



Accelerated Medical Education: Impact of a 48 Hour Hospice Home Immersion

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Abstract

Introduction: The importance of learning and understanding palliative and end of life care has become important with today's aging population. Medical schools have been using varied approaches to teach end of life care, however it is often relegated to the hidden curriculum. Providing students with the opportunity to observe and participate in end of life care early on in their medical education has a positive effect on attitudes toward the care of dying persons. The research presented here was conducted by one pair of medical students who were immersed for 48 hours into a palliative and end of life care environment, a local 18 bed Hospice Home.

Methods: Qualitative ethnographic and autobiographical research designs were utilized by two second year medical students who were immersed in a hospice home for 48 continuous hours. They worked with an inter professional team and provided care, pre and post mortem, to patients and families throughout the immersion. Data were in the form of written student journals that included subjective and objective reporting of observations and experiences over 3 stages: (1) pre-immersion (pre-field notes); (2) immersion (field notes); and (3) post-immersion (post-field-notes).

Results: Four themes were selected that addressed the research questions and were mutually important to the students. (1) Facing and Talking about Death and Dying; (2) The Power of Touch; (3) Catering to the Patient's Comfort; and (4) Listening to the Patients/Reading the Signs. Student experiences and learning were presented through the selection of representative quotes associated with each theme.

Conclusion: The 48 Hour Hospice Home Immersion project provided a unique educational and research experience that accelerated their learning about palliative and end of life care for older adults. This time intensive immersion creates a depth of learning and advances medical education in death and dying beyond any classroom experience.

Keywords: End of life care; Palliative care; Medical education; Hospice home; Experiential learning

Introduction

The importance of learning and understanding palliative and end of life care has become ever more important with today's aging population; a population that is facing an increasing incidence of cancer and chronic illness [1]. Life expectancy in the United States rose from age 47-78 in one century, and the most rapidly growing portion of the population are individuals over 90 years of age [2]. Death is mostly thought to come at the end of a chronic illness or the frailty that accompanies old age [2]; however, accidents or trauma (such as falls) and acute diseases can bring on death within weeks or months after diagnosis to even the most vibrant older adult adults. In 2013, a total of 2,596,993 resident deaths were registered in the United States, approximately 81% of those deaths occurred in people aged 60 and older [3].

Medical schools have been using varied approaches to teach end of life care, however the palliative care competencies are too complex and universally important to be relegated to a minimum of classroom time, random clinical exposures, and the hidden curriculum [4]. Providing

students with the opportunity to observe and participate in end of life care early on in their medical education has a positive effect on attitudes toward the care of dying persons [5]. Until recently, the University of New England College of Osteopathic Medicine (UNECOM) integrated the subject of death and dying within the pre-clinical curriculum through the use of case studies, observational preceptorships, and lectures, but dedicated time allotted to teaching about palliative care, hospice care, and end of life care is minimal and non-practice based [6].

This article introduces an innovative medical education modality based on ethnographic and autobiographic research that was designed and implemented by the UNECOM Director of Geriatrics Education and Research. The research presented here was conducted by one pair of medical students who were immersed for 48 hours into a palliative and end of life care environment, the Gosnell Memorial Hospice Home.

Hospice Home Immersion Project Defined

The UNECOM 48 Hour Hospice Home Immersion project (heretofore referred to as Hospice Home Immersion) was first piloted in December 2014 to provide second year medical students the

opportunity to live in a hospice home for 48 hours to work with an inter-professional team providing patient, family, and post mortem care. This project, based on ethnographic/auto-biographic research, was modeled after the UNECOM Learning by Living project where medical students are “admitted” into nursing homes for two weeks with a diagnosis and standard procedures of care to live the life of an elder resident [7,8]. Since the initiation of the of the Hospice Home Immersion project, 12 pairs of second year medical students (24 medical students) and 1 pair of physician assistant students (2 students) have been immersed into a local hospice home that included sleeping in a bed where other patients have died and providing patient, family and post mortem care. During the 48 hour immersion they worked with an inter professional hospice staff team, including volunteers, and encountered numerous admissions and deaths (4 deaths average per weekend). The average patient stay at the Hospice Home is 4.5 days. The experiential learning model of the Hospice Home Immersion is based on progressivism associated with Dewey, first published in 1916 [9], whereby living in a hospice home enables medical students to build knowledge about end of life care by constructively adapting to the environment, “learning by doing,” and reflecting on it [7,8].

Medical students who were immersed in the Hospice Home were required to answer these two questions: “What is it like FOR ME to live in the Hospice Home? What will I take from these experiences and apply to my future career as a physician? The emphasis on the phrase “FOR ME” applies to the autobiographic segment of the project and establishes the expectation that the student will self-reflect on his/her subjective experience, rather than objectively assess the Hospice Home environment or staff [6].

Methods

Qualitative ethnographic and autobiographical research designs were utilized. The Hospice Home Immersion project is a volunteer experience opened to University of New England College of Osteopathic Medical (UNECOM) second year medical students that express interest in learning about and participating in palliative and end of life care [6]. The two medical students featured in this article included a 27 year old female and 26 year old male selected to be immersed based on their completion of the required registration form and their essays on why they wanted to be immersed in the Hospice Home (see Pre-immersion, below). Neither student had experience with hospice nor had much experience with death in their families. They were required to live, eat, and sleep in the Gosnell Memorial Hospice Home (referred to as the Hospice Home) in Scarborough Maine for 48 continuous hours. The Hospice of Southern Maine, who manages the Gosnell Memorial Hospice Home, is the only non-profit Medicare certified agency with an inpatient hospice facility in Maine [6]. The Hospice Home has 18 patient rooms, but is staffed for 14-16 patients, a central kitchen, sanctuary, living room, conference room, spa, and has been designed to embrace the circle of life. There are outdoor gardens, a patio, and walking path; all accessible to patients regardless of their wheelchair or bed reliance.

While living in the Hospice Home the students had multiple opportunities to work with an inter-professional staff team and volunteers as they provided care to a variety of patients. Additionally they engaged with family members, assisted with the grief process, and provided post mortem care. The patient population during this immersion included primarily adults 60 years of age or older, many in their 80's or 90's.

This project was deemed exempt by the University of New England IRB as the students were the research participants as well as the researchers. The Hospice of Southern Maine Ethics Committee approved the Hospice Home Immersion project.

Data for the research were in the form of written student journals that included subjective and objective reporting of observations and experiences. There were 3 stages to the Hospice Home Immersion project (1) pre-immersion (pre-field notes); (2) immersion (field notes); and (3) post-immersion (post-field-notes) [6].

Pre-immersion

The two medical students completed a registration form that included demographic data, an essay on why they were interested in participating in the project and a list of assumptions about hospice care and death and dying [6]. A week before the immersion into the Hospice Home, the students met with the project principle investigator (PPI), and discussed the scope of the project, the research methods, expectations, data collection, as well as what to pack [6]. The students began journaling (pre-field notes) at the close of this meeting. These pre-field notes captured their prior experiences with death/dying, reactions to the meeting, reactions from their friends and family about being immersed in a Hospice Home and any other associated reflections that students' wanted to write about [6].

Immersion

The students were driven to the Hospice Home on the day of admission by the PPI and were given a 60 minute orientation and tour by the Hospice Home manager. The students shared a room where others have died before and ate the same food prepared for the patients. Throughout the 48 hours they worked side by side with the doctors, nurses, certified nursing assistants (CNAs), social workers, volunteers, and chaplain providing patient care, family care, and post mortem preparation for those who have died. They also interacted with patients and/or families on their own, staying up through the night to sit with dying patients. At the end of each day the students were required to document in their journals what they experienced and how they felt about living in the Hospice Home (field notes). Journals were emailed to the PPI each night for review. The PPI was available by phone to the students throughout the 48 hours. Two planned conversations were scheduled during the immersion: one by text on the first evening and one by phone on the second evening. At the end of the 48 hours, there was a debriefing session with the PPI and Hospice Home staff to discuss the students' experiences and reactions to this immersion.

Post-immersion

The students were then driven back to the medical school and journaling continued for another 5-7 days (post-field notes). The PPI was available to support the students during this re-entry time. Once submitted, the journals received a final review by the PPI, which, in some cases, required additional data or further explanations to complete the journals [6].

After post-field notes were written and approved, data analyses commenced and included journal reviews, thematic categorizations, and coding through content analysis. The completed journals were read through at least twice by each student and themes were identified. The students met to determine points of overlap and points of departure regarding themes and how best to convey their experiences

and observations utilizing representative quotes. Final themes and associated data determinations (quotes) were made by the students regarding their Hospice Home Immersion outcomes [6].

Results

The following presents the experiences of one pair of medical students who lived in the home from April 3-5, 2015. 90% of the patients during this weekend were 60 years of age or older. Although in qualitative research the identification of themes and sub-themes tend to be numerous, for this article only four themes were selected as these themes addressed both research questions simultaneously and were significant to the students. These four themes were: (1) Facing and Talking about Death and Dying; (2) The Power of Touch; (3) Catering to the Patient's Comfort; and (4) Listening to the Patients/ Reading the Signs. The quotes provided by each student were representative of the data associated with the theme. Names of staff, patients/families have been changed for anonymity.

Theme 1: Facing and talking about death and dying

The son-in-law then asked the big question "so this means she is not going to get better?" Dr. Doe replied clear and with a simple answer, "no." As much as I would hate to hear that from a doctor, I could see in their eyes that they needed to hear that, they needed that confirmation that she will pass away and all they can do is support her and make her comfortable and make sure she is not in pain (Natasha Tobarran, OMS III).

There is a peaceful sanctuary at the Hospice Home where I would go to write in my journal. One time in particular, a grieving family member walked in, sat down and started sobbing. I felt so out of place in my shirt and tie typing on my computer so I gently got up and gave her some privacy. In hindsight I wish I would have said something to her, asked her if I could get her anything, gave her a tissue (Taylor Byrne, OMS III).

Taylor eventually gained the confidence to approach the grieving woman and comforted her as her husband was dying. She opened up immediately and it appeared to be therapeutic for her to share the adventures she had with her husband over the course of their life together.

As medical students we learn how to communicate clearly and effectively with patients. However, this skill is often lost when we face challenging situations such as death. It is an intimidating subject to even talk about. One of the main things we wanted to get out of the project was learning to talk to patients and family members about death and dying. As implied within these quotes, we learned first-hand that this is much easier said than done. We know that nothing can make these conversations easier, but this experience has given us the courage to be clear, conscious and empathetic when having these conversations.

Additionally, we learned there is a time and place for certain conversations. We found out that family members and patients let us know when they wanted to be alone, when they needed their loved one, or when they wanted our company. This experience gave us the confidence to no longer be afraid of the awkwardness that might come with lending a listening ear or approaching a grieving family member or patient.

Theme 2: The power of touch

The doctor used her hands as her primary tool. She would feel for their radial pulse and then put her hand to their chest. She said that you could feel everything you need to know from just that. It was enlightening to see that blood pressure cuffs, stethoscopes and all the tools that we are used to having at our disposal are not needed at end of life. Touch, the most basic and simple tool, shows the patient love, care, kindness and compassion (Natasha Tobarran, OMS III).

I was impressed with how much knowledge the physician was able to gather just by touching the patient. She was able to gather a pulse, get a respiratory rate, estimate their blood pressure, and even estimate the amount of fluid in a patient's lungs only by using her hands. This may sound fairly simple but I have rarely seen just touch used in a medical setting. Possibly of more importance, the physician did not underestimate the power of touch and its ability to establish a deeper bond with the patient and provide comfort as the patient transitioned (into actively dying) (Taylor Byrne, OMS III).

From day one in medical school, as aspiring osteopathic physicians, we are taught the importance of strong palpatory skills and "listening hands". In hospice care, we found these skills to be invaluable. During our Hospice Home Immersion, we observed physicians using these skills to assess their patients. Conversely, in our other clinical experiences, we rarely saw a physician touch a patient aside from a quick listen with their stethoscope. In the Home, everything from assessing a patient's pulse to estimating how much fluid was in a patient's lungs was done by touching the patient. Through touch they were able to gather enough information to help the patient transition comfortably. We also observed how simply touching the patient during the physical exam facilitated the physician patient relationship; which also extended to the family. Touching established a connection that allowed patients and their family to feel comfortable and it prompted open communication. This ultimately resulted in better and more personable care.

Theme 3: Catering to the patient's comfort

I was very surprised to hear that Eve's glucose levels were up to 419! The nurse administered some insulin but explained that it was mainly for comfort measures. Eve had become so used to checking her glucose levels at home that it was still something she insisted on doing. Rather than stopping the glucose checks altogether, the staff decided on slowly weaning her off that habit so that she would be more comfortable. This is when I realized that the definition of comfort measures is unique to each patient. One might think it unnecessary or even cruel to poke a patient multiple times a day to check their blood glucose levels when they are in hospice care. On the contrary, it made Yvette more comfortable (Taylor Byrne, OMS III).

During the nurse exchange, they did not just talk about what was going on with the patient medically, but they discussed what the family was going through, how they felt, and what they needed help with. The dying process is not just about the patient it is about the family of the patient and what they are going through as well...I really feel that every aspect of care is being addressed (Natasha Tobarran, OMS III).

Before living in the home, we might have explained "hospice care" to a patient as simply comfort care. Once we started spending time with hospice patients, we discovered that it is much more complex. The word "comfort" has a unique meaning to each patient. This was apparent as we met each patient. For those with family present, hospice

assists in comforting them as well; another way to augment patient comfort. The beauty of hospice is that it allows physicians to cater to each individual patient and address their needs. For some patients it means eating just ice cream for dinner. For Eve, it meant holding onto her autonomy by continuing to check her blood glucose levels daily even though she was dying. Determining what comfort means to the patient assists them in finding peace during the time they have left.

Theme 4: Listening to the patients/reading the signs

As Joe became more and more incoherent, his wife became his voice. She felt that she knew Joe the best and that after sleeping in the same bed with the man for 36 years that she could tell when he was in pain. She felt like the hospice staff listened to her input and this really meant a lot to her. She looked at Natasha and me and said “whatever you do in your career as doctors make sure you listen to your patients” (Taylor Byrne, OMS III).

The doctor said patients may not be able to tell you if they are in pain. As physicians we have to deduce that by their furrowed brows or from their family members telling you that is not their normal behavior. The doctor made an important point, if the patient can't tell you they need to go to the bathroom then they can't tell you they are in pain. In medical school we are trained to listen to words, reading patient signs of what they may be going through takes experience (Natasha Tobarran, OMS III).

Physicians have time constraints and may not be able to devote the time necessary to truly listen to patient concerns and expectations. Hospice care is about getting back to the basics and listening to what the patient and family wants. During our immersion patients couldn't always verbally express their wants and needs. It is at these times that the art of nonverbal communication becomes crucial. We observed and learned this art first hand. Alongside nurses, CNAs, and physicians, we observed patients who were actively dying and assessed their comfort level. We observed their body position, facial expressions, and overall appearance to determine if the patient was in pain or comfortable. This was the first time we consciously used these kinds of tools when assessing a patient.

The family should also be considered when providing patient care. They may have insights to changes the patient may be exhibiting. We found it equally important to read the body language of the family in order to assess whether or not they are overwhelmed. This is important when providing comfort to the family but is especially useful before delivering bad news. From just the tone of voice you use and the way you position your body, this can show the family you care and are concerned for the patient's well-being.

Discussion

These student physicians quickly learned how to address patients and families in an appropriate manner when they discussed end of life care and issues. They immediately realized that this alone would impact their practice as future physicians. The immersion experience humanized death and dying; a feature that is often lost when working in a hospital environment. During their third year clerkships it became readily apparent to them that physicians and other healthcare providers easily become numb to the process of death. For example, on Student Physician Tobarran's first clinical rotation, she watched a full code unfold with an 84-year-old woman and reflected on the impact the Hospice Home Immersion experience had on her: “I won't be another physician who just sees this everyday and it doesn't faze them.”

After seeing broken ribs from chest compressions, blood being vomited, and agonizing breaths from the patient while she was surrounded by strangers during the last moments of her life, it solidified Natasha's learning about the importance of advance care planning and hospice care. She also realized the importance of educating physicians and family members on the services that hospice can provide as well as teaching patients and their families what a full code entails and the harm it can cause.

This 48 Hour Hospice Home Immersion project accelerated these students' learning that dying is part of life and provided them with experiences to understand what an honor it is to be part of the care processes that alleviates pain, increases comfort, values communication, and human connections [6]. They also learned there is a reverence in providing post mortem care, ensuring the patient after death continues to be respected and that family has time to say goodbye.

Student Physician Tobarran reflected on how this experience will affect her future career as a physician. She stated: “No matter what field I decide to go into I will work with patients that have a terminal diagnosis. It is important to know how to talk to them, how to talk to their families and what to expect during the dying process. There are certain discernible changes that we see in the body and mind when people are dying and we need to educate patients and families about these changes.”

Two key learning points that Student Physician Byrne will incorporate into his career as a physician are the power of touch and to how to truly listen to patients. He states: “I am confident that I will take these lessons with me throughout my career. I believe good medicine involves a fine-tuned listening ear and fine-tuned listening hands. I think it takes experiences like living in the Hospice Home to remind you of these essential medical skills.”

When asked for a key clinical pearl from the Hospice Home Immersion experience Taylor expressed that it was when the doctor told him to ‘tolerate the unknown...in order to be a good physician you need to accept that you don't always know the answer and you can't always predict what will happen next.’ Taylor knows now it is not a sign of weakness to say ‘I do not know.’ However, he learned the importance of working with an inter professional staff; different views provide broader options of care. Additionally, it is essential to stay engaged with the patient and family, listening and acknowledging them.

Student Physician Tobarran stated that the clinical pearl she will take with her during her medical career is to look for the magic in every day. She noted that people often lose perspective very quickly on what is important until it is lost. She learned this from the Hospice Home physician. Regardless of how many deaths occur in a day at the Home, the physician goes outside at least once to take in the magic of life.

Conclusion

First and second year medical students at the University of New England College of Osteopathic Medicine (UNECOM) have 28 hrs of scheduled geriatrics education with additional hours included in case-based learning sessions. For medical schools, this is a laudable amount of education in geriatrics. However, within this dedicated geriatrics curriculum only 60 minutes is allocated to end of life care and advance directives. The assumption was that medical students learned about

palliative and end of life care during their third and fourth year clerkships, but there is no measure or evaluation process in place.

The 48 Hour Hospice Home Immersion project is in the pilot stage with plans to expand the program so that all UNECOM medical students participate in this project. Students who conducted this immersion research reported that this unique educational and research experience accelerated their learning about palliative and end of life care. Although being immersed in the Hospice Home and experiencing death and dying first hand was at times overwhelming and intense, it allowed these students to become more comfortable with death [5]. Being present with older adults during decision making about treatment and care while in the Hospice Home, often times with decisions made by the older adults, provided the students with life altering experiences and lessons that will aid their journey to becoming compassionate and competent physicians. This time intensive immersion creates a depth of learning and advances medical education in death and dying beyond any classroom experience.

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