



## Medical School Hotline

### **End-of-Life Care Curriculum for Internal Medicine Residents at the John A. Burns School of Medicine, University of Hawaii**

**Lam V. Nguyen MD, Assistant Professor**  
**Shellie Williams MD, Assistant Professor**  
**Emese Somogyi-Zalud MD, Assistant Professor**

**Division of Geriatric Medicine**  
**John A. Burns School of Medicine**

In recent years, the American medical community and indeed the nation as a whole have become increasingly concerned with improving the quality of care for chronically and terminally ill patients and their families. In November 2002, Last Acts, a coalition of more than 1,000 professional and consumer organizations including the American Medical Association, the American Hospital Association, AARP and NAACP, released a national report card on end-of-life care. The report rated the quality of end-of-life care in all fifty states. Only 11% of Americans polled believed that the U.S. health care system is doing an "excellent" or "very good" job caring for the dying. 93% of those surveyed found improving medical care for the dying to be important. Hawaii received high ratings in several areas including advance care planning and the care of dying patients in intensive care units. Hawaii fell short in areas such as the number of health care professionals trained in palliative medicine, hospice referrals and pain policies.<sup>1</sup>

In response to the growing interest and need, the American medical community has begun to develop training guidelines and a variety of curricula in palliative medicine and end-of-life care. In 1993, the American Board of Internal Medicine (ABIM) initiated a special project dedicated to improving end-of-life care. The project helped to define care of the dying as an important issue in clinical care and resident competency. Data from the 1997-98 AMA Annual Survey of Graduate Medical Education revealed that only 60% of all responding programs had formal curricula in end-of-life care. In 1997, the ABIM added end-of-life care to its educational requirements for post-graduate education and began including end-of-life care content in examinations. In 1998, the Accreditation Council on Graduate Medical Education (ACGME) made palliative medicine education a residency training program requirement. The ACGME stated that,

*"Each resident should receive instruction in the principles of palliative care for terminally ill patients, including the role of the health-care team. Instruction should include psychosocial, cultural, and religious issues related to death and dying. It is desirable that residents participate in hospice and home care."*

In recent years, many organizations have published curricular guidelines for end-of-life care. The Canadian Palliative Care Association's palliative care curriculum, the American Board of Internal Medicine's *Care for the Dying: Identification and Promo-*

*tion of Physician Competency*, and the National Consensus Conference on Medical Education for End-of-Life Care are three important examples of such guidelines. To facilitate the implementation of end-of-life care curricula, Weissman and colleagues developed an educational program targeted toward residency training directors in internal medicine and family medicine. The program includes resident and faculty needs assessment, knowledge testing and attitudinal surveys. 210 residency programs have or are currently scheduled to participate in the educational initiative.<sup>2</sup>

Despite the increasing interest in end-of-life care and development of curricular templates, multiple barriers to education exist in this area. Many training programs lack the knowledge, resources and commitment required to improve training in palliative medicine. The number of medical school faculty trained to provide and teach palliative medicine is inadequate. Other factors cited as barriers to education include physician attitudes that dying patients are not good "teaching cases"; clinician focus on treatment of disease rather than the patient's issues regarding end-of-life; the lack of structured palliative medicine programs in teaching hospitals; and the under-representation of care of the dying in standard medical textbooks. The result is insufficient clinical exposure to palliative medicine and over-reliance on lectures as the vehicle to teach end-of-life care.

It is estimated that 75% of deaths nationwide occur in hospitals or nursing homes. Resident physicians provide the bulk of care to hospitalized dying patients, yet many feel they are unprepared to deliver adequate end-of-life care. In a 1997 study by Block et al, third year residents rated their ability to provide care at the end of life lower than their ability to handle many other common clinical tasks. Such tasks include the ability to address psychosocial problems, to communicate effectively, to critically analyze medical literature, and to provide preventative care.<sup>3</sup>

The University of Hawaii internal medicine residency program, like many others in the nation, has a commitment to improving physician training in end-of-life care. Currently, aspects of palliative care training are included in resident rotations in critical care, geriatrics, and hematology/oncology. As a first step in the development of a program to teach end-of-life care, curricular needs were assessed to understand both the perceived and prescribed needs of faculty and residents. Perceived needs of the learner were obtained through written surveys completed by the internal medicine residents. Prescribed needs, or those areas that educators or program planners determine as deficient and that need educational intervention, were assessed through individual interviews with residency curriculum faculty and end-of-life content experts. Faculty and residents agreed that more training on end-of-life care was necessary. The majority of the residents ranked their comfort level and preparedness for dealing with end-of-life issues as "fair". They perceived a need for more instruction in three main areas: pain management, advance care planning, and withholding/withdrawing of treatment.

Based on the results of the needs assessment, an end-of-life training program was developed to teach residents the basic attitudes, knowledge and skills necessary to provide sound end-of-life care for patients and their families. The curriculum was divided into three, one-hour sessions, each designed to address a specific end-of-life care issue via an interactive format that involved both residents

and faculty preceptors. The sessions were developed and presented by geriatric medicine faculty. The project was supported in part by the Donald W. Reynolds Foundation Comprehensive Programs to Strengthen Physicians' Training in Geriatrics Grant, Division of Geriatric Medicine, John A. Burns School of Medicine, University of Hawaii.

**Session 1** focuses on addressing the characteristics of a "good" and "bad" death experience, as well as aspects of advance care planning. In small group discussions, residents share their experiences with end-of-life care and the positive/negative aspects of such encounters. The session concludes with discussions of clinical cases highlighting advance care planning.

**Session 2** addresses several topics such as physician-assisted suicide, physical/psychosocial issues related to end-of-life, pain management, and determining the goals of care. Faculty and residents participate in a jeopardy-style game followed by brief discussions on each topic.

**Session 3** deals with the withdrawal of invasive care treatment. Residents are presented with a standardized patient scenario and are given 15 minutes to discuss end-of-life issues with the patient's family. Topics include addressing goals of care, resuscitation status, and withdrawal of ventilatory support. The session closes with a debriefing by the faculty preceptor and the residents who conducted individual standardized patient encounters. Discussions emphasize elements of each interview that were effective and helpful.

A comprehensive, integrated, and longitudinal curriculum is the key to effective training in care at the end of life. At the University of Hawaii, the development, implementation, and sustainability of a high-quality end-of-life care curriculum will have additional benefits including compliance with ACGME guidelines. The curriculum would also help to improve resident performance on standardized tests such as the Internal Medicine In-Training examination and the ABIM certification examination.

The provision of quality care for the chronically and terminally ill is a critically important task. A comprehensive curriculum for resident physicians is a step to ensure better care for patients nearing the end of their lives. Decisions made by dying patients and their families are difficult and challenging. Preparing physicians-in-training with the knowledge, skills and attitudes necessary to address issues in end-of-life care will help patients and their families experience death and dying in a more meaningful way.

#### References

1. Last Acts. Means to a Better End: A Report on Dying in America Today. Nov 2002
2. Block S. Medical Education in End-of-Life Care: The Status of Reform. *J Palliative Med* 2002;5:243-248
3. Weissman DE, Block S, Blank L, et al: Incorporating palliative care into acute medical-surgical hospital education. *Acad Med* 1999;74:871-877.

"Case Report..." continued from p.127

used in this case it is impossible to ascribe clinical signs and symptoms with absolute certainty to any one substance, however Hawaiian Baby Woodrose is suspect as the major cause of this patient's psychotic state 1) due to the number of seeds of a known hallucinogen that were ingested, 2) given the prominence of hallucinations in the overall clinical syndrome, 3) given the clinical syndrome's similarity to previous reports of Hawaiian Baby Woodrose intoxication, and 4) since the other substances ingested are either not known to cause hallucinations as their most prominent feature or have a relatively short half-life/were taken in relatively low doses and are thus unlikely to cause this clinical scenario.

Due to the risk of psychosis, it is important for Hawaii physicians to recognize the effects of Hawaiian Baby Rosewood ingestion since it can be found growing locally in Hawaii. Furthermore, although the patient failed to disclose where he procured the seeds, the authors were able to find several internet web sites with a sophisticated commentary offering direct-to-consumer marketing of Hawaiian Baby Woodrose seeds as a recreational hallucinogen (\$11-15 per dose of 10 seeds). Further investigation into anecdotal experiences with this substance published on the World Wide Web suggests that serious psychotic episodes may not be as uncommon as would be suggested by the paucity of medical literature on the subject. In conclusion, the authors suggest that Hawaiian Baby Woodrose seed ingestion should be present in the differential diagnosis when dealing with the acutely psychotic young adult patient.

#### Authors

\* University of Hawaii, John A. Burns School of Medicine, Honolulu, Hawaii

\*\* University of Hawaii, John A. Burns School of Medicine, Department of Psychiatry, Honolulu, Hawaii

#### References

1. Borsutzky M, Passie T, Paetzold W, Emrich HM, Schneider U. Hawaiianische Holzrose: (Psycho-)Pharmakologische Wirkungen der Samen der *Argyreia nervosa* Eine fallbezogene Darstellung. *Nervenarzt* 2002, 73(9):892-6.
2. Al-Assmar S. The Seeds of the Hawaiian Baby Woodrose are a powerful Hallucinogen. *Arch Intern Med* 1999, 159(17):2090.

