Palliative Care Training for the Generalist
A Luxury or A Necessity?

In their article, "Creating Enduring Change: Demonstrating the Long-Term Impact of a Faculty Development Program in Palliative Care," Sullivan et al.[1] demonstrate that their training program resulted in significant improvements in self-assessed competencies and behaviors relative to teaching and clinical care, which were sustained over 18 months of follow-up. A remarkable 90% of program participants reported launching palliative care initiatives. Following 1 week of on-site training in palliative care, attendees received 6 months of distance learning and support. The course was rounded out by a final week of on-site training. Attendees included physicians from various specialties and nurses. The authors are to be congratulated for the quality of their training program and its demonstrated educational impact. Still, one might ask, of what relevance is this to the General Internist? Here, I will highlight 2 issues—faculty development and associated education research, and the relationship of palliative care to general internal medicine.

The Harvard Program in Palliative Care Education and Practice (PCEP) stands as a model for faculty development, which educators in other fields would do well to study and emulate.[2] They attended to basics of curricular design and pedagogy by grounding their course in adult learner theory. They dealt with the ubiquitous challenge of limited time availability for faculty development on the part of busy clinician-trainees by sandwiching distance learning between on-site training. Small group sessions and distance learning were skillfully used in a complementary manner. Trainees were encouraged to expand beyond personal development to address problems of organizational change and systems-based practice.

The research methodology used to study this intervention, while limited to self-report, also stands as a model for education researchers. They use a retrospective pre-post design in which learners were queried at the end of the intervention regarding both pre- and postintervention knowledge, attitudes, and behaviors.[3] Such an approach is particularly advantageous when learners "do not know what they do not know," thereby underestimating their deficits preintervention. Standard pre-post approaches in such situations may result in paradoxical decreases in self-assessed competencies before and after, as learners come to realize how little they really knew at the outset and how much in fact remains to be learned. While self-report of educational efficacy can be problematic in terms of validity, the attention paid in this study to behavioral change (how much something was taught or done pre-post) would seem to increase the chance of accuracy. Measured changes in behavior, even via self-report, are ultimately better markers of educational impact than are self-assessed measures of confidence or competence. Finally, the study is remarkable in its attention to the sustainability of the educational impact over time, something too often neglected in education studies.

The article raises broader questions regarding the relationship between General Internal Medicine and palliative care. Is such training a necessity or a luxury for generalists? Numerous studies have documented inadequacies in physician training in palliative care.[3] While addressing such deficiencies is important for all physicians, it is especially important for physicians who pride themselves on caring for the whole patient and for those who care for the chronically ill. These attributes largely define the generalist. If one scans the content areas taught in the PCEP course—teaching fundamentals, management of pain and other symptoms, communication skills, cross-cultural issues, program development, organizational change, and self-care—how many of us can honestly say we were adequately taught these topics in medical school or during residency? And yet, could one seriously argue that these are not core competencies for the generalist? While new skills can be acquired in these areas postresidency through experience, available evidence suggests that more senior physicians tend to overestimate their competence, relative to measured knowledge and skills—at least in terms of palliative care.[4] Evidence suggests the experiential learning curve tends to flatten out over time. Thus, relying solely on experiential learning, simply "learning by doing," appears to be inadequate; most of us will require some remedial training in palliative care, if we wish to achieve a reasonable level of competence appropriate to our roles as generalists. Training such as that offered through the PCEP course is not a luxury, but has become a necessity, given both the historical neglect of training in this area and the growing importance of chronic illness management.

The American College of Graduate Medical Education has just approved an accreditation process for palliative medicine fellowships and the American Board of Medical Specialties is likely to approve palliative medicine as a formal subspecialty later this year. What implications does this hold for generalists interested in palliative care? Clearly, significant overlaps in skill sets and interests exist between the disciplines. Broadly speaking, management of chronic illness is largely "palliative" to the extent that it is not curative and focuses on helping patients to live with their illnesses. Leaders in Palliative Medicine, working to establish subspecialty status for the field, are acutely aware that most palliative care will and should be provided by nonspecialists. Why then, a subspecialty at all? Certainly, a subset of patients will benefit from care and consultation from physicians, who have chosen to acquire advanced-practice knowledge and skills at a subspecialist level. Equally or more important is the creation of a cadre of leaders, who will develop formal systems of palliative care, such as palliative care consultation teams, who will engage in palliative care research, and who will function as educators of other clinicians. Thus, somewhat paradoxically, 1 important goal of Palliative Medicine as a subspecialty is to disseminate palliative care throughout everyday practice.

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The birth of this new subspecialty is to be celebrated. However, certain challenges are obvious. Where extensive overlap exists among disciplines both collaboration and competition are possible. Some generalists, particularly hospitalists, who are increasingly performing palliative care consultations, may feel threatened by subspecialty status. Eventually, it seems likely that only physicians board eligible/certified in palliative medicine will be credentialed to perform such consults, to the extent this work is recognized as requiring advanced-practice skills at the subspecialist level. Generalists devoting a significant portion of their work to palliative care may wish to consider studying for board certification in Palliative Medicine and becoming subspecialists. It is anticipated that a grandfathering period of approximately 5 years will be allowed, following formal approval of subspecialty status, wherein physicians may sit for board certification without formal fellowship training.[5] Hopefully, in this evolving process a collegial and respectful relationship between generalists and palliative medicine specialists will be fostered. Subspecialty status for Palliative Medicine means that the field has come of age and represents a distinct body of knowledge and skills which require advanced-practice training. This should be respected. In turn, palliative medicine specialists need to respect the fact that the provision of palliative care is intrinsic to the role of the generalist and, as such should be encouraged and supported. More training of and partnering with General Internists, as admirably modeled in the PCEP program, would go a long way toward enhancing such mutual respect and improving the overall quality of care.—**James Hallenbeck, MD,** *Stanford University, VA Palo Alto HCS, Palo Alto, CA.*

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