COVID-19 tells us we have work to do in end-of-life care: a plea to improve medical education

Jiseop Kim*

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INTRODUCTION

The COVID-19 pandemic uncovered the need to improve end-of-life training for doctors and medical students. With only .7 percent of physicians accredited with a palliative care license (about 6,000 out of 900,000 physicians in the US),[1] other doctors need to fill in and "assuage the patients' fears and physical symptoms, honestly and thoroughly."[2] Doctors, regardless of what specialty they practice, should receive end-of-life training so that they are prepared for pandemics like COVID-19 or other disasters. Many doctors treating terminally ill patients are unprepared to provide the same level of care as the trained physicians due to the lack of training and experience.

ANALYSIS

I. Background

A survey of US medical schools shows that palliative education is varied.[3] The number of instruction hours offered for palliative care ranges from two to 80 hours. Moreover, over half of the 51 medical schools in the survey reported occasional incorporation of end-of-life care into coursework that lasts only for a couple weeks. Less than one third of medical schools reported offering a course or clerkship that is focused on the end of life.[4] Medical students interested in palliative care in schools with no reported palliative care course or rotation must actively seek seminars and visit hospices on their own time. Insufficient time in a palliative care setting, lack of faculty expertise, and lack of funding toward palliative care make it challenging to integrate end-of-life care into the medical school curricula.[5] The pandemic has proven the importance of palliative care competency and that "it cannot be relegated" to minimal classroom time and random clinical exposures.[6] Senior medical students have reported that they feel much better prepared to care for dying patients after some formal training.[7]

* Jiseop Kim, MS Candidate Columbia University

Doctors have reported that the lack of experience and exposure makes them unprepared to take care of the terminally ill. They do not feel confident especially when assessing mental capacity.[8] They describe their experiences in caring for patients at the end of life as, "being thrown in the deep end."[9] Hospitals in the US promote the idea that healthcare is about treating people to keep them alive. The culture does not encourage doctors or medical students to learn about palliative care.[10] Notably, medical students have stated that hospital culture portrays death as a "taboo" and equates it to a failure.[11] Most healthcare providers state that if they do learn effective palliative care, it is through "trial and error" while "doing the job."[12] Clinicians who use guesswork potentially could provide unwanted interventions or fail to meet the needs of their patients creating unnecessary suffering.

II. COVID-19 Palliative Care

The demanding conditions and limited resources resulting from the COVID-19 pandemic force doctors to do more guesswork in treating their patients. Real patients tend to be different from model patients in medical textbooks. For example, a doctor can have "an elderly patient in respiratory failure who has hypertension, diabetes, and cancer… there are studies that offer prognostic or therapeutic insights into several of these demographics but rarely all of them at once."[13] Even if there were no COVID-19 pandemic, most new doctors would need to make fast and accurate decisions despite limitations of the educational setting. With COVID-19 a hands-on education in end-of-life care is crucial.

With the rapidly deteriorating conditions of patients and severely limited resources during the pandemic, even trained palliative care physicians face challenges to effectively deliver treatment. Clinicians claim that making quick decisions based on short discussions is challenging. "Across the country, coronavirus has disrupted normal palliative care measures. Conversations are much more abbreviated."[14] While palliative doctors are finding new challenges, those without training are encountering more severe challenges. The "Coronavirus Disease 2019 Shared Decision Making Tool" provides useful information. For instance, it asks physicians to assess the likelihood of survival and to ask patients whether they have advanced directives. While guidelines can help, a thorough education would complement all available guidelines. Providing comprehensive education around palliative care will help familiarize doctors with the range of guidelines and specific palliative care issues like pain management, patient requests, shared family decision making, legal rights, and medical choices.

"In the new era of COVID-19, the protocols aren't clear. Some hospitals are considering a do-not-resuscitate (DNR) order for all infected patients."[15] Dedicated palliative care, and in some cases, hospice, is not available for COVID-19 patients because of limited facilities. Some healthcare facilities are completely ignoring patients' wishes to be treated at all. The lack of physicians trained in palliative care available to consult coupled with a lack of clear guidelines leads to rash decisions, which can risk the life of patients. Doctors need to understand conditions necessary to ensure that consent is explicit and made with a complete understanding of treatment options even if almost every treatment is palliative or experimental.

Clinicians emphasize the "need to be able to communicate effectively with patients and their families early on to understand their wishes and be able to provide high-quality palliative care in the Intensive Care Unit (ICU) and eventually hospice, given the shortage of resources."[16] Patients are making decisions based on their own interpretations of statistics and fear when doctors do not meet patients' end-of-life needs. There is not enough guidance for patients to make proper, well-informed decisions. The lack of time and resources should not

hinder the decision-making process and cause patients to make decisions that are contrary to their interests or beliefs.

Many doctors have used media and literature to argue that there is a need for more people to write advanced directives during this time.[17] Doctors must inform patients of all of their options so that patients and their lawyers or assigned hospital administrators can ensure documentation reflects the patients' preferences. Patients base end-of-life decisions on how dire their prognosis is, something only the doctor can convey and discuss. Therefore, it is important for doctors to have an end-of-life skillset.

III. The disconnect: Doctors treating COVID-19 are not prepared enough for end-of-life discussions with patients

For doctors to better understand end-of-life issues, medical schools must define basic palliative care competencies and integrate them into the medical school curriculum. In surveys, many healthcare providers have stated that they struggle to have end-of-life discussions with patients and family members.[18] Adding palliative care training in medical school should further a future physician's ability to devise treatment methods to serve the patients' best interests. Additionally, medical schools and health organizations must work together to increase funding for courses covering palliative care to encourage basic competency among a broader array of doctors. By reserving palliative care training for those pursuing it as a specialty, schools allow general medical students to graduate without the minimum level of competency necessary.

The media have also reported the availability of palliative care hotlines for potential patients during COVID-19.[19] Many doctors have complained that the use of these hotlines is difficult because identifying cues doctors usually notice in person is challenging over the phone.[20] Therefore, there is a need to train students to communicate with their patients over the phone or through video.

There must be a user-friendly system that allows physicians to discuss pressure and stress with their peers whether it be through clinical meetings or through hospital vlogging networks. Increased social support for doctors will ensure that they are not "thrown into the deep end."[21] Support systems should also allow clinicians to inquire about their cases. Ongoing workshops, continuing education classes, and professional seminars or webinars must provide contemporaneous training for doctors inexperienced in palliative care thrust into COVID-19 care.

Some may argue that palliative training for all doctors is unnecessary since the pandemic is an unusual situation and such a large number of deaths in a short period is unprecedented. While some doctors may never use their palliative training, the pandemic has shown the danger of being unprepared. Stakes are high in a crisis, and the benefits of training every doctor outweigh the costs. Doctors take many classes outside of their specialties that might not be put to use. Basic competency in many areas is part of well-rounded core training necessary to be a doctor. Furthermore, almost all doctors will encounter palliative issues at some point. Absent COVID-19, an ability to discuss death, priorities, and treatment options with patients is a basic medical skill that every doctor should have.

Some argue that palliative care is worse due to scarcity: if we had enough ventilators, facilities, and PPE, the issues would be resolved. However, the scarcity issue should be separated from physician training, education, and preparation. Regardless of scarcity, doctors lacking skills central to their profession are failing to communicate end-of-life options effectively.

CONCLUSION

Physicians must provide the best palliative care possible at a time when people need their healthcare providers the most: near the end of their lives and during times of extreme suffering. Improved education will allow doctors to master approaches that meet patients' and families' goals and expectations. Medical school education is central to the US system and palliative care must become a priority in the curriculum. If doctors are graduating without the basic skills surrounding end-of-life care, the US system will remain weak, especially in times of crisis.

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[6] Horowitz, p. 62

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[21] Campbell, p. 1