Palliative Care Education

The need of practical exposure and interactive learning in the future certificate training[1]

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Introduction

The need for Palliative Care education in India is obvious. A lot is done already, but the task is still too large for a sufficient success, even if all present player would join and dedicated more work in education (and less in that actual seeing of patients). That is what I understood when Dr. Rajagopal invited me in April 2013 to participate in a training of doctors nurses and social workers at Calcutta and even conduct two parts of this workshop myself.

With the 12 years of experience German Palliative Care full-time educationalist and CEO of the largest German Palliate Care Training institute and with a great love for India, through my six yeas stay at Tiruvannamalai / Tamil Nadu I decided to come back to India in summer 2012 to promote with my German Company training her as well. There was a great deal of help, understanding, support and welcoming in all these last months.

Here are my findings and suggestions. Please take them as word of exert, who fall in love with India many years back in 1985, even if I have to point out from time to time some shortcomings, which I discover in the recent education.

The educational need

There are different systems of Palliative Care training available. In Europe we categorize three levels: Beginners level with 40 teaching hours duration it is called BASIC TRAINING; certificate level with 160 teaching hours of interactive learning are called POSTGRADUATE DIPLOMA and degree level (Like MD in Palliative Care) with at least 3 years duration of teaching and work exposure in palliative care centers is called SPECIALIST TRAINING.[2] I will the example of Great Britain and Germany, of which is in the focus in the different countries and make a suggestion for India.

In Great Britain they decided to go for the full specialized training – here MD in Palliative Care – and respectively for the other professions. To became a MD in Palliative Car in Great Britain it takes even 6 years of study, work exposure in different systems (indoor, outdoor, homecare) and do research as well. This system was established in 1987, 25 years after Great Britain had been the forerunner in Palliative Care worldwide looking back to the opening of the first hospice in the 1960s. Until now (2014) 474 MD who perform half time and full time work are fully educated. The Aim: There shall be 505 specialists MD in Palliative Care in 2015 and some 600 in 2020. That is: One full time MD specialist for 1.6 lakhs population.[3] In addition: nurses, general practitioners, social worker and all the others are skilled in different levels. If India would go this British way of MD in Palliative Care India would need now 7.700 MD specialists to have the same capacity.

In Germany hospice work started slow. Only in the 1980s the first hospice was opened and the first palliative care work a decade later. The voluntary hospice work had been stronger. A curriculum was written for doctors, nurses, social workers and spiritual guides in 1999, but it took three years until we really started to train the German doctors. The German decision makers did not go for the specialized training, but decided to do it with the certificate level, as to reach in quicker time many interested people. We do not have MD in Palliative Care. We

train the MD (Oncology, Internal Medicine, MD General Practitioner, Urology, Gynecology, Anesthesia and others) with the 160 hours teaching with interactive work without additional practical exposure, as the training needs do differ to each and every of the specialization and one uniform practical exposure would not help. After undergoing these 160 hours, the MD has an oral exam with the Medical Council, is further on "Palliative Care educated" and can a take part in Palliative Home Care or work in a Hospice. Alternatively one year of work exposure at a Palliative Care Ward in Hospitals will give the same recognition. Nurses get their 160 hours training, social workers, psychologists and other professionals a 120 hours training. Until now we have trained in Germany approx. 10.000 MD doctors to be "Palliative Care educated" and they do their work in their respective individual context. And we have trained approx. 20.000 nurses. 10 % of them were trained at the 14 MediAcion Training centers in the Northern Part of Germany. As these 160 hours training can more easily be accessed, it would be a good scope for India as well to establish it.

Present Indian situation

As a foreigner I might not know the present situation of the Indian Palliative Care Education very well. Therefore I will quote Rajagopal[4]: E-Learning is available all over India with some two to three contact days in the states Assam, West Bengal, Orissa, Delhi, Chandigarh, Madhya Pradesh, Gujarat, Uttar Pradesh, Rajasthan, Andhra Pradesh, Maharashtra (2), Tamil Nadu (3), Karnataka (5), Kerala (7) and some 4.000 students have completed this course. E-Learning is mostly knowledge centered. It can reach many people. It can be done in spare time. You will have 15 hours academic training or 10 day „hands on" training.

Now 4 weeks courses started at Tata M. H. Mumbai, MNJ, Hyderabad, JIPMER Pondicherry and 6 weeks at Kochi, Calicut, and Trivandrum. Other trainings at CMC Vellore and at Bangalore are available. The focus is practical exposure and two hours teaching a day. The students have to leave their homes and work places to join for four/six continuous weeks at the centers with the specialized palliative Care knowledge.

Tata Memorial Hospital Mumbai has a 2 year MD in Palliative Care since 2012. 2 got enrolled in 2012/13. Others will follow. There are 2 years Palliative Care and Pain Relief Courses available as well. Whereas the E-Learning seems to be not enough for the practical work without getting further support by more experienced palliative care staff, the 2 years courses are highly demanding and will reach only a few high profile experts in the beginning.

Dr Rajagopal will speak in session 11 on Sunday more on that. With the four and six week's courses a good time-measure seems to have been found.

Ways to teach: Head – Hand - Heart

As EAPC puts it: knowledge (cognitive), skills (psychomotoric) and attitude (affective) shall improve through a proper Palliative Care Training. Or better say it in the Indian way: Head, Hands and Heart: Rajagopal, 2012[5]

E-Learning can´t attribute to psychomotoric skills (Hands). And due to the missing group structure of the learning process there are little possibilities to attribute to the change one`s attitude (affective component, Heart). But it attributes well to the **cognitive-knowledge-head** learning. Maybe all students should undergo an E-Learning first.

In palliative care expanding one's skills improvement for the practical work is as important as in all other medical specialties. One can learn as well from the role – model of the seniors.

Therefore **4-6 weeks internships** together with daily once or maximum twice a one to two hour learning block is offered at the different universities and palliative care centers wards all over the country. On the Hyderabad 4-weeks training it is explained: "*There will be one or two academic exercises every day - majority of the topics will be covered in the form of interactive tutorials. Candidates will be expected to make short presentations on topics from the modules and to present cases from their clinical experience.*"
Both is very apt for the present and future training and to improve the **Head & Hands** on knowledge of the participants. To my understanding these courses have 40 hours of teaching and nearly months of bed-side work/teaching. These trainings can be and should in future be performed at all functioning centers for palliative care in the country. It will not be available in many states, where palliative care is in the beginning process. And it enforces the students (let it be MD or MBBS) to stop their present work for a month to join these programs. Learning from role models (senior palliative care experts train the newcomers on the bed-side) is helpful, but is a hierarchic way of teaching, which is clinically proofed and common in clinical and Indian context. For developing own and individualized skills in communication, ethics etc. additional teaching interaction is needed. I will explain that later.

On the last of the three teaching aspects **"Heart"** in our European curricula called: attitude / affective learning, there is no teaching example given by Dr Rajagopal in this cited talk. When I asked myself why, it came to my mind, that all the palliative experts I have experienced in India are "full of emphatic and heart felt" approach in all their work, that there is even no need to point it out separately. The "heart" will be present in all the teaching as well. But for future students who come - and I'm speaking from my 12 years of teaching experience with doctors with up to 10 weeks exposure annually and 1.200 doctors taught – after the first years of educating the interested ones, there will be a time, when students will participate in the future courses, who do not bring the attitude approach with them right from the beginning. In the UG training for MBBS this might be the case already just after starting his education there. In the next chapters I will elaborate on that.

Teaching aims addressed to "heart / attitude"

- *Learn to emphasize with the patients emotional needs and his family members*
- *Improve one´s own communication skill*
- *understand and reflect one´s own role in groups / teams*
- *actively include the other professions in the treatments process as "equals"*
- *reflect on one´s own work behavior/ethics*
- *have an attitude of ethics in the life-end-phase*
- *find one`s own strength*
- *find one`s own way of palliative treatment*

Topics to learn: Table of Contents

As an example see the IAHPC Manual of Palliative Care 3rd edition:

I. Principles and Practice of Palliative Care
II. Ethical Issues in Palliative Care
III. Pain
IV. Symptom Control
V. Psychosocial
VI. Organisational Aspects of Palliative Care

Similarly you will find in India the new UG Curriculum for MBBS and Nurses which we started to write in a workshop in May 2013 at Trivandrum and which was handed over to the official bodies in Oct. 2013.

There are not really great differences in the topics to learn in all these and other Indian curricula or even the curricula in the West. But there are typically Indian needs.

Additional Teaching Topics for Indian needs

At the Trivandrum Workshop in May 2013 for the UG Curricula we tried to find a "definition" on "collusion". Did you ever try to google an answer or look it up in the Oxford Handbook on Palliative Care? Outside India, "collusion" only exists as an illegal conspiracy within stock market, I believe all participants of IAPCON 2014 agree, that collusion is not helpful in the palliative state and we agree, that this is deeply rooted in the culture and frequently in use with medical staff. Palliative Care Learning has to get answers in how to overcome collusion and how to take along in an apt and applicable way those , who did "not break the bad news to the patients" up to now all their lives. Indian palliative care teaching will face similar problems unless certain rule and laws on certain drugs and ethical approaches on ethical issues are not passed.

Learn to emphasize and improve QoL

To Emphasise with the patients emotional need and to improve patient´s and his families Quality of Life (QoL) the doctors and nurses will face the following problems and known palliative symptoms: strenghlessness, fatigue, sleep disorders, loneliness, fear of death and the time BEFORE death, anxieties, forsakenness, worthlessness, depression, bereavement (even before the patient's death, see my work on that[6]). It will not be enough to know these symptoms, but it is necessary to find solutions to some of them. The medical staff will jointly work with the family, but will include experts like therapists and social workers as well. In addition even music therapy will improve QoL (see the talk in the same session on the body tambura), but as well: Laughter yoga, yoga, reiki, prana work/prana healing (for example done by Help Age), acupressure. The German teaching of courses encompasses at least two (more western) types of these approaches, the MD courses at least one (mostly called: "basic stimulations"). These will be helpful for patients with other cognitive states (coma, dementia) as well.

Self-care

Self-care is needed. Some say, self-care within palliative care is not needed more than in other areas of treatment. Most studies say that this assumption is not true. There are reasons for it: The patient you have treated well, you cannot ask, if he liked it and get a direct feed-back in the end, as the palliative patient in the end will be dead. And his relatives either will praise you a lot, or scold you - just in "how they **feel**" and <u>not</u>: "how the **feel about your work**". Often bereavement situations make us avoid getting a feed-back from them too. There are more reasons, why palliative care work is strenuous: Apart from pain- and symptom relief we do not have clear cut aims. And sometimes even with best skills we do not achieve these two.

Thus the success of our work can´t be measured and evaluated easily. Within the work we are undergoing specific problems, other doctors and nurses do not face as frequently: resistance and non-compliance, coping with collusion / difficult relatives, coping with disgust, transference and countertransference, even some say, that the constant exposure with death and dying will interconnect with one´s own fear of death (see latest issues of jpalliativecare.com). There are Western studies and books that support this idea.

There are many ways in the German palliative care teaching to improve the self-care. Some are applicable in India too and I have gathered them: yoga, and all other item I have gathered in the chapter above; „take a minute" (Suleikha) or any other movement approach even a „workout"; supervision, Balint or regular professional counselling; exchange of the professionals in groups called "Intervision" and of course the great strength in India: spirituality. For the last please see my speech I gave at AIIMS in Jan. 2013[7]

Communication

As we communicate every day - and according Paul Watzlawick it is not possible not to communicate - everyone thinks, they are experts in that, especially those, who need communication in professional life. I again and again explained, that I love Indian and that I have a deep respect for the task of being a doctor, but I have to say: Doctors and especially the Indian doctors – in spite of thinking to be exerts in communication - they aren´t. Of course, there is very little time for communication left, especially as the typical Indian doctor has to treat six times more patients than German doctors do. And German doctors are not good in communication as well. Just after less than half a minute in general they stop the patient to talk in the first examination of his needs and sicknesses.

But it is not always a question of time. It is a question of respect, a question of attitude, and of listening. These are the tasks identified for better communication: To break / to bring the „bad news", not to go for collusion, support during the decision making in end-of-life decisions (ethics), find ways out of the resistance / non compliance.

In the German/European mode of teaching we use these methods to train doctors in communication: In academic course: Act storming (Schulz v. Thun), Role play (psychodrama), "Inner Team" Work (Schulz v. Thun), Balint work (Balint) and others. 35 % of the training in palliative care in Germany is reserved for that.

Proposal of 20 day academic courses

In continuation of the said I propose to start with 20 day academic courses in India according to the European/German model as well. All topics of IAHPC Manual or UG Curricula will be covered in 160 study hours (45 minutes each), that is 120 time-hours or 20 days with each 6 time hours of teaching. This means: 4 times 40 study hors/30 time hours each quarter once within one year (mostly Wednesday midday till Sunday midday). Only a few additional topics will be added, like self-care. Additional teaching methods will be applied: interactive learning, communication training. The teacher will work out a program, which will have less repetitions (less redundant) and the group process will be part of the teaching itself. After the teaching, the participants get models to be teachers themselves with more ease.

But even if a 20 day course would not be viable in the future in the Indian context, it is easy to use the active learning, the interaction and some of the communication methods available from the western palliative care trainings within the present teaching systems.

Up to now, we have trained in 20 days all academic (4 times 5 days) courses more than 10.000 doctors and 20.000 nurses in Germany with the success, that the palliative care treatment is available in all our 16 states and even in rural and remote areas.

Advantages of an academic 20 day course:

- Can reach distant regions
- Can offer training in regions without palliative care centers
- Can thus be adjusted to regional needs/possibilities
- Can complimentary accompany students professions
- Can give skill/attitude access to „palliative care - part-timers“
- Can thus include palliative care in their specialisations
- Can relief active specialists from high teaching workload
- Giving teaching workload to well trained/field-experienced full- and part-time teachers

Need to train the trainers

Whereas during E-Learning is contact to the students group is only of short duration, the contact to the students in the 4-6 weeks training is well established and the learning-teaching contact followed clearly depicted patterns and roles. This will be different for sure in the 4 time 5 days training to come. These are the topics, trainers of such courses shall be trained at beforehand according to the experience of the train the trainer programs in Europe and US:

- Alternative methods of teaching: group work/ interactive learning
- close interaction with the other faculty as to avoid duplication of teaching contents
- learn how to cope with emotions of the students
  - Outbreak of emotions, tears, grief…
  - resistance, non-cooperation, even anger
  - „knowing better“ or „have reason why this should not be done“
- To live with sometimes student´s lack of palliative practice – not to over demand
- conducting difficult group processes

Conclusion

1. **try to enrich in the present 4 and 6 weeks teaching formats with specialised half day communication methods and interactive sessions**
2. **try full academic 20 day training Diploma Course (EAPC) or Certificate Courses (Germany)**
3. **have train the trainer courses for those who the teach and support trainers in their first courses**
4. **have even full time trainers on palliative care for UG / PG**

Realisation at Manipal and Kidwai in 2014

Dr M. Vijaya Kumar, Director of Kidwai, Bangalore accepted the wish of Prof. Linge Gowda Professor & Head. Dept. of Palliative Medicine and his team to start such 20 days trainings (with oncology focus) in August 2014. In the first batch of students some future teachers for palliative care will attend as well. It is the plan of Dr. M Vijaya Kumar, Prof. Linge Gowda and the team of Kidwai and MediAcion to extend the training to 5 rural districts of Karnataka still in 2015.

The vice-chancellor of the private Manipal University, Prof. K Ramnarayan agreed to start in August 2014 the first 5 day session of the 20 day course in palliative care at their Mangalore Campus. The New chair in Geriatrics with special interest in Palliative Care is Prof. Prabha Adhikari, who will jointly with Dr. J Becker-Ebel and a joint faculty of Manipal and MediAcion conduct the training. The other three parts of the training will take place at Mangalore in December 2014 and in January and February 2015[8]

Additional information (MMC, JIPMER, AIIMS)

With the written support of GoI Dept. of H&FW Ms Sujaya Krishnan F.No.T.21020/63/2012-NCD(M), Dept. of H&FW, of Feb. 6th, 2013 and the oral support of Dr. J Radhakrishnan , Secretary Health, Gov. of Tamil Nadu, the Madras Medical College MMC Dean and Director of Medical Education, Dr. V Kanagasabai, M.D., agreed to start the 20-day palliative cum geriatric care certificate course at Chennai under the tenure of his successor and under the guidance of Prof. Krishna Swamy, Chair of geriatrics in summer 2014. Prof AB Dey said, that AIIMS, New Delhi, will learn from that and take it up at a later stage due to lack of staff and funds at this moment. The director of JIPMER Dr T. S. Ravikumar is willing to start the same training at JIPMER at the earliest. Presently a six-week oncology cum palliative care training starts at JIMER. A person in-charge for 20 days palliative / geriatric care is still to be found. FORTIS Gurgaon (Prof. B Mohanti) and Apollo (Dr V Girinath) as interested too. The director/CEO of Help Age India, Mathew Cherian agreed on sending all his palliative care staff engaged in the rural palliative care projects to the courses.

Palliative Care with a geriatric emphasis

It will be too long to explain in length the need of palliative care for the non-cancer patients. The Gericon 2013 at Chennai on Dec. 13-15th saw the Indian Academy of Geriatrics addressing the topic again and again, even their chief guest Dr. Radhakrishnan pointed out the need for it. In his talk Dr. J Becker-Ebel could provide the audience with more details and figures[9]. Australia is the fore runner on that. MediAcion had given training in the old aged sector since 2003 and focused on topic of palliative care in old aged homes and within home care. India will see an increase of patients with dementia from 2010 estimated 37 lakhs to nearly 64 lakhs in 2025.[10] In addition those with incurable strokes, heart problem due to age and respiratory problems will need special attention. Geriatrics and Palliative Care providers will and should work together.

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[1] Find the digital version on "articles (English)" at www.PalliAction.com after IAPCON 2014; (as on 15-01-2014).
[2] www.eapcnet.eu/LinkClick.aspx?fileticket=2DHXbM1zaMI%3d (as on 15-01-2014).
[3] www.rcplondon.ac.uk/sites/default/files/palliative_medicine.pdf (as on 15-01-2014).
[4] ebookbrowsee.net/teaching-palliative-care-in-india-m-r-rajagopal-ppt-d419648038 (as on 15-01-2014).
[5] ebookbrowsee.net/teaching-palliative-care-in-india-m-r-rajagopal-ppt-d419648038 (as on 15-01-2014).
[6] See: article on bereavement on "articles (English)" at www.PalliAction.com (as on 15-01-2014).
[7] See: talk on spirituality at AIIMS, New Delhi in Jan 2013 on "articles (English)" at www.PalliAction.com (as on 15-01-2014).
[8] See time table on "articles (English)" at www.PalliAction.com (as on 15-01-2014).
[9] See: Gericon 2013 talk on "articles (English)" at www.PalliAction.com (as on 15-01-2014).
[10] See: www.alzheimer.org.in/assets/dementia.pdf (as on 15-01-2014).