For the past 3 years we have had the great privilege of serving as our own grant-making agency, as faculty in the Medical School Palliative Care Education Project (MSPCE), under the auspices of the End of Life/Palliative Education Resource Center (EPERC). With support from The Robert Wood Johnson and Y.C. Ho Helen and Michael Chiang Resource Center (EPERC), we have funded 16 U.S. allopathic and osteopathic medical schools to bolster their palliative care educational programs for medical students. We challenged schools to develop three specific, and heretofore neglected, aspects of medical student education in palliative care: (1) a required experiential opportunity for medical students during the third or fourth year of medical school; (2) an elective experiential opportunity for medical students during the third or fourth year of medical school; and (3) a faculty development program to provide the necessary clinical and educational foundation to offer excellent palliative care experiences for students. We sought schools with the necessary infrastructure and depth of both hospice/palliative medicine faculty and training sites to be successful in all three project objectives. Finally, to help cement these new experiences in the curriculum, we mandated that 50% of the grant funds be used to support the medical student clerkship director(s) who would be directly responsible for working with the palliative care faculty to help design and administer the new educational experiences.

Over the course of 3 years we reviewed 90 applications. A very small number of applications came from schools with well-established, educationally sound, clinically based medical school education programs; we chose not to fund these schools, reserving funding for schools with greater need. A slightly larger cohort of applications did not have sufficient depth of palliative care faculty or training sites to support a mandated clinical experience in palliative care.

The remainder of applications listed sufficient faculty and training sites to meet the grant objectives. However, description of the required clinical palliative care educational experience was clearly the most challenging part of the grant for most applicants. The majority of applicants relied on two types of experiences to meet this requirement: (1) accompanying a hospice nurse on a home visit and attending an interdisciplinary team meetings (IDT) and (2) one or more observed structured clinical encounter (OSCE) stations for students to practice palliative care communication skills. Although both of these experiences have great educational merit, and should certainly be included within a larger package of educational experiences in hospice and palliative care, neither, by themselves, met our goal for an adequate clinical experience. The analogy in driver’s education would be to say that riding in the back seat of a car and participating in a driving simulator are sufficient to allow one to obtain a driver’s license!

Let’s look at these experiences in more depth. Hospice home visits are valuable in teaching students that patient care in the home is an entirely different experience from hospital or clinic medicine. Furthermore, the exposure to nonphysician health professionals, the individuals most likely to accompany the student, can provide a valuable learning about the knowledge and skills of these professionals. IDT meetings help the student learn the value of interdisciplinary team function, knowledge transfer concerning the world of hospice regulations, and again, reinforce the importance and functioning of a spectrum of health professionals necessary to provide comprehensive palliative care. As structured in most of the grant applications, the hospice home visit and attendance at IDT rounds were largely observational experiences with little creativity in developing robust, engaging, student experiences. Furthermore, if they are the only direct clinical experiences, a covert message is communicated that hospice and palliative medicine are distinctly outside the mainstream of medical practice.

The use of OSCEs has rapidly expanded in medical education as an excellent teaching and/or evaluation tool for a wide range of critical attitudes, knowledge and skills in palliative medicine. Many applications included an OSCE station as the sole required clinical experience for medical students in palliative care, without any required direct patient experience. But like practicing in a driving simulator, they are just that, simulations, usually with very scripted scenarios that do not allow for the richness, drama and unpredictability of real clinical encounters that makes our specialty so rewarding. The final 2 years of medical school are designed first and foremost to have students work as active participants in the care of real patients, under the supervision of physician role models. History taking, physical examination, interpretation of laboratory and radiology studies, and developing care plans, are the focus of training necessary for students to master core competencies in clinical care and to be prepared for residency training.

The ideal education curriculum in hospice and palliative medicine for medical students during the clinical years has never been defined, but we believe includes five components:

- Supervised experiential opportunities—students complete at least one detailed palliative care patient assessment, physical examination, and develop care plans based on that assessment, under supervision of a hospice and palliative medicine (HPM) board-certified/eligible physician. Ideally students would have the opportunity to follow the patient to establish a therapeutic relationship and to see how care plans evolve over time.
- Communication practice and feedback—students learn and demonstrate the requisite knowledge and skills.
concerning a core set of critical communication encounters, through processes of both observation and reflection, as well as receiving feedback about their own communication with patients. These skills might be practiced with standardized patients, but are perhaps best learned during the clinical years in supervised encounters with real patients.

- Knowledge transfer—students learn the core palliative care principles/facts to be competent physicians. This knowledge must be tested in a seamless manner alongside more traditional clinical content.
- Reflective time—students reflect and debrief about their own emotional reactions concerning the care of seriously ill and dying patients. Student self-awareness about their personal responses is an essential element of the learning experience in palliative medicine.
- Interdisciplinary participation—students participate in a hospice or palliative care clinical team, ideally discussing patients the student has personally interviewed and examined, learning the roles and responsibilities of the full range of health professionals caring for seriously ill patients.

HPM is now an ABMS-certified medical specialty; we are physicians with specific competencies and practice behaviors that differentiate us from other primary and specialty physicians. Detailed competencies for hospice and palliative medicine specialty practice have been developed and promulgated. As such, we need to be designing educational initiatives that directly reflect this new reality, exposing students to physicians who not only “talk the talk,” but “walk the walk.” The importance of faculty physicians serving as role models for medical students cannot be overemphasized; role modeling is essential if we hope to increase the number of students who consider HPM a viable career choice, and if we want basic elements of our skill sets to be incorporated into the practice patterns of other specialties that care for seriously ill patients.

The growth of palliative care programs has opened a significant opportunity for more in-depth clinically based student experiences, under direct supervision by hospice and palliative care faculty. Indeed, comparing applications received in this program in 2007 with those received in 2009, we saw a steady improvement in infrastructure, with increasing number of palliative care faculty and facilities that could support required medical student educational experiences and faculty development. As medical education moves towards a more competency-based model, we need to highlight the necessity of clinically palliative care training to master a range of competencies in symptom management, communication, and professionalism. We should be moving away from the exclusive use of observation and simulation-based medical student experiences, and moving towards required encounters that allow students to experience first-hand the work of palliative care physicians as they assess and examine real patients, struggle with multidimensional, biopsychosocial/spiritual challenges, and realize the benefits that palliative medicine can offer to patients and families, and to physicians themselves.

We can already hear the naysayers: “There is no time in the curriculum, our palliative care consultation team is already overloaded with trainees, the faculty is too overcommitted with clinical duties to take on students.” We fully understand the challenges our young field faces, especially the problems of finding required time in an overburdened medical school curriculum and finding support and time for already overcommitted palliative care faculty to take on new responsibilities. We would argue that with creativity, it is possible in most schools with an established palliative care clinical program, to secure curriculum time for palliative care experiential training, and to use that time to provide robust student educational experiences that include direct clinical encounters with real patients. We have learned that there are unrealized opportunities for educational synergies to occur when educators bring disparate and disorganized experiences in ethics, doctoring, professionalism, and other related topics, into clinical clerkships to coordinate with structured experiential learning. Forward-thinking schools have developed sustainable training experiences by spreading the teaching load across hospital, long-term care and hospice training sites. We recognize that each school is an N-of-1; that is, the optimal curriculum at each school will be different to account for unique resources, opportunities and barriers. However, the first step in curriculum development is to have a vision of what an educationally rich experience might look like combined with the fortitude of working through the medical education bureaucracy to slowly achieve the desired outcome. Educating the next generation of physicians in palliative care is not an option; we can and must do better.

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