Clinical Medicine 2012, Vol 12, No 2: 108–10

Improving end-of-life care: recommendations on professional development for physicians

From the report of a working party of the Royal College of Physicians, the Association for Palliative Medicine and National End of Life Care Programme

Background

There is broad recognition that the delivery of good care at the end of life cannot be left to specialists in palliative care but is an important part of the role of most physicians. Recognising someone is entering the last phase of their life is pivotal to establishing patient priorities and balancing therapeutic burdens and benefits.

The Royal College of Physicians, the Association for Palliative Medicine and National End of Life Care Programme set up a joint working party whose remit was to review what professional development is available to support physicians in this area of practice, what physicians see as their priorities, and the types and styles of learning that are most valued and then to recommend how these can be enhanced in practice.

The report of this working party has now been published.[1] This report:

- describes the current workload for consultant physicians and final-year registrars in end-of-life care, where this is not their main specialty focus
- considers the importance attached to this area of work, uptake of development opportunities and areas where physicians feel confident or in need of further support
- provides practical recommendations on how to prioritise and address the issues raised that should be taken up by individuals and organisations to improve this area of care.

The main recommendations of the working party are set out below.

Recommendations

These recommendations have been grouped under subheadings to highlight where the main responsibility for their implementation lies.

Recommendations for Trust boards

1. Trust boards should make the delivery of high quality care at the end of life a priority for their organisations. End-of-life care metrics should be developed, based on the End of Life Care Strategy Quality Markers for Acute Hospitals, and included on their management dashboards and risk registers.
2. Senior management support is critical to enable professional development in end of life care. This must include:
   - provision of time for learning
   - appropriate appraisal systems which encourage continuing professional development in end-of-life care
   - an organisational culture which values quality of care at the end of life.
3. Hospital trusts should review the provision of learning opportunities for their consultant, trainee and non-training grade workforce and, where necessary, increase the availability of local end-of-life care training and education.
4. Tools such as care pathways for end-of-life care must be properly implemented and receive continuing support to sustain the learning that is required, otherwise such tools can be counterproductive by encouraging a 'tick box approach' rather than promoting high quality care.
5. The introduction of systems of care that help to highlight patients who may be at risk of dying during a hospital admission, such as the AMBER care bundle or equivalent, should be considered as a tool to help professional development within teams and to guide day to day practice.

Recommendations for commissioners

1. Commissioners and hospital trusts should consider how they can support the uptake of training in end-of-life care, for example by using the Commissioning for Quality and Innovation (CQUIN) framework. Example standards should be based on the End of Life Care Strategy Quality Markers and might include specifying a proportion of physicians conducting a patient/carer survey of experience under their care, team-based learning events around death reviews and a percentage for educational uptake in a target proportion of medical staff.
2. The role of hospices and specialist palliative care units/teams in providing experiential placements for physicians should be recognised and resourced.
3. Advanced communication skills training for physicians caring for those with long-term conditions should have equal priority and resources with those required for cancer.
4. Hospital palliative care teams should be available in each hospital and resourced to lead the delivery of professional development in end-of-life care. As experiential learning is most valued, this should include time to work with colleagues in clinical practice and to provide clinical placements and mentorship.

Recommendations for physicians

1. Physicians whose practice includes patients in the last phase of their lives should consider using the 'Top Ten Tips' and 'Prompts for ward rounds and mortality and morbidity meetings'. (see Boxes 1–3) during their routine practice.
2. Medical consultants should provide leadership in establishing opportunities for professional development in end-of-life care in their own settings, including agreeing how best to implement this as a department/directorate and Trustwide.
3. Teams involved in end-of-life care should actively plan for cultural change in the delivery of end of life care by identifying medical leaders, engaging colleagues, and supporting the development of expertise among colleagues.
4. In order to influence their practice and ensure that patients have time to adjust, physicians must recognise that end-of-life care is not just care in the last few hours and days but that it marks the last phase of life which may be many months or sometimes years.
5. Professional development for end-of-life care should:
   - strengthen multi-professional teams and promote collaboration between team members
   - support the development of effective communication skills through interactive approaches, such as simulation, observation and practice with feedback
   - use opportunities in routine practice to draw on clinical experiences with a direct relevance to patient care, developing problem solving and reflective skills
   - actively seek engagement with, and feedback from, patients and caregivers to improve understanding of the patient experience
   - be embedded into a wide range of educational events, including conferences, workshops and study days, not just those specifically focussing on end-of-life care
6. Reflection and learning on end-of-life care should be integrated with daily clinical practice. This may be done through directorate meetings, structured multi-disciplinary meetings, mortality and morbidity meetings, joint ward rounds and outpatient clinics with palliative care colleagues, grand rounds, mentoring or placements.
7. Consultants who provide care at the end of life should incorporate this into their CPD and undertake at least one learning event in end-of-life care within a five year CPD cycle. This should be reviewed at their annual consultant appraisal.
8. Hospital and primary care teams should acquaint themselves with the range of general and disease specific tools to identify patients with advanced illness, or who may be approaching the end of life, and consider their applicability and use within their routine practice.
9. Joint learning with GPs should be encouraged to further the understanding of each other's roles and services, and to improve co-ordination of care across traditional boundaries.

Box 1. Top ten tips for physicians

1 **Integrate palliative care into your daily practice** – ask a member of your palliative care team to attend clinics, ward rounds and multidisciplinary team meetings, especially in areas with a high proportion of patients who require palliative care.

2 **Adopt the 'prompting tool' during the post-take ward round** to help identify patients who require supportive care (see Box 2).

3 **Adopt the 'prompting tool' during mortality and morbidity meetings** to see whether patients' choices for type and place of care were ascertained in a timely way and acted on (see Box 3).

4 **Actively incorporate feedback from patients and carers** to guide your professional development.

5 **Refer to your local palliative care guidelines** for quick reference and a stepwise management guide to common palliative care problems.

6 **Include at least one learning event on 'end-of-life care'** within a 5-year continuing professional development (CPD) cycle.

7 **Find an up-to-date list of useful courses on palliative and end-of-life care** locally and nationally at www.apmonline.org.

8 **Approach your hospital palliative care team** to find out about professional development opportunities in your trust or unit.

9 **Find advice and guidance on prescribing in palliative care** by registering at www.palliativedrugs.com.

10 **Try out the free e-learning resource on end-of-life care** at www.e-elca.org.uk.

Box 2. Prompt tool for post-take ward rounds/general ward rounds

- Does the patient have an advance care plan?
- Does the patient have a valid and applicable advance decision to refuse treatment (ADRT)?
- Does the patient fall into one of the following categories?
  - Advanced, progressive, incurable conditions(s).
  - General frailty and coexisting conditions that mean they may be expected to die within the next 12 months.
  - Existing condition(s) as a result of which they are at risk of dying from a sudden acute crisis.
  - Life-threatening acute condition caused by sudden catastrophic event(s).

If so, discuss preferences of treatment and place of care with the patient and their family.

Box 3. Prompt tool for mortality and morbidity meetings

- Was this death expected?
- Were the patient's priorities for end-of-life care (eg place of care/death) known?
  - If yes, were they adhered to?
  - If no, were there opportunities for advance care planning?
- Was the patient's terminal care supported by the integrated care pathway for the dying patient?
  - If not, should it have been?

10. The use of e-learning, such as e-ELCA, to support work-based learning should be included where relevant.

Recommendations for palliative care teams

1. Specialist palliative care clinicians should develop wide ranging educational skills in supporting colleagues through formal and non-formal learning by:
   - using structured interactive events
   - facilitating effective bedside teaching
   - conducting joint ward rounds, mentoring colleagues
   - facilitating mortality and morbidity meetings.
2. Hospital palliative care teams should include leading professional development in end-of-life care as an integral part of their role. This should include providing support as well as working with staff from other disciplines and professions to learn with, and from, them.
3. Local palliative care providers should work with the palliative and end-of-life care networks to deliver more extensive and targeted CPD for physicians.

Recommendations for medical schools and Foundation programmes

1. All UK medical schools should review their undergraduate curricula to ensure that they provide an adequate grounding in end-of-life care as outlined in Tomorrow's Doctors.
2. All Foundation Schools should review their delivery of the Foundation Curriculum in relation to end-of-life care.

Reference

1 Royal College of Physicians. I*mproving end-of-life care: professional development for physicians*. Report of a working party. London: RCP, 2012.