

AMSA-VITAS End-of-Life Education Fellowship Program Curriculum Outline

I. CURRICULAR GOALS AND OBJECTIVES:

Goals

- Introduce medical students to end-of-life care and its role in health services delivery, in order to produce an informed cadre of future medical care providers and leaders in end-of-life care and medical education;
- Introduce students to the delivery and management of end-of-life care through interactive and didactic methods; and
- Stimulate medical students to return to their institutions and to share their experiences with their colleagues, as well as facilitate end-of-life care education and activities within their schools and communities.

Objectives

As a result of participating in the end-of-life educational sessions, students should be able to:

- Understand the psychological, sociological, cultural and spiritual aspects of death and dying;
- Understand the patho-physiology and management of common symptoms at the end of life;
- Recognize and respond to cultural, linguistic, and spiritual diversity;
- Gain familiarity with an interdisciplinary team of EOL care providers (e.g., physicians, nurses, social workers, pastoral counselors, bereavement counselors, and volunteers) and learn to work together in providing comprehensive, coordinated care for terminally ill patients;
- Identify significant points of consensus and controversy in the ethical aspects of EOL care;
- Improve the ability of students to reflect self-critically on personal and professional experiences around death and loss;
- Design and develop a plan for integrating EOL education into the curricula of the students' medical schools with the help of attending mentors;
- Develop and distribute a Project in a Box on EOL education and resources to be made available on the AMSA website; and
- Share resources on AMSA's Interest Group on the Death and Dying list-serve and present sessions at AMSA's regional and national conferences focusing on the need for EOL education, which offer models for EOL training and experience.

II. CURRICULUM FRAMEWORK¹

A. Palliative Medicine

- i. Definition of palliative care (reference to the World Health Organization's definitions, origins and history of palliative care (PC), distinctions between palliative medicine and other medical disciplines, etc.)
- ii. List of clinical components of PC (i.e., pain and symptom management, psychosocial support, etc.)
- iii. Developing goals of care at the end of life
- iv. Indications and benefits of PC
- v. Integrating palliative care as a continuum of care (e.g., making transition from acute care to palliative care)
- vi. Role of hospice and hospice philosophy (history of movement, political and economic aspects, etc.)

B. Patient Assessment

- i. Prognosis
- ii. Recognition of actively dying state
- iii. Recognition of emergency situations (spinal cord compression, DVT, etc)

C. Pain (e.g., as distinct from suffering and psychosocial distress)

- i. Epidemiology of pain and significance (i.e., public health view on pain at the end of life (EOL) for patients and populations)
- ii. Barriers to adequate pain management (professional, political, or economic, i.e., attitudes toward opioids, addiction, restrictive regulations, inadequate knowledge on the part of physicians, etc.)
- iii. Neurobiology of pain (i.e., pathophysiology of pain)
- iv. Pain characteristics (i.e., frequency, intensity, site, quality, triggers, acute/chronic, etc.)
- v. Pain syndromes (i.e., somatic, neuropathic, visceral)
- vi. Pain-related history and physical exam (i.e., focused H&P to evaluate pain)
- vii. Complementary therapy history (e.g., elucidate patient's use of complementary therapies for pain, such as acupuncture)
- viii. Diagnostic assessment of pain (i.e., ability to formulate differential diagnosis re: etiology/sources of pain, etc.)
- ix. Non-opioid pharmacologic management of pain (i.e., use of non-opioids, etc.)
- x. Use of opioids (i.e., World Health Organization's analgesic ladder, tolerance, dependence, addiction, therapies, drug conversions, route of administration, dosing, side effects, etc.)
- xi. Non-pharmacologic management of pain (i.e., surgery, physical therapy, etc.)

¹ SA Meekin, JE Klein, et al. Development of a Palliative Education Assessment Tool for Medical Student Education. *Academic Medicine* (2000) 75: 986-992.

- xii. Efficacy of pain management (and ability to assess and revise treatment plan, i.e., ability to adjust opioids due to side effects).

III. Neuropsychologic Symptoms (i.e., agitation, depression, delirium, dementia, and other mental status changes, as well as psychological distress)

- A. Epidemiology and significance (i.e., prevalence of depression at EOL)
- B. Neurobiology of symptoms (i.e., agitation, depression, delirium, dementia, etc.)
- C. Symptoms as complications of therapy (i.e., changes in mental status, i.e., sedation from opioids, etc.)
- D. Disease-specific neuropsychologic symptoms (i.e., influence of underlying disease on mental status, personality changes from frontal-lobe tumor or AIDS-related dementia, etc.)
- E. Neuropsychologic symptom history and physical exam (i.e., mental status and directed physical exam, etc.)
- F. Complementary therapy history (e.g., patients' use of agents for depression, i.e., St. John's Wort, etc.)
- G. Diagnostic assessment of neuropsychologic syndromes (ability to formulate differential diagnosis using Diagnostic and Statistical Manual—IV [DSM IV])
- H. Counseling/psychotherapeutics
- I. Pharmacologic management (i.e., treatment of depression with tricyclics and selective serotonin reuptake inhibitors (SSRIs), use of psychostimulants with opioids, etc.)
- J. Pain management in substance abuse patients
- K. Other management strategies (i.e., acupuncture, complementary therapies, etc.)
- L. Efficacy of neuropsychologic management (and ability to assess and revise treatment plan, i.e., adjust from one antidepressant class to another due to inefficacy)

IV. Other Symptoms (i.e., dyspnea, nausea/vomiting, constipation, diarrhea, pruritus, etc.)

- A. Epidemiology and its significance
- B. Pathophysiology of non-pain symptoms (i.e., pruritus in hepatobiliary disease, etc.)
- C. Disease-specific syndromes (i.e., AIDS-related diarrhea, wasting, and weight loss in cancer, dyspnea in advanced lung disease, etc.)
- D. Symptoms as complications of therapy (i.e., constipation from opioids, paresthesias from chemotherapy, etc.)
- E. Symptom history and physical exam (i.e., focused H&P to evaluate other symptoms)
- F. Complementary therapy history (e.g., elucidate patient's use of complementary therapies for other symptoms)
- G. Diagnostic assessment of non-pain syndromes (ability to formulate differential diagnosis regarding etiology/sources of other symptoms)

- H. Pharmacologic management (i.e., laxatives for constipation, bronchodilators for respiratory compromise, etc.)
- I. Non-pharmacologic management (i.e., enemas for constipation, use of oxygen, physical therapy, etc.)
- J. Efficacy of symptom management (and ability to assess and revise treatment plan, i.e., adjust therapies for desired effect)

V. Ethics and the Law

- A. Professional obligation to dying patients and families (i.e., principle of non-abandonment, commitment to clinical competence, etc.)
- B. Professional self-reflection regarding attitudes, beliefs, and experiences with death, dying, and bereavement.
- C. Analyzing ethical issues at the EOL (i.e., instruction in moral problem solving at EOL)
- D. Awareness of ethics committee and other institutional resources (e.g., awareness of committee role and function and guidance options for ethical dilemmas)
- E. Clinical capacity determinations and the legal concept of competence
- F. Truth-telling (e.g., ethical norms with respect to providing information regarding diagnosis, prognosis, and the therapeutic exceptions)
- G. Legal and ethical basis of informed consent/informed refusal process
- H. Legal and ethical basis of do not resuscitate/resuscitation issues
- I. Surrogate decision making and advance directives (i.e., decisions made by others on patient's behalf, role of living wills, health care proxies as advance directives, etc.)
- J. Withholding/withdrawing life-sustaining treatments, including artificial nutrition and hydration (ANH) (i.e., ethical and legal basis, legal precedent, etc.)
- K. Definition of physician-assisted suicide and voluntary active euthanasia (VAE) within moral continuum of EOL decisions (e.g., distinction between withholding/withdrawing life-sustaining treatments versus physician-assisted suicide and voluntary assisted euthanasia)
- L. Principle of double effect (e.g., ethical justification for opioid use when goal is relief of suffering, not hastening death)
- M. Futility (e.g., prevailing definitions regarding medical futility and strategies regarding resolution of futility disputes)
- N. Definition of brain death (e.g., physiologic basis, reasonable accommodations for religious objections under New York State law)
- O. Organ transplantation (i.e., laws and applications)
- P. Pronouncing death
- Q. Autopsy requests
- R. Procedures on newly deceased (i.e., intubation, pericardiocentesis, and issues of surrogate consent, etc.)
- S. Death certification
- T. Public policy dimensions of end-of-life care (i.e., changes in law regarding physician-assisted suicide, Medicare hospice benefits, etc.)

VI. Patient/Family/Nonclinical Caregiver Perspectives of End-of-Life Care

- A. Establishing goals of care
- B. Cultural aspects of care
- C. Spiritual aspects of care
- D. Psychosocial support needs at the EOL
- E. Loss of bodily functions
- F. Suffering (e.g., distinction between pain and suffering)
- G. Perceived powerlessness/loss of control/sense of dignity
- H. Burden of illness on patient/family/intimates (patient abuse, caregiver burn-out)
- I. Fear of abandonment
- J. Suicidality
- K. Caregiver and family dynamics and their influence on care (recognizing caregiver pathology)
- L. Social-work interventions
- M. Community resources and social support (e.g., societal context of illness, funeral planning)
- N. Bereavement process and therapeutic interventions for survivors

VII. Clinical Communication Skills

- A. Understanding the experience of dying
- B. Respect for and knowledge of differing values, cultures, and beliefs
- C. Instruction in empathic interviewing skills
- D. Eliciting relevant narrative and clinical information in the clinician—patient encounter
- E. Ability to empathize with patients and their intimates
- F. Ability to work and communicate with an interdisciplinary care team
- G. The following specific communication skills with patient and families/intimates/surrogates:
 - i. Breaking bad news
 - ii. Informed consent/refusal
 - iii. Withdrawing/withholding life-sustaining treatments (i.e., having a do-not-resuscitate conversation with the patient, etc.)
 - iv. Advance directives (i.e., designation of health care agent by competent patient, etc.)
- H. Communicating and negotiating goals of care to patients and intimates
- I. Conflict resolution/negotiation skills (i.e., address and resolve conflicts regarding EOL care, etc.)
- J. Communicating with patients and intimates as death approaches (e.g., for the imminently dying)
- K. Notification of patient's death

VIII. Grief and Bereavement

- A. Assessment of bereavement risks
- B. Available services for bereavement care
- C. Normal vs. complicated grief

D. Role of the physician in the grieving process

IV. Learning Approach

Each seminar will use a variety of instructional methods including lectures, cases discussions, self-assessment instruments, small group discussions, role plays, and computer-based instruction (EPEC CD-ROM).