Journal of Palliative Care & Medicine
ISSN: 2165-7386

MacLeod, J Palliative Care Med 2013, 3:1
DOI: 10.4172/2165-7386.1000e124

Editorial Open Access

Learning and Teaching Palliative Care: Can We Do Better?

Roderick D MacLeod*

HammondCare, Greenwich and Royal North Shore Hospitals, University of Sydney, Sydney, Australia

Palliative care and medicine are relative newcomers to the field of population health. With any new discipline comes an expectation that its practitioners are able to convey to those who don't know, what it is that is special or different about that discipline. Can we be sure that we are giving enough attention to learning and teaching of palliative care and medicine? Twenty years ago, James and MacLeod identified a number of aspects of palliative care education that were problematic [1]. There are a number of those elements that remain potentially problematic today, particularly with regard to the way in which they are addressed in teaching. They include the lack of a long tradition and adequate conceptualisation of palliative care; the significance of psychological, emotional and spiritual aspects of care; the importance of, but at times, inadequate understanding of symptom management; the multi- and inter-professional nature of palliative care; the range of different settings of palliative care and the fact that palliative caregivers work in situations where the emotional, psychological and spiritual demands on them may be immense. Over the last two decades there have been huge advances in all aspects of palliative care but there remain challenges for the way in which it is taught.

What is Education?

It is often wrongly assumed that there is a general understanding of what education is. Education is an activity in its own right – worth pursuing for its own sake. Jerome S Bruner, in his book "The culture of education" wrote:

"Education is not simply a technical business of well managed information processing, not even simply a matter of applying "learning theories" to the classroom or using the results of subject centered "achievement testing". It is a complex pursuit of fitting a culture to the needs of its members and its members, in their ways of knowing, to the needs of the culture" [2].

Wenger [3], in outlining his view of a social theory of learning, argued that because learning transforms who we are and what we can do, it is an experience in the development of our identity. In order that we can optimise the experience for both ourselves as teachers and as learners, we need to be mindful of what he terms the community of practice. That is, the way of clarifying the social arrangements in which what we do is seen as worth pursuing and our involvement in that activity is recognizable as a form of competent practice. In that social theory of learning other components are:

1. Meaning – a way of talking about our abilities and our experiences that can be shared.
2. Practice – a way of talking about our shared histories and social frameworks that can mean that we understand each other.
3. Identity – a way of talking about how learning changes who we are.

Is it possible for us all to explain for example why we do the things we do? How did we learn those things and is it possible for others joining our community of practice to easily learn how we do those things?

Janssen et al. [4] address how we might teach medical students the art of caring for the person rather than simply treating the disease - a question particularly relevant to end-of-life care. They examine how we learn to care and cultivate caring human relationships. But is this enough? They propose a model for medical education based on patient contact, reflection, self-care, role model development, and feedback that will see students learn the art of human care as well as the science of disease management.

Teaching and Learning

Teaching and learning of palliative care should be core components of the day to day practice of palliative care. Teaching implies that we engage the learners in a number of ways [3] and that those learners should be oriented, understanding the context of learning about palliative care. It implies reflection, learners looking at themselves and their situation with new eyes. Finally it involves exploration, not accepting things as they are but experimenting and exploring possibilities for the development of the self.

Every clinical encounter is a potential teaching opportunity – one-to-one teaching is a powerful way of teaching students. Every clinician could take the opportunity to use these encounters to provide the chance to learn something new. And these are powerful opportunities. For example, a cohort study of 179 Dutch medical students (79% of the cohort) undertaking an internal medicine clerkship located at 14 different clinical sites found that the quality of supervision had a greater impact on clinical competence and knowledge than the number of patients seen [5].

Improving Teaching

Although we don't know exactly how much time is required to create a powerful learning environment, teaching is clearly being increasingly squeezed out of most patient care settings. It is up to us, the practitioners to ensure that our places of work become those learning environments. Creating a structure to build in and pay for teaching time will become increasingly important. Whilst research excellence has been rewarded for decades this is not so for teaching excellence; this must change. It is imperative that we, as a community, find ways of rewarding faculty teaching efforts and creating academies of medical educators to reward and support notable teachers.

There are numerous examples of guides for how teaching might be improved – one such is the Teaching Round series in the British Medical Journal first published in 2008 (www.bmj.com/bmj-series/teaching-rounds). A revised and update version of the successful British Medical Journal series ABC of learning and teaching in medicine is also invaluable [6]. Specific to the field of palliative care and medicine is Wee and Hughes' fine book, Education in palliative care - building a culture of learning [7].

***Corresponding author:** Roderick D MacLeod, Greenwich Hospital, 97-115 River Road, Greenwich, NSW 2065, Australia, E-mail: rmacleod@hammond.com.au

Received January 02, 2013; **Accepted** January 05, 2013; **Published** January 07, 2013

Citation: MacLeod RD (2013) Learning and Teaching Palliative Care: Can We Do Better? J Palliative Care Med 3:e124. doi:10.4172/2165-7386.1000e124

A quote attributed to Aristotle is that "teaching is the highest form of understanding" that is, the ultimate test of understanding rests on one's ability to transform one's knowledge into teaching. By increasing our own understanding of the process of education and the development of ourselves as teachers and as clinicians, we should be able to maximise the opportunities that present themselves to us to be influential in improving the care for people dying in our care.

References

1. James CR, MacLeod RD (1993) The problematic nature of education in palliative care. J Palliat Care 9: 5-10.
2. Bruner JS (1996) The Culture of Education, Cambridge, MA: Harvard University Press.
3. Wenger E (1999) Communities of practice; learning meaning and identity Cambridge: Cambridge University Press.
4. Janssen AL, Walker ST, MacLeod RD (2008) Recognition, Reflection, and Role models: Critical elements in education about care in medicine. Palliat Support Care 6: 389-395.
5. Wimmers PF, Schmidt HG, Splinter TA (2006) Influence of clerkship experiences on clinical competence. Med Educ 40: 450-458.
6. Cantillon P, Wood D (2010) ABC of Learning and Teaching in Medicine. (2ndedn), London: BMJ Books.
7. Wee B, Hughes N (2007) Education in palliative care - building a culture of learning. Oxford University Press, Oxford.