

Over the last three decades palliative care has emerged as a discrete specialty that has brought with it a developing field of education. Problematic areas have been identified within palliative care education that may limit its effectiveness. Areas of particular concern are identified that may prove obstructive in the pursuit of effectiveness in palliative care education. The possibility of developing performance indicators is explored with reference to the development of such indicators in other areas of education. Proposals are made as a starting point for the evolution of such indicators.

Mots clés: formation, médical; études d'évaluation; modèle, instructif; soins palliatifs

Pendant les trente dernières années les soins palliatifs ont apparu comme une spécialité discrète qui comportait un domaine de formation en évolution. Des domaines problématiques ont été identifiés dans la formation en soins palliatifs qui peuvent limiter son efficacité. On identifie les domaines d'interêts particuliers qui peuvent enrayer la recherche d'efficacité dans la formation en soins palliatifs. On explore la possibilité de développer des indicateurs de performance concernant le développement de tels indicateurs dans d'autres domaines de formation. On fait des propositions pour le point de départ d'évolution de tels indicateurs.

Introduction

The development of palliative care as an identifiable specialty has meant that many areas of care have been re-examined and consequently some aspects of education in those areas will need to be reviewed. A number of indicators, for example, world-wide increases in the age structure of populations, the rising incidence of cancer and the world-wide spread of HIV/AIDS, point to an increase in the need for palliative care in the coming years. As the need for palliative care increases so does the need for palliative care education. For a variety of reasons, not least of which is the requirement for efficient use of resources, there are increasing demands for effectiveness in this form of education. Meeting those needs is particularly challenging because the nature of palliative care means that teaching and learning about it are complex and problematic.[1] The purpose of this paper is to review some of those problematic areas in order to explore ways of improving the effectiveness of teaching and learning in palliative care.

Address for correspondence: Dr RD MacLeod, Mary Potter Hospice, PO Box 7442, Wellington, New Zealand.
E-mail: marypotterhospice@xtra.co.nz

0269–2163(97)PM045OA

The breadth of education in palliative care

Throughout the world there is wide variation in palliative care education. The European Association for Palliative Care has surveyed the current status of professional education in this discipline in Europe[2] and others have attempted broader reviews.[3,4] Palliative medicine curricula have been written and adopted in the UK, Canada and all member states of the European Union, which embrace not only undergraduate but also postgraduate and higher professional training. Work continues on curricula for nursing education in many parts of the world. Formal education programmes have been developed both in Australia[5] and in the UK and plans for further expansions are in progress. Higher professional training in palliative medicine has been available in the UK for some years and there are currently numerous training posts in that country.

Increasing effectiveness in palliative care education: some problematic areas

James and MacLeod[1,6] have previously identified areas that may be problematic in the field of education in palliative care. These included:

- palliation as an emerging field of care;
- an inadequate definition of the field of care;
- palliative care as a new specialty;
- the difficult relationship between palliative care and palliative medicine;
- the problem of identifying a good palliative carer;
- individual expertise and teamwork in palliative care;
- the emotional and psychological demands of palliative care;
- the wide range of settings for palliative care.

To this list could be added the problems of distance, cost and access to effective programmes of education. Some of these issues have been clarified by recent publications (e.g. Doyle *et al.*[7]). Although welcome as contributions to the debate, such frameworks and outlines for practice still leave the educator with very challenging decisions to make about how to put such guidelines into practice.

The use of the term effectiveness in education causes difficulties. The term itself implies that the purpose of an educational act or process is clear and that since the outcome is predetermined, it is then possible to measure its effectiveness. Unfortunately, only very few aspects of palliative care education lend themselves to such a technical approach. In the main, much of this palliative care knowledge is in a different form. It lies in the hermeneutic/interpretive domain (where establishing the meaning of phenomena is essential), in the moral–ethical domain or in the personal domain. In addition, these aspects are, for the reasons outlined above, problematic and lacking in universally accepted unequivocal support. For these reasons, the central question for palliative care educators becomes 'How can we attempt to achieve effectiveness when it is not clear what we are trying to effect?' There is a risk that such is the drive to achieve measurable quality that this question may be side-stepped. Two possible dangers could result from this simplistic approach.

One danger is that this simplification could lead to a technologizing of palliative care education. This mechanistic approach would deny the complexity of palliative care education and view it as a set of particular instrumental responses to a requirement to learn about the different aspects of palliative care. Such an approach sees palliative care education as providing discrete answers to practice problems. This problem-solving view of teaching and learning where teaching is designed to achieve a set of predetermined behavioural objectives is not an appropriate one in this context. It would fail to do justice to the holistic character of palliative care with its multiplicity of interrelated, interconnected and dynamic facets of a personal, technical, practical, moral, social, cultural, emotional and spiritual kind. That is not to say that educational activities in palliative care must inevitably be aimless; they should have intentions and purposes. It is simply recognizing that the complexity of many aspects of palliative care make it impossible to predict and specify the nature of the educational outcomes in any prescriptive way. Neither is this criticism of mechanistic approaches intended to undervalue the teaching of basic skills essential in palliative care such as the use of a problem-solving approach, assessment and listening that are measurable to some degree. Such basic skill development will

always be an important part of palliative care education.

A second danger which could arise from a simplistic approach to palliative care education is that it could lead to a response to meeting the needs of learners in palliative care in which teaching is founded on a deficit model. Such a response would be characterized by a reliance on didactic approaches which sought to transmit the knowledge of those 'who know about palliative care' to those 'who do not know' or by an overemphasis on learning objectives which promote a depersonalized and technical view of palliative care. Simplistic approaches to palliative care education are not appropriate. We would assert that this area of care is best characterized by forms of knowledge that are personal and shared, which seek to reveal meaning through interpretation and which have moral and spiritual dimensions. This implies that a more therapeutic learning environment needs to be created or facilitated and more emphasis placed on ownership and accountability from the learners. Measuring effectiveness in these domains of knowledge is notoriously difficult. The practice of adopting a 'jug and mug' approach to education so loved by medical teachers is still widespread. A survey of medical teachers in hospice programmes[8] found that didactic approaches still predominate, with 66% of topics being taught by lecture. The idea is, perhaps, that by providing 'tips and tricks' for the learners, those teaching in this way may consider themselves to be efficient because they are able to test the knowledge acquired by these means fairly readily. This criticism of lectures is not saying that aspects of palliative care cannot be represented by factual knowledge in propositional form. It is, however, asserting that palliative care is best characterized by other forms of knowledge such as those outlined above, a point emphasized by Sheldon and Smith.[10] Achieving effectiveness in these forms of practice and education requires teachers to be reflective practitioners capable of reflecting both in and on their practice.[10] Reflective practice remains a robust model of professional action although it has been challenged. For example, Eraut[11] has criticized it for its dismissal of technical rationalist approaches and Fenstermacher[12] has called into question the narrow range of cases on which Schon bases his assertions. Van Manen[13] has sought to extend the modes of reflection, stressing the importance of reflection before action and 'stop and think' reflection when action is suspended for reflection to take place. Eraut[11] has sought to separate out the purpose of reflection, stressing the importance of reflection for action. Clarke *et al.*[14] have emphasized the importance of reflection in action in professional action and as a focus for research to redress a shift in emphasis towards reflection on action in the discussion and debate about the nature of reflective practice. They have also stressed two kinds of reflection for professional practitioners: deliberative reflection which takes place within the accepted norms of practice and deep reflection which seeks to extend the bounds of accepted practice. The importance of reflective practice for educators in palliative care is that by reflecting in and on action they will, perhaps, develop their own understanding of palliative care and may move towards being able to facilitate the development of that knowledge by others. By reflecting on their own experience, practitioners and educators can facilitate reflection by others (the learners) and so enable some self-recognition of effectiveness. Attempts have been made at measuring effectiveness in such areas as the ability to cope with stressful situations or self-perceptions of confidence in dealing with physical or psycho-social aspects of care following a course designed for principals and trainees in general practice[15] as measured by changes in self-rating scales for these items.

The issue of effectiveness is made more difficult by changes in philosophy or emphasis within clinical care. The urgent need to control pain and other distressing symptoms effectively can shift the emphasis of the specialty from dying to palliation and for some this has reinforced the need for a medical approach. Such a view of palliative care devalues the broader and, from an educational point of view, more problematic vision of the task of caring for people who are dying. It also has the potential to develop mechanistic and simplistic responses to palliative care education.

However, there is a possibility that in being sensitive to these dangers in the provision of palliative care education and being overcautious about measures of effectiveness, palliative care education is seen as practically beyond evaluation. It is seen almost as being:

- too complex to evaluate, so wide-ranging are its different purposes, processes and content;

- too precious to evaluate, so personal and intimate are the nature and outcomes;
- too problematic to evaluate, so unclear is the nature of palliative care learning;
- too difficult to evaluate, so uncertain and unpredictable are the outcomes of palliative care education.

Performance indicators

Despite the difficulties encountered in evaluating education in palliative care, those involved do have a responsibility to ensure that as far as possible that education is effective and appropriate. Evaluation can give insight and we suggest that performance indicators, refashioned into an appropriate form for palliative care, may be helpful in that evaluation process. Three particular aspects of the use of indicators need to be considered if such indicators are to be helpful.

First, although performance indicators can be used as measures, typically quantitative ones, of performance against preset objectives, there is general agreement that in education, performance indicators should be seen as indicating, signalling and guiding performance rather than as categorical, absolute and definitive measures of performance. They should be viewed as statements against which achievement in an area or activity can be assessed[16,17] and therefore are very likely to be qualitative in nature. If performance indicators are to be used in palliative care education, it is essential that they be seen as indicators rather than as measures of absolute standards. (To use them as absolute measures would encourage mechanistic and simplistic approaches to palliative care education.) In practice, the indicators could perhaps be best used in a group discussion to frame the responses of the learners and to provide rich and illuminating qualitative indications of the learners' experience. This approach would be most useful at an individual problem/issue level and comparison between programmes, for example, could be difficult. It has to be said, however, that such is the variation in any palliative care education that comparisons between programmes will always be difficult. The performance indicators could also help to frame responses in student feedback questionnaires used in the evaluation of many palliative care education programmes.

Secondly, the focus of the indicators must be broader than simplistic measures of outcome: they must embrace inputs, processes and outcomes of educational practice.[18] All three aspects of educational practice are of value and it is quite likely that input and process indicators will be a more helpful gauge of value than outcome indicators. Developing tools to evaluate, for example, lectures, group work, independent work, practical experience, tutorial support or the overall programme organization will also be useful. Other activities which support and enrich learning (for example, library facilities, rest-rooms and social activities) should also be evaluated.

Thirdly, the way that performance indicators are constructed needs to be considered. For example, in the UK, in 1987 the then Department of Education published guidelines for establishing performance indicators.[19] In essence, these guidelines suggested that performance indicators must:

- relate to the stated objectives of the organization;
- be as simple and as few in number as possible;
- be acceptable and credible to those concerned;
- be capable of acting as signposts to key areas where questions concerning operations can and should be asked;
- be specific, quantifiable and standardized.

This set of guidelines may provide a starting point for the development of performance indicators in palliative care education. So, using these guidelines, we suggest the following guiding principles for the development of such indicators.

Guiding principles for the development of performance indicators for palliative care education

1) Performance indicators must be consistent with the values, beliefs, ethos and purpose of the organization where the educational activity is taking place. Further to that, indicators of performance must be consistent with the nature and purpose of palliative care itself. An example might be that the educational activity encourages the exploration of dimensions of care that embrace some ethical principles of health care (e.g. justice, veracity, autonomy, beneficence).

2) Performance indicators must be simple and relatively few in number. This will help to ensure that their meaning can be grasped by all those involved in the educational process. Simple indicators are likely to reveal as much as more complex and elaborate ones and are often more appropriate because they can be more penetrating in terms of revealing information. The case for simplicity is strengthened because the evaluation process is not simply addressing output measures but input, process and outcome measures at a level of appropriateness.
3) Performance indicators should be acceptable to all those concerned in terms of the performance indicators' credibility, appropriateness and relevance to their practice of palliative care and the values that underpin it. To achieve this acceptance, those involved in the educational activity should participate in the specification of the indicators. This has the added benefit of ensuring that the creation of the indicators becomes a development activity in its own right. Involvement of the learners in formulating those indicators may increase active engagement in the learning and promote learner autonomy. Despite the recognition and importance of self and peer review there is little evidence to suggest that these practices are widespread in the caring professions.[20] The creation of a learning environment where these processes are fostered could be seen in itself as a performance indicator for those developing a programme.
4) Performance indicators should act as signposts, guiding educational practice rather than as benchmarks or standards to be attained. Such is the uncertainty of the process of education in palliative care that defined standards are not likely to be of use in promoting the improvement of practice. Negative performance indicators or elements of practice which should not occur may be of particular value.
5) Performance indicators should be specific in that they should focus on the development of learning, in particular that learning which influences practice. However, it is not appropriate for such indicators necessarily to be quantifiable and standardized. Many aspects of palliative care are susceptible to neither quantitative analysis nor standardization since many of the data will be subjective and personal and will be concerned with higher order outcomes. Evidence from the way in which physicians learn, for example, suggests that forces for change take the form of personal, professional and social forces or combinations of these forces.[21] There will be performance indicators where evidence will be collected in the cognitive domain (for example, is the pharmacological knowledge of the learners increased?) but there may also be evidence of aspects of knowledge of a physical and emotional kind which may not be measurable objectively. There will be indicators where the evidence will be of a personal nature concerned with an individual's self-awareness, insight and personal understanding. There will be performance indicators that are concerned with the development of processes, particularly higher order ones, in individuals. These might be concerned with developing new ways of thinking or with the development of metacognition or reflective processes. Although performance indicators should relate to features that are observable,[22] it has to be recognized that this may not be possible in palliative care education. It is quite possible for outcomes in palliative care education not to be immediately observable. For example, the outcome of enhanced self-awareness may not be observable except by the individuals themselves and the ability to reflect at a deeper level may not be apparent in an individual's practice.

Writers such as Schon[9] and Nowlen[22] acknowledge the importance of theoretical bases for knowledge but also point to other dimensions such as cultural influences, professional meaning and the 'art' of practice as guided by 'the inner voice'. These components should all act in concert in practice as well as in the educational process but the latter dimensions may not lend themselves readily to the development of performance indicators.

Theoretical bases for knowledge are becoming well established but one of the difficulties faced in palliative care and therefore in palliative care education is an apparent reluctance to make judgements or even observations about the practice of others. Until we can feel comfortable in that area we are in danger of reducing our practice to mere caretaking and minimizing the professional nature of both palliative care and palliative care education. Participation in the shared development of perfor-

mance indicators in the way we have suggested may reduce the anxiety and discomfort associated with making judgements about educational practice.

Conclusion

This paper has identified and reviewed some of the issues surrounding the concept of effectiveness in palliative care education. It has proposed the use of performance indicators as a way of assisting with the difficult task of evaluating palliative care education and establishing its effectiveness and appropriateness. The paper has outlined some considerations and guiding principles for the development of performance indicators in palliative care education. What is now required is further research into the development and use of indicators, particularly in the form of case studies of educational practice. The sharing of such research will help to improve the quality of education in a highly complex and challenging area.

References

1 James CR, MacLeod RD. The problematic nature of education in palliative care. *J Palliat Care* 1993; **9**(4): 5–10.
2 Doyle D ed. *Survey on the current status of professional education in palliative care.* Geneva: EAPC, 1992.
3 Billings A. Medical education for hospice care; a selected bibliography with brief annotations. *Hospice J* 1993; **9**: 69–83.
4 MacLeod RD. Education in palliative medicine: a review. *J Cancer Educ* 1994; **8**: 309–12.
5 Maddocks I, Donnell J. A masters degree and graduate diploma in palliative care. *Palliat Med* 1992; **6**: 317–21.
6 MacLeod RD, James CR eds. *Teaching palliative care: issues and implications.* Cornwall: Patten Press, 1994.
7 Doyle D, Ford G, Webb P, Sheldon F, Murray D. *Working party on education and palliative care.* London: National Council for Hospice and Specialist Palliative Care Services, 1996.
8 MacLeod RD. Teaching postgraduate palliative medicine. Master of Medical Education thesis, University of Dundee, 1992.
9 Schon DA. *The reflective practitioner: how professionals think in action.* New York: Basic Books, 1983.
10 Sheldon F, Smith P. The life so short, the craft so hard to learn: a model for post-basic education in palliative care. *Palliat Med* 1996; **10**: 163–64.
11 Eraut M. Schon schock: a case for reframing reflection in action. *Teachers Teaching* 1995; **1**: 9–22.
12 Fenstermacher GD. The place of science and epistemology in Schon's conception of Reflective Practice. In: Grimmett PP, Erickson GL eds. *Reflection in teacher education.* New York: Teachers' College Press, 1988.
13 Van Manen M. *The tact of teaching: the meaning of pedagogical thoughtfulness.* New York: State University of New York Press, 1991.
14 Clarke B, James C, Kelly J. Reflective practice; reviewing and refocussing the debate. *Int J Nurs Stud* 1996; **33**: 171–80.
15 MacLeod RD, Nash A, Charny M. Evaluating palliative care education. *Eur J Cancer Care* 1994; **3**: 163–68.
16 Hopkins D, Leask M. Performance indicators and school development. *School Organisation* 1989; **9**: 3–17.
17 CNAA. *Towards an educational audit.* London: Council for National Academic Awards, 1989.
18 OECD. *Innovation in education. The search for educational indicators.* Paris: OECD News, 1988.
19 DES. School indicators – a discussion paper (mimeo) circulated Spring 1988. Cited in: Hopkins D, Leask M. Performance indicators and school development. *School Organisation* 1989; **9**: 3–17.
20 Jennett P. Lifelong self-directed learning. In: Coles C, Holm HA eds. *Learning in medicine.* Oslo: Scandinavian University Press, 1993.
21 Fox RD, Mazmanian PE, Putman RW. *Changing and learning in the lives of physicians.* New York: Praeger, 1989.
22 Nowlen PM. *A new approach to continuing education for business and the professions: the performance model.* New York: Macmillan, 1988.