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A Hospice Rotation for Military Medical Residents: A Mixed Methods, Multi-Perspective Program Evaluation

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Abstract

Background: An estimated 6,000 to 18,000 additional hospice and palliative medicine (HPM) physicians are needed in the United States. A source could be the military graduate medical education system where 15% of U.S. medical residents are trained. A community-based hospice and palliative care organization created a one-week rotation for military residents including participation in interdisciplinary group visits at patients' homes, facilities, and an inpatient hospice unit.

Objective: Our goal was to evaluate the effectiveness of a one-week community HPM rotation for military medical residents.

Methods: A mixed-methods, multi-stakeholder perspective program evaluation model was used for program years 2011 to 2013. Data were managed and analyzed using Microsoft Excel and Atlas.ti. Participants in the rotation were residents training at two local military hospitals. Program evaluation data were collected from residents, military program liaisons, and hospice clinical preceptors. Quantitative data included pre- and post-tests based on Accreditation Council for Graduate Medical Education competencies completed by residents. Qualitative data included resident essays and semi-structured interviews with hospice preceptors and military program liaisons.

Results: Quantitative and qualitative data suggested that the rotation increased military residents' knowledge, attitudes, and comfort level with HPM. Quantitative analysis of test scores indicated improvements from pre- to post-tests in each of five areas of learning. Qualitative data indicated the rotation created a greater appreciation for the overall importance of HPM and increased understanding of eligibility and methods for pain and symptom management.

Conclusions: A one-week community hospice rotation for medical military residents impacts participant's knowledge of and attitudes toward HPM.

Introduction

Although there are approximately 4,400 practicing hospice and palliative medicine (HPM) physicians in the United States, an estimated additional 6,000 to 18,000 individual physicians are needed to meet the demand for HPM specialists by existing U.S. hospice and palliative care programs.[1] One contributing factor is that graduate medical education (GME) programs are not adequately preparing physicians for a career in HPM, and GME funding is often not available to support those training in HPM.[1] Evidence suggests clinical rotations are critical elements of a multi-faceted approach to palliative care education[2]; however, only 70% of family medicine and internal medicine programs offer clinical palliative care experience.[3] Additionally, a minority of residency programs have required training in end-of-life (EOL) care, or hospice care, indicating room for tremendous improvement.[4]

Over 25 military treatment facilities currently sponsor GME, which, in conjunction with the Veteran's Administration, trains

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TABLE 1. EXAMPLE CALENDAR FOR ONE-WEEK ROTATION IN HOSPICE AND PALLIATIVE CARE AT LOCAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

Calendar for John Smith, MD, resident at the Walter Reed National Military Medical Center – week of March 25, 2013

Monday March 25, 2013	*Tuesday March 26, 2013*	*Wednesday March 27, 2013*	*Thursday March 28, 2013*	*Friday March 29, 2013*
Orientation and evaluation	*HPM didactics*	*Patient home visits*	*Inpatient hospice*	*Patient home visits*
9–11 am – Introduction to rotation and review pre-test results	8:30–9:30 am – Weekly HPM fellowship didactics Topic: Complementary and Alternative Therapies	8:30 am–5:30 pm Home care visits with social worker	8:30 am–5:30 pm Halquist Memorial Inpatient Center with hospice medical director	9 am–2 pm Home care visits with nurse case manager
Long-term care patient visits 11 am–5 pm Patient visits at assisted living and skilled nursing facilities with nurse practitioner	*Clinic* 10:30 am onwards Clinic at Walter Reed Military Medical Center			*Discussion* 2:30–4:00 pm Discussion of grief and loss with bereavement counselor *Evaluation* 4–5 pm Complete post-test and write reflective essay

HPM, hospice and palliative medicine.

15% of all U.S. medical residents.[5] The training of military residents in HPM is not only required by the Accreditation Council for Graduate Medical Education but is also necessary to care for the increasing number of wounded warriors and military veterans. Most military medical residents acquire training within the federally owned Military Health System (MHS), although some training is provided externally where clinical care is limited by available military resources, such as hospice and outpatient palliative care services. Although MHS beneficiaries have been shown to be similar to civilians,[6] military physicians often find themselves caring for active duty and retired service members in unique clinical settings without the robust resources of medical centers. To address these needs, in 2004, collaboration began between two local military medical centers and a large not-for-profit community-based hospice serving the greater metropolitan Washington, DC area to provide military family medicine and internal medicine residents with a rotation in HPM. Beginning in 2011, this collaboration was standardized and educational outcomes measured as a result of grants from external supports.

The primary goal of the structured one-week rotation is for medical residents to gain exposure to HPM operations and core clinical skills. The rotation begins with an orientation to learning objectives for the rotation and provision of a reference packet. This includes two books,[7,8] clinical practice guidelines,[9] and readings relevant to opioid equianalgesic calculation, use of the World Health Organization (WHO) pain ladder,[10,11] use of Buckman's six-steps for breaking bad news,[12] recognizing and treating different types of pain,[13] and recognizing signs and symptoms of approaching death. Over the course of a week, residents shadow members of the interdisciplinary group (IDG) in visits at patient homes, long-term care facilities, and an inpatient hospice unit; Table 1 shows a sample schedule. To ensure learning objectives are met, a set of micro-skills is taught to each resident.

Methods

Design

To evaluate the effectiveness of a one-week community HPM rotation for military medical residents, a mixed-methods, multi-stakeholder perspective program evaluation was conducted for program years 2011 to 2013. The study used multiple data types to triangulate and gain a detailed understanding of process and context and to address the evaluation aims.[14]

Human subjects. This mixed-methods program evaluation was evaluated and declared exempt by the Institution Review Boards of Medstar Health Research Institute on behalf of Capital Caring and by the Defense Medical Research Network.

Objective

The stated learning objectives for participating residents were to: 1) define key elements of hospice and palliative care operations, including hospice eligibility criteria and payment systems; 2) demonstrate knowledge of grief, loss, and bereavement, and management strategies; 3) distinguish between nociceptive and neuropathic pain and demonstrate knowledge of treatment strategies; 4) recognize the family as the palliative unit of care; 5) demonstrate knowledge of

effective communication strategies with patients and families facing EOL. The program evaluation used those five objectives as a framework for qualitative and quantitative analysis.

Setting and subjects

Participants in the HPM rotation were residents training at two local military hospitals. Program evaluation data were collected from all participating residents (quantitative and qualitative), a convenience sample of interdisciplinary hospice clinical preceptors, and all military program liaisons.

Measurements

Quantitative assessments were made through a 52-item test administered before and after the rotation. Questions were chosen, with permission, from a 150-question practice test for the HPM certification exam,[15] according to their relevance to the learning objectives. Qualitative data included a one-page reflective essay by residents.

Semi-structured in-depth interviews[14] were conducted with hospice program preceptors regarding strengths and weaknesses of the program and changes observed in residents' knowledge, attitudes, or behaviors. Interviews were audio recorded and transcribed before being uploaded to Atlas.ti[16] (Scientific Software Development GmbH, Germany) for coding. In addition, several meetings were held with program liaisons at both military medical centers to review and discuss findings from the program evaluation and to include their perspective in validating the results.

Data analysis

The learning objectives were used as an analytic framework. Quantitative data were analyzed for mean change in test scores for each test item and for groups of questions by learning objective. Qualitative analysis techniques included immersion, coding, examining patterns, and writing memos.[17,18] The codebook reflected learning objectives and was applied systematically by two independent analysts.

Results

Quantitative results included pre-tests and post-tests for 45 residents and are presented in Table 2. Qualitative results included 100% of submitted resident essays ($n=43$). Interviews were conducted with 11 interdisciplinary hospice preceptors including two nurses, two grief counselors, two physicians, two chaplains, one nurse manager, one social worker, and one certified nursing assistant. Two meetings were held with four military program liaisons across both sites. Qualitative results are presented by learning objective domain in Table 3 and by additional emergent themes regarding professional development and reflections on potential programmatic changes in Table 4.

Test scores increased from pre- to post-test within all five domains of learning objectives; the average improvement ranged from 9% (communication) to 24% (family as unit of care). Residents typically scored highest on pre-test questions within the domain of effective communication; in this domain improvement at post-test was lowest but the highest percentage correct across learning domains. Residents' essays provided insight into growth across all five learning domains, attributed to ''seeing hospice in action'' and gaining exposure to methods and tools commonly used in palliative care, such as subcutaneous medication administration, or supporting the family's experience through conflict in coping or grief. One resident subsequently published a version of his reflective essay in the *Journal of Palliative Medicine.*[19] Hospice preceptors felt it was important that residents be exposed early in their training to all aspects of hospice care, including home care and those ''difficult conversations''; preceptors opined that the rotation should be 2 weeks long at minimum. Military program liaisons recommended that residents travel with preceptors to patient homes to maximize teaching time and to increase the amount of structured teaching by physician fellows or academic faculty.

Discussion

As a result of the learning experience, residents demonstrated significant improvement in their knowledge and understanding of HPM, including the importance of caring for the whole family and how grief affects the family unit, general hospice care guidelines and eligibility, and commonly encountered pain and non-pain symptoms in HPM. Residents had higher baseline knowledge of communication, and therefore demonstrated less improvement. McFarland hypothesized that improvements in communication, an ''art of medicine'' skill, may be less quantifiable and more evident by qualitative assessments.[20] Qualitative

Table 2. Change in Score Comparing Pre- and Post-Rotation Test Outcomes ($N=45$ residents) from a One-Week Rotation in Hospice and Palliative Medicine for Military Residents

Categories of test questions, by learning objective (n = *number of questions per group*)	*2011–2012 pre-test*	*2011–2012 post-test*	*2012–2013 pre-test*	*2012–2013 post-test*	*Average improvement in scores from pre- to post-test*
Hospice and palliative care operations ($n=9$)	55.0%	75.2%	54.7%	77.5%	21.5%
Grief, loss, and bereavement ($n=13$)	57.9%	76.0%	54.8%	78.4%	20.9%
Pain assessment ($n=16$)	51.2%	67.6%	49.3%	75.7%	21.4%
Family systems ($n=7$)	57.1%	79.0%	54.6%	80.4%	23.9%
Communication ($n=14$)	76.5%	89.1%	76.0%	81.7%	9.1%

Percent of multiple choice assessment questions correctly answered by military residents before (pre-test) compared with after (post-test) completing a one-week rotation in hospice and palliative care at a local non-profit hospice and palliative care organization. The 52 pre/post test comprised questions chosen with permission, from a 150-question practice test for the HPM certification exam.[14]

HPM, hospice and palliative medicine.

Table 3. Qualitative Results by Learning Objective Domain of a Mixed-Methods Program Evaluation of the One-Week Rotation in Hospice and Palliative Medicine for Military Residents

Thematic domain	*Residents (n = 43 reflective essays)*[a]	*Preceptors (n = 11 interviews)*[b]
Hospice and palliative care operations	Residents generally had little (if any) prior experience with hospice care prior to the rotation, but by ''seeing hospice in action'' gained new knowledge, perspectives, and understanding. Illustrative quote: ''During this week, I was able to learn a lot about hospice and palliation as a medical sub-specialty and the multi-disciplinary elements that go into delivering good palliative care.''	Preceptors also stressed the importance of early exposure to hospice and palliative care. Illustrative quote: ''The notion and idea of exposing physicians early in their training to what palliative care and hospice is, is invaluable. That is part of the ongoing needs for physicians to be more informed and gives them a different option for the broad area of services that can be provided, different from the traditional model. … It comes at an important point for transition to deal with end of life … that's again, an invaluable need.''
Knowledge of grief, loss, and bereavement	Residents described learning about how important hospice was in supporting not only the patient, but also his/her family and friends. Some also reported not knowing much about grief counseling prior to this rotation. Many residents described specific experiences working with the patient and family experiencing intense grief surrounding the death of their loved one, although not all experiences were positive. Illustrative quote: ''Physicians often feel helpless in regards to grief and I now feel that I have some tools to, at least, begin to address the grief experienced by these individuals.''	Preceptors expressed the importance of exposing residents to all aspects of hospice care, including grief and bereavement care. Additionally, preceptors commented on the importance of helping the residents work through their own thoughts and emotions as they go through the week. Because of the intense nature of this experience, and the fact that they encounter many patients and families who are facing the end of life in one week, some of the preceptors thought that it was important to discuss with the residents how the experience affected them.
Pain and symptom identification and treatment	Residents described new knowledge about pain management, including learning about different medications to treat pain as well as new routes of administration. They also described the importance of communication with patients and their families about pain, non-pain symptoms, and their management. Illustrative quote: ''It was interesting learning the different forms of pain management. It certainly is an art form that must be learned, and I am sure, very much appreciated by patients.''	
Family as the palliative unit of care	Residents described numerous experiences where they witnessed conflict within the family unit due to the illness and death. This was sometimes related to the family not accepting the death, or to differences in coping strategies and abilities among family members.	Preceptors described the value for residents to work with patients in their homes, rather than only in clinics and hospitals, to which many residents are limited. Residents are able to experience a whole new aspect of the patients and families that they are not accustomed to seeing in the acute care setting. Illustrative quote: ''They're able to interact with people in homes … and I think they, from what they have told me, they benefit a lot from seeing, personally. … It's a total eye opener for them.''
Effective communication strategies with patients and families facing the end of life.	Residents chronicled numerous examples of effective communication between the care team and the patient and family, including communicating about goals of care and how important this communication is in shaping quality of care. However, residents identified communication about non-medical issues as equally important to the patient and family.	Preceptors described the importance of exposing residents to those ''difficult conversations'' with patients and families, even if the resident is not having conversations or holding family meetings with patients during the rotation. Illustrative quote: [It is valuable for residents to appreciate] ''the importance of bedside manner when having those difficult conversations, what it looks like to be compassionate.''

[a]Qualitative dataset includes 43 essays by military residents reflecting on their one-week rotation in hospice and palliative medicine at a community-based provider organization.

[b]Interview dataset includes 11 interdisciplinary hospice preceptors including two nurses, two grief counselors, two physicians, two chaplains, one nurse manager, one social worker, and one certified nursing assistant.

Table 4. Results Reflecting Professional and Programmatic Themes of a Mixed-Methods Program Evaluation of the One-Week Rotation in Hospice and Palliative Medicine for Military Residents

	Residents (n=43 essays)[a]	*Preceptors (n=11 interviews)*[b]	*Military liaisons (n=4 liaisons, 2 meetings)*[c]
Professional growth and development	Residents reported this rotation had a substantial effect and commented on how much they have grown as a result of this rotation, even in a week. For example, one resident commented that this rotation was "invaluable" and "will have a lasting impact on my career." Residents also expressed more interest in hospice and palliative medicine as a result of this rotation, and some acknowledged how much more they need to learn about this specialty. Many residents commented that they will utilize the knowledge gained in their own practice of medicine, despite the differing specialties represented. Residents expressed changes in attitudes and beliefs regarding death, dying, and hospice care, as well as changes in their intended behaviors and practice	Preceptors describe the impact of even a brief exposure to hospice care on residents' career trajectories, even if that career is not specifically in HPM. Illustrative quotes: One preceptor quoted a resident, "You know, I never considered going into this field, but, I have to say, now I might think about it." "Their experience is very similar to our responsibility for the experience of the patient and the family – to impact them for a lifetime. Their experience here can carry on with them, even if they never end up in a hospice. Just the philosophy, and the care and the nurturing, and the consideration …that can be life-altering in a good way."	Program liaisons reported that the home care training residents receive during the rotation is valuable because residents otherwise are generally uncomfortable with home care due to little prior exposure.
Recommendations for program improvements	Residents noted that their biggest regret was that the rotation is not long enough, and that they were not always given enough time away from their own program responsibilities to fully appreciate this rotation.	Many preceptors opined that this rotation should be at minimum 2 weeks of dedicated time to fully expose the residents to the field of HPM.	Program liaisons recommended ensuring access to academic faculty or physician fellows for more structured teaching, balanced with exposure to other members of the IDG. To counteract the inefficiencies of travel to patient homes (as compared with inpatient hospice or outpatient clinic settings), liaisons recommended ensuring that residents travel with their preceptor to allow the time to be used for teaching. Although the training in hospice and palliative care during the rotation was lauded, stakeholders recommended adding explicit training in geriatric palliative care. Finally, liaisons requested the development of a method to share assessments of the residents by hospice preceptors with the military training institutions, even information from "triggered observations" of the residents by the hospice's clinicians, for example, if the resident was abrupt with someone or had good eye contact.

[a]Forty-three essays by military residents reflecting on their one-week rotation in hospice and palliative medicine at a community-based provider organization.
[b]Interview dataset includes 11 interdisciplinary hospice preceptors including two nurses, two grief counselors, two physicians, two chaplains, one nurse manager, one social worker, and one certified nursing assistant.
[c]Program liaison dataset includes two meetings with four stakeholders across both military institutions.
HPM, hospice and palliative medicine; IDG, interdisciplinary group.

data from essays likewise are suggestive that even a one-week learning experience positively impacts knowledge and attitudes, although feedback from military program liaisons and residents suggests a study of the incremental benefits of a 2-week HPM rotation is needed.

Competent educational opportunities are critical to the success of the emerging HPM medical sub-specialty. To achieve the multi-domain competencies necessary for HPM, interactive and experiential teaching methods are essential[2,3] and more comprehensive curriculum evaluation is needed.[2] Curricular evaluation of a multi-faceted discipline should encompass multi-dimensional techniques.[2,3] Quantitative measures have been advocated by some but are uncommonly reported or included in systematic reviews.[2]

Limitations to this program evaluation include a single-site intervention, a small convenience sampling of preceptors, a short interval between pre- and post-test, the lack of validated tools to assess outcome measures, as well as the lack of measurement of learned skills or performance. Knowledge and attitude self-assessment also has inherent limitation and bias.[21] Finally, long-term impact of the rotation was not assessed.

Chronic, progressive and life-limiting illnesses afflict persons indiscriminately, yet there is a scarcity of palliative care certified physicians within the Department of Defense military treatment facilities. Additionally, palliative medicine has been overlooked in most military residencies until recently. Military residents care for young and middle-aged active duty service members, family members, and retirees, many of whom have complex physical and psychological scars connected to combat experiences. Thus, competency in HPM is a valuable skill in this population. Exposing military medical residents to the principles of HPM, even if only for a brief period of time, is invaluable because, in the words of one preceptor, ''the more physicians know about what is done, and what is offered, and what can be offered to help their patients, then obviously it's beneficial for everybody.''

Conclusions

HPM, although emerging as an essential component of the health care system, remains underdeveloped, particularly in military treatment facilities. Quality palliative care education that improves practice and increases competency is essential to the growth and development of the field. This is one of the few residency rotations to be evaluated using a robust, mixed-methods, multi-stakeholder approach. Based on our evaluation, this rotation improves knowledge of HPM in military residents and can serve as inspiration for other military training programs looking to develop rotations in HPM.

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Author Disclosure Statement

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