2nd October 2019

Annual Conference of APM Special Interest Group for Undergraduate Medical Education

Stephen Barclay:

Review of undergraduate curriculum initially written in 2006 and revised at Cambridge in 2014

Now for review

Discussed undergraduate education at PCC at Harrogate 2019

Previously developed recognising dying patients in cancer patients for medical students and junior doctors. Plan is to develop another one for non-cancer diseases. Should be autumn ready for Cambridge students 2020. It will also have a generic care of the dying care plan document.

Questions for national bank for final year students revisited in February 2019. This is now fed back to national bank (Medical Schools Assessment Alliance). In 2023-24, there will be national licensing exams by GMC. There will be Palliative care questions there as well. That will also be for Overseas doctors as well. There may be another day for this practice. That will also be available/relevant for some other practices e.g., GP, Elderly care etc. Questions should be from seven areas. The day would be in February/March 2020.

Kate Gregory/Johanna Kulia (GMC):

Expectations from newly qualified doctors in the UK: Outcomes for Graduates:

KG

GMC has responsibility for regulation and standards.

Published document for ‘Outcomes for Graduates’. GMC has legislative powers to set standards at postgraduate level but not at undergraduate level. The document is for evolution, not revolution. Outcomes published in June 2018 and implementation is due by June 2020.

Need to increase knowledge to look after patients in different settings, comorbidities, scientific knowledge and evidence base. All stages of diseases, communicate effectively and work in MDT. Healthy lifestyle choices. Leadership qualities. Need to know about social care, mental health and interaction with agencies.

2009 – Good medical practice

2016 – Foundation programme curriculum

2017 – Generic professional capabilities

Medical Licensing Assessments

Practical procedures list published in Spring 2019.
JK

CQC: It’s irrelevant where the patients die. Its more important that they receive individualised care as per their needs, compassion is shown and communication is good.

Undergraduate – Outcomes for Graduates 2018

Foundation – Outcomes for provisionally registered doctors

Specialty – Specialty curricula

All governed by Generic professional capabilities and Good Medical Practice.

Order to manage the expectations is Behaviours, Skills and Knowledge.

Newly qualified doctors expectations are:

- Compassion
- Needs and safety
- Principles of person-centred care
- Work collaboratively
- Work in MDT
- Confidentiality
- Deal with complexity
- Evaluate challenges
- Communicate at every important step
- Prescribe safely
- Managing expectation for place of choice
- Describe the relationship between agencies e.g., social and healthcare.

Mapping to APM curriculum to GMC outcomes for Graduates – Elliot Leonard (Medical student)

Outcome e15: End of life care

APM curriculum covers that.

Outcome 20: How palliative care is delivered in health service

APM: Demonstrate that

Outcome 7: Vulnerable patients

APM covers it.

Outcome 16: care in medical and psychiatric emergencies

APM curriculum covers.

Outcomes not covered:

Outcome 5: Quality and safety – raise incidents
Outcome 13: Able to diagnostic tests

23 mental health conditions

25 population health

26 Scientific methods to medical research

Question: Should we teach all of domains or identify those which are absolutely only done by Palliative care like bereavement and deliver it?

Making impact in medical curriculum: Educational principles: John Ellershaw

Get familiar with GMC document and gaps

Get to know your medical school’s curriculum

Question: Should we tag on with our clinical colleagues and lobby to include palliative care in curriculum there or shall we have our presence in curriculum?

If opportunity does not knock, build a door

Some hospices have 3 weeks hospice placements. If they only do one day, they may feel more terrified as they are now aware what they don’t know!

So what should be the learning outcomes?

- WHO ladder
- Manage death
- Communication skills

What makes the placements work?

- Positive experience of patients and MDT
- Make them a normal part of hospice life
- Learning should be patient based

Step 1: Key documents

2: Understand your curriculum

3: Establish Palliative Medicine in curriculum

4: Vertical integration

Years 1 and 2: Lectures on death and bereavement

Year 3: Integrating palliative in medical and paediatric learning

Year 4: GP placement and palliative care in that setting

Year 5: Acute Medicine and palliative care in that setting
So a real outcome is: Competent, Confident and Resilient FY doctor

**Table discussion (barriers and strategies):**

Students find the experience of hospice placement fulfilling, esp. If these are for longer periods. However, not every area is providing it.

Is teaching really happening even if they say it is under other specialities?

If it is not branded, how will students understand that good palliative care works and that it is working?

Is it really on other specialities agenda to talk about dying?

Students still question whether it is relevant to their needs as a junior doctor?

If we are doing lectures in various years, how do we make sure that it is not repetitive?

Can we join our teaching with other specialities e.g., Oncology, Elderly care and remind students that they will be doing palliative care?

Are the other specialities teaching a consistent message i.e., dying is everyone’s business or they are saying to pass on to others e.g., Palliative care nurses?

Other specialities also want more time; therefore 3 week placement gets harder to get from medical schools. Some schools have half day a year.

Are all hospices/providers getting paid same tariff per student or is there a discrepancy?

How will specialty cope with increased number of students nationally? Will hospices be willing to take more students?

**Geoffrey Wells (Palliative care Registrar) – Can simulation improve confidence and preparedness of medical students to care for dying patients?**

End of life care is a core competency

FY doctors can look after 40 dying patients in a year

Publications tell us that FY doctors feel distressed by the experience.

Despite theoretical knowledge, students do not have pressure of exams to get it right.

Feasibility study with 6 students

Thanatophobia (Fear of death) scale improved after simulation practice.

Next step is:

- To do a systemic review
- Measure students attitude in all years
Upscale services

12 studies in 6 countries

General lack of confidence in caring for dying patients

Thanatophobia scale remains the same in all years

Simulation training improved confidence

Question: If improvement in confidence sustained over time?

Simon Tavabie (Palliative care Registrar) - Emotional intelligence in Palliative Medicine Education

25% of junior doctors are getting burn out

EI is important to have well being and patient management but is hard to measure

What we did in research was providing a lecture and found whether that improved.

Intervention 1: Reflection based meetings

Intervention 2: Conversation around dying

Intervention 3: Multidisciplinary study day covering ‘what is the goal of care?’ follow up at 6 weeks with a selected number of people

Conclusion: Emotional Intelligence has significant positives in carers as well as professionals well being

Helen Makins (Consultant in Pain Medicine & Anaesthesia – Gloucestershire) – Essential Pain Management (A framework to teach pain management)

Faculty of Pain Medicine at Royal College of Anaesthesiologist initiative

No commonly used structure to teach pain

Pain management taught by different specialities

Inconsistent for medical students and therefore variable skills among them

Therefore Faculty’s main role is to raise profile and improve quality of teaching of pain management and develop a framework for EPM

Australia and Newzealand have done it jointly

Now being done in 55 countries

EPM course: Complete package

RAT (Recognise, Assess & Treat) structure: Framework of EPM course – Ideal in UK
ABC of Pain

Course material on RCA website

FPM can provide MCQ and answers

Iphone app is available

It is now accredited by RCA, BPS and BMA prescribing guidance

Now discussing with Medical School council and Foundation Programme Committee

Palliative care should individually run course and include in their teaching.

Facilitators can receive an instruction sheet and run RAT/EPM course.

**Steven Walker – National undergraduate palliative care education survey – The next phase, seeking your views**

Already known that there is room for improvement in care of the dying patients.

Questionnaire was distributed to 30 medical school palliative care teachers.

40-point survey

Time varied in terms of teaching

Paediatric palliative care not offered

90-92% offered hospice visits but not usually patient contacts.

Some course organisers put more time to some topics than others (quite a variation)

Most organisers were positive about the courses which they offered but not sure that it prepared students for care of dying, delivering quality care

Barriers were staffing issues and support.

Lots of variation in teaching topics, methods, placements and evaluation.

Need to develop survey for future: Hours of teaching/compulsory/integrated?/topics/structure of teaching/by whom/contact with patients/assessment and examination/evaluation.

There is no funding for future survey of this kind.

**Review of APM curriculum:**

To get table discussions and amalgamate them

**BIG QUESTION:**

Should Palliative care be teaching all topics from curriculum or should it liaise with other specialities to find out
1) Topics which others can teach
2) Topics which it can teach along with other specialities
3) Topics which Palliative care must teach and divide these in Lectures and placements

John Ellershaw will be keen to share what they are doing at Liverpool