

Are family medicine residents adequately trained to deliver palliative care?

Ramona Mahtani MD CCFP Allison M. Kurahashi MEd Sandy Buchman MD CCFP FCFP Fiona Webster PhD
Amna Husain MD CCFP MPH Russell Goldman MD MPH CCFP

Abstract

Objective To explore educational factors that influence family medicine residents' (FMRs') intentions to offer palliative care and palliative care home visits to patients.

Design Qualitative descriptive study.

Setting A Canadian, urban, specialized palliative care centre.

Participants First-year (n=9) and second-year (n=6) FMRs.

Methods Semistructured interviews were conducted with FMRs following a 4-week palliative care rotation. Questions focused on participant experiences during the rotation and perceptions about their roles as family physicians in the delivery of palliative care and home visits. Participant responses were analyzed to summarize and interpret patterns related to their educational experience during their rotation.

Main findings Four interrelated themes were identified that described this experience: foundational skill development owing to training in a specialized setting; additional need for education and support; unaddressed gaps in pragmatic skills; and uncertainty about family physicians' role in palliative care.

EDITOR'S KEY POINTS

- To meet the demands of the increasing number of patients who need palliative care, family physicians are encouraged to take a lead role in management of these patients, with access to palliative care specialist support when needed. The reality in Canada is that a minority of family physicians are providing palliative care and home visits to their dying patients.
- Contrary to intentions, palliative care education might be disengaging family medicine residents by reinforcing a notion that palliative care is a specialized area of medicine.
- Family medicine residents highlighted potential educational changes such as improving access to family medicine mentors who practise palliative care, teaching how to incorporate palliative care into one's practice, and improving access to both palliative care continuing professional education and palliative care specialists when needed.

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Conclusion Residents described experiences that both supported and inadvertently discouraged them from considering future engagement in palliative care. Reassuringly, residents were also able to underscore opportunities for improvement in palliative care education.

Les résidents en médecine familiale ont-ils une formation appropriée pour prodiguer des soins palliatifs?

Ramona Mahtani MD CCFP Allison M. Kurahashi MEd Sandy Buchman MD CCFP FCFP Fiona Webster PhD
Amna Husain MD CCFP MPH Russell Goldman MD MPH CCFP

Résumé

Objectif Déterminer ce qui, dans la formation des résidents en médecine familiale (RMF), a une influence sur leur intention de prodiguer des soins palliatifs et de faire des visites à domicile à des patients en fin de vie.

Type d'étude Une étude descriptive qualitative.

Contexte Un centre de soins palliatifs en milieu urbain, au Canada.

Participants Neuf résidents-1 et 5 résidents-2 en médecine familiale.

Méthodes On a effectué des entrevues semi-structurées avec des résidents en médecine familiale qui avaient suivi un stage de 4 semaines en soins palliatifs. Les questions portaient sur leurs expériences pendant le stage et sur leur façon de percevoir leur rôle comme médecins de famille chargés de prodiguer des soins palliatifs et de faire des visites à domicile. Une analyse des réponses des participants a permis de résumer et d'interpréter les différents thèmes en lien avec ce qu'ils avaient retenu de leur stage.

Principales observations Cinq thèmes inter-reliés ont été identifiés, qui décrivent ce qu'ils avaient retenu: le développement de compétences fondamentales grâce à un stage dans un milieu spécialisé; le besoin de plus de formation et de soutien; le manque de formation relative à certaines habiletés pragmatiques; et l'incertitude à propos du rôle du médecin de famille dans les soins palliatifs.

Conclusion Les résidents ont décrit des expériences qui les avaient encouragés à prodiguer des soins palliatifs dans leur future pratique, mais aussi, à certains égards, découragés de le faire. Il est toutefois rassurant de constater que les résidents ont aussi été capables de faire des suggestions pour améliorer la formation en soins palliatifs.

POINTS DE REPÈRE DU RÉDACTEUR

- Pour faire face au nombre croissant de patients qui nécessitent des soins palliatifs, les médecins de famille sont encouragés à jouer un rôle majeur dans le traitement de ces patients, avec l'appui, lorsque nécessaire, des spécialistes de ce domaine. Au Canada, toutefois, ce n'est qu'une minorité de médecins de famille qui fournissent des soins palliatifs aux patients en fin de vie et qui les visitent à domicile.
- Contrairement à ce qu'on aimerait, les résidents en médecine familiale hésitent à s'engager dans cette voie parce que leur formation renforce l'idée qu'il s'agit là d'un domaine spécialisé de la médecine.
- Les résidents en médecine familiale ont insisté sur la nécessité de faire certains changements dans leur formation, tels que : permettre plus d'accès à des mentors de médecine familiale qui prodiguent des soins palliatifs, enseigner comment incorporer ces soins dans leur pratique, fournir plus de formation continue sur ce type de soins et faciliter l'accès aux spécialistes de ce domaine lorsque c'est nécessaire.

Cet article a fait l'objet d'une révision par des pairs.
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Evidence suggests that most people with a terminal illness want to die at home,¹ which requires appropriately trained health care providers to support them and their family members. Unfortunately, such support is not readily available. Despite the increasing proportion of elderly Canadians with complex care needs and longer survival,² there has not been a corresponding increase in the number of skilled health providers to care for them in their homes.

Local health authorities are encouraging family physicians in Ontario to take a lead role in managing palliative care patients, including providing home visits,³ and are suggesting that palliative care specialists further supplement the care for difficult-to-manage cases. However, evidence suggests that fewer family physicians are providing palliative care and home visits for homebound dying patients. For example, the 2010 National Physician Survey revealed that an average of 42.4% of Canada's family physicians offered home visits, and that this rate was lower in younger family physicians.⁴ However, these numbers might overestimate the number of physicians providing *regular* home visits⁵ and, to a greater degree, the number of home visits made to palliative patients.⁶ As a result, there is additional demand on an insufficient number of palliative care specialists.⁷

Several recent studies have identified lack of palliative care skills and insufficient training as reasons why family physicians chose not to do home visits or manage patients requiring more intensive palliative care.⁷⁻⁹ Considering how adequate training appears to influence one's decision to engage in palliative care and home visits, it is critical to understand how to optimally structure these educational experiences to promote engagement.

In this study, we asked whether there was a connection between family medicine residents' (FMRs') educational experiences in palliative care and their intentions to integrate palliative care and home visits for dying patients (hereafter referred to as *palliative care*) into their future practices. While the context of our study is palliative care for patients with advanced disease, the results have broader implications for training FMRs to care for frail elderly patients. Although these are currently viewed as 2 distinct populations, they share characteristics of complex care. Increasingly, we are recognizing that there are specific skills needed to deliver care to those with chronic and complex disease beyond providing a diagnosis and prognosis.

METHODS

Overall design

This qualitative descriptive study is nested in a larger mixed-methods palliative care education research study. The design was exploratory and structured to capture

experiences that were perceived by participants to be the most salient.¹⁰ We approached both our questions and our analysis with the goal of understanding the meanings participants assigned to their experiences rather than attempting to apply an a priori theoretical framework or generate a new one.^{10,11}

Sample size and recruitment

Participants were recruited from the 2013 to 2014 double cohort at the University of Toronto in Ontario, consisting of 12 first-year and 13 second-year FMRs, during their mandatory 4-week palliative care rotations. This cohort was purposively sampled to best represent FMRs with diverse experience and because it offered double the number of potential participants. Family medicine residents were approached in person at a teaching session by the research coordinator (A.M.K.).

Rotations were completed at a specialized palliative care centre in the urban centre of Toronto. Twenty-four physicians offer palliative care services to patients in their homes (*community*) and in inpatient settings (*inpatient*).

The year was divided into 13, 4-week blocks. During their palliative care block, residents spent 2 weeks each in the inpatient and community environments. Each block consisted of a first-year resident and a second-year resident, except for block 8, which only had a second-year resident. Ethics approval was obtained from the Mount Sinai Hospital Research Ethics Board in Toronto.

Data collection

Following their 4-week rotation, residents participated in a semistructured interview about their educational experience during the rotation and their perceptions about their roles as future family physicians in the delivery of palliative care. Interviews were done face to face or over the telephone.¹² To minimize influence on participant responses, interviews were conducted by the research coordinator (A.M.K.), who had no involvement in the participants' educational experience or evaluations. Interviews were audiorecorded and professionally transcribed clean verbatim.

Data analysis

A thematic analysis approach was used to summarize salient participant experiences and perceptions. After 6 interviews had been conducted, 2 reviewers (R.M. and A.M.K.) met to collaboratively review the transcripts and identify high-level recurring concepts, which formed the coding framework. The 2 reviewers independently applied the coding framework to the initial 6 and 9 subsequent transcripts on an ongoing basis in NVivo software, version 10. New codes were created and applied as required. The reviewers met twice more to discuss the creation of new codes and compare their application of coding to the interviews. The text within each

code was reviewed to identify patterns among participant responses. The patterns were then further grouped into broader themes, which were reviewed and refined. After the first 6 interviews, themes related to knowledge and skill acquisition appeared to reach saturation. Simultaneously, perceptions about roles, educational gaps, and intentions to integrate palliative care into future practice emerged as important concepts to participants. The remaining 9 interviews were adjusted to further prompt these topics.

FINDINGS

Fifteen of 25 residents consented to participate in the semistructured interviews (9 first-year residents and 6 second-year residents). This was the first palliative rotation for most participants (9 of 15), although many (n=8) reported having previous experience with palliative care during medical school. Participants described how their educational experience shaped their perceptions of their roles in providing palliative care. Using thematic analysis, we generated 4 themes that describe FMRs' experience in palliative care rotations: foundational skill development owing to training in a specialized setting; additional need for education and support; unaddressed gaps in pragmatic skills; and uncertainty about family physicians' role in palliative care.

Foundational skill development owing to training in a specialized setting

Training in a specialized palliative care context afforded FMRs exposure to a larger number of palliative patients than would have been possible in a family medicine practice. Participants placed value on assessing a wide variety of palliative care cases and observing experts in this setting. As a result, they expressed increased capacity in their essential palliative care skills, particularly in 2 main areas: pain and symptom management; and communication with patients and families.

The biggest thing I learned is communication The way I've learned to communicate with people—like the physical gestures and how to bring up difficult conversations—that's probably the thing I'll carry with me the most. (Participant 1, second-year FMR)

Family medicine residents believed these 2 skills were of prime importance to them, and described this rotation as their first opportunity to both observe and receive feedback on difficult conversations with patients and families: "But [speaking about goals of care with families] is something we don't really get taught and to see an expert do that was really useful." (Participant 2, first-year FMR)

During their home palliative care experience, FMRs indicated having a greater appreciation for the determinants of holistic health from the patient's perspective and a greater understanding of what is needed to keep patients at home in the final stages of life.

They can tell you that they're coping, but if you go into the house and you see things are in shambles, then you know that they're not actually coping, so it gives you so much more information when you do the home visit. (Participant 3, second-year FMR)

Additional need for education and support

Family medicine residents anticipated that their communication and pain and symptom management skills would not be enough for them to independently provide palliative care. As one participant expressed, "With the skills and knowledge that I have right now, I would probably say I don't feel comfortable [caring for palliative patients] at this point." (Participant 4, first-year FMR)

To offset this deficiency, some participants intended to seek additional training in palliative care: "I think family physicians are more than capable of doing it, provided they get a little bit of extra training in some of the areas that we don't get so much exposure to during our training." (Participant 4)

Alternatively, some participants would address their knowledge gaps by using palliative care specialists either as consultative supports or as a way to transition care via referral. Participants suggested they would reach out to palliative care specialists when patients' needs exceeded their capability and anticipated this would be when patients had multiple complex symptoms or were in transition from being stable to imminently dying.

Unaddressed gaps in pragmatic skills

Family medicine residents also expressed gaps in their understanding of the pragmatic skills that would prepare them to integrate palliative care into their practices. In particular, participants wanted further education about funding, on-call systems, and how to access home-care nurse practitioners: "At the end of the day I really don't have a clear picture of how you make a living doing it, so I think I probably would have benefited from more formal information on that." (Participant 6, first-year FMR)

While some FMRs indicated that training with family physicians who incorporate palliative care into their practices would not offer any additional benefits, others suggested that this might present an opportunity to acquire more pragmatic skills.

I think from my perspective as someone who is interested in not doing solely palliative care, that would have been hugely valuable, just to be able to witness what the barriers are and how to overcome them. (Participant 6).

During this rotation, FMRs only observed processes and infrastructure unique to a specialized centre, which might not be transferrable to a family practice setting.

Further, some participants indicated that their palliative care preceptors suggested that palliative care was easier to offer as a specialty and not as part of a family practice.

I was working with mostly specialists, whether they were GP-trained or otherwise, and they all did only palliative care. So, I think the majority of them basically said it would be too hard to do more than that. And, I think generally they advocated for full-time palliative care. (Participant 6)

Uncertainty about family physicians' role in palliative care

When reflecting on the role of family physicians in palliative care, FMRs emphasized the considerable value of maintaining lifelong relationships with their patients. They underscored that their intimate knowledge of and the trust they establish with patients and patients' family members make them best suited to provide palliative care. However, lack of expertise and infrastructure are barriers that might prevent them from continuing to care for their dying patients, particularly when home visits are required.

I think I would be happy to manage them and prescribe treatment but unless you are going to be available to do home visits or take calls at night or have some infrastructure to deal with that, I think that's still a barrier. Especially when we have these [specialized programs]—we could probably refer them to someone who has that infrastructure. (Participant 8, second-year FMR)

Many FMRs believed they might need to consider sacrificing their relationships with patients by referring them to specialized palliative care programs so that they receive “better care.”

Sometimes you have to say, “Is it better that I'm providing care because I've been with the patient forever or is it better that someone with the expertise provides the care because they can do a better job?” (Participant 7, first-year FMR)

DISCUSSION

Participants' training in a specialized palliative care centre provided many benefits, but also resulted in tensions related to the goal of promoting family medicine engagement in palliative care. Residents completed their 4-week rotation feeling more confident in pain and

symptom management and in discussion of goals of care, and valued working with physicians they viewed as experts in palliative care. They described substantial benefit in being exposed to a “holistic approach” to care, a finding that suggests educators should consider patients' homes as important learning environments for students and residents. For the first time, many residents witnessed how patients' environments, resources, and social circumstances affect their health throughout their lives, including while dying. The importance of providing an opportunity to make this link has been noted by Kuper and D'Eon, who argue for an expansion of medical education to include practical knowledge and skills in humanities and social sciences.¹³

Our findings also highlighted that despite the curricular goal of new graduate engagement in palliative care, the delivery of the curriculum has the unintended effect of discouraging FMRs from incorporating palliative care into their future practices. Our study suggests that this disjuncture might be at least partially the product of an education system driven by a list of competencies without considering future empowerment of trainees.¹⁴ It might also result from a misalignment between learners and the most appropriate mentors. A palliative care rotation created for FMRs in which educators are part of a specialized program might reinforce the notion that palliative care is best offered by palliative care specialists. This suggests the existence of a “hidden curriculum” in the way palliative care education is delivered. The hidden curriculum was first described in the medical education literature by Hafferty.¹⁵ It refers to what is actually modeled in educational practice rather than what is formally endorsed.¹⁶ We found this to be a useful sensitizing concept for understanding our findings that could be applied more explicitly in future studies.

Additionally, minimal exposure to family medicine preceptors who incorporate palliative care into their practices contributes to residents' disempowerment in the provision of palliative care. Failure to address this gap in FMRs' current palliative care education might perpetuate uncertainty about family physicians' role in palliative care.

When combined with feelings of discomfort stemming from insufficient palliative care skills and lack of clarity around how to integrate palliative care into a family practice, FMRs were faced with a dilemma: Although they greatly valued the physician-patient relationship that developed over time, many FMRs also felt obligated to refer their dying patients to specialized palliative care programs, which were perceived as providing better care owing to more expertise and appropriate infrastructure. Fortunately, the recognition of these root causes highlights opportunities for improvement in palliative care education.


Finally, our findings suggest that FMRs would seek out supplementary professional development to feel

competent to provide palliative care to their patients. This finding might conflict with the current expectations, indicated in the *Red Book* by the College of Family Physicians of Canada, that all FMRs should be comfortable providing basic palliative care.¹⁷ The dependency on palliative care specialists, or *tertiary experts*, for the provision of everyday palliative care goes against initiatives by the Ontario government to rely on family physicians for disease management with periodic specialized consultation for difficult-to-manage cases.¹⁸ This knowledge gap indicates that residents are not being adequately prepared to provide palliative care as part of their everyday practice. It also points to the need for 2 essential enablers: professional development programs that are readily available to new graduates in family medicine; and consultative palliative care support that is easily accessible to family physicians providing palliative care. The findings of this study also suggest a need to develop a more explicit theoretical framework on the potential hidden curriculum in palliative care education.

Limitations

Our study participants were from a single geographic site. Therefore, our findings from this specialized palliative care program in an urban centre might not be generalizable to other centres. Nevertheless, we believe that this training model is common in many education programs and that studying this specific environment allowed us to delve deeply into the effects that this training has on residents' learning and potential future engagement in palliative care.

Conclusion

The findings from this qualitative study suggest that there are important benefits and detriments to limiting palliative care training for FMRs to a specialized palliative care setting. Contrary to intentions, palliative care education for FMRs might disengage them by reinforcing a notion that palliative care is a specialized area of medicine. Fortunately, FMRs highlight potential changes such as increasing access to family medicine mentors who practise palliative care, teaching pragmatic skills on how to incorporate palliative care into one's practice, and improving access to both continuing professional palliative care education and palliative care specialists. These changes might better prepare residents to overcome obstacles in the future, underscoring tangible opportunities for improvement in palliative care education. 

Dr Mahtani is Lecturer in the Department of Family and Community Medicine at the University of Toronto in Ontario and Inpatient Residency Education Lead and a family physician practising palliative care at the Temmy Latner Centre for Palliative Care at Mount Sinai Hospital in Toronto. **Ms Kurahashi** is Research

Coordinator at the Temmy Latner Centre for Palliative Care. **Dr Buchman** is Associate Professor in the Department of Family and Community Medicine at the University of Toronto, Lead of Quality Improvement and Primary Care Engagement in Palliative Care at Cancer Care Ontario, and Education Lead and a family physician practising palliative care at the Temmy Latner Centre for Palliative Care. **Dr Webster** is Associate Professor and Scientist in the Department of Family and Community Medicine at the University of Toronto and is cross-appointed to the Institute of Health Policy Management and Evaluation at the University of Toronto. **Dr Husain** is Associate Professor in the Department of Family and Community Medicine at the University of Toronto and Research Lead and a family physician practising palliative care at the Temmy Latner Centre for Palliative Care. **Dr Goldman** is Assistant Professor in the Department of Family and Community Medicine at the University of Toronto and Director of the Temmy Latner Centre for Palliative Care.

Contributors

All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests

None declared

Correspondence

Dr Ramona Mahtani; e-mail rmahtani@mtsina.on.ca

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