Providing quality allied health placements in palliative care

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Abstract

Introduction: Palliative care is a complex area for student placements due to the high level of grief and loss encountered. There is limited research into allied health student experiences in palliative care. The aim of this study was to investigate the attitudes, behaviours, perceptions and personal challenges faced by allied health students in palliative care. We sought to explore student preparation for a palliative care clinical placement and the impact of the placement on their self-efficacy in the areas of communication, patient management and interdisciplinary teamwork.

Methods: Eleven consecutive eligible allied health students undertaking a placement in palliative care were recruited to participate in this study. Each participant took part in a semi-structured interview at the beginning and end of their placement. Interviews were transcribed and analysed qualitatively. Questionnaires were also given to participant's pre and post placement to identify the impact of self-efficacy and outcome expectancies on learning outcomes.

Results: The analysis of the results demonstrated that most, but not all, of participants experienced anxiety prior to placement. Participants' perception and understanding of palliative care was positively influenced by their placement, and there were a wide variety of learning experiences described.

Conclusions: Allied health student placements in palliative care provide a positive environment for student learning and can be altered to maximise the learning experience. With careful planning, and by encouraging a culture of support, effective approaches and strategies can be identified to make a placement in palliative care more appealing and appropriate for individual students.

Keywords: allied health student; education; attitude; palliative care.

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Introduction

There is an increasing tendency for people to die at an older age as a result of a chronic illness, rather than acute, and in a hospital or institutional setting (Gomes & Higginson, 2008). With this trend comes the need for a workforce skilled in providing palliative care, which is defined by the World Health Organisation (2016) as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual" (para. 1). Allied health professionals are an important part of the interdisciplinary, holistic and compassionate healthcare team providing this care. Amongst other things, their management aims relate to patient empowerment and self-determination, the maintenance of functional ability and independence, and the provision of evidence-based interventions for symptom relief (Frost, 2001; Goodhead, 2011; Kwon, Kolomer, & Alper, 2014). Training new allied health professionals and students is an integral part of maintaining the capacity to provide a specialised service.

To assist in the development of the palliative approach to care as a core skill, material relating to palliative care should be included in all allied health entry-level programmes. However, few allied health courses in Australia are including palliative care concepts to any major degree, with little standardisation in the content or the teaching methods, possibly reflecting the earlier stage of development of the allied health role in palliative care when compared to their medical and nursing colleagues (Hegarty et al., 2010). Including specific palliative care material in physiotherapy training programs has been shown to increase knowledge, attitudes, beliefs and experiences (Kumar, Jim, & Sisodia, 2011) as well as self-rated confidence (Chiarelli, Johnston, & Osmotherly, 2014), but the latter study also showed that some of the underlying attitudes and emotional responses were less easily influenced by this form of training. Challenging misconceptions surrounding palliative care is seen as a key part of medical students' training (Arolker et al., 2010; Gibbins, McCoubrie, Maher, & Forbes, 2010), and this should be of equal importance for allied health students preparing to work alongside them in the palliative care setting. Also, for medical and nursing students, palliative care training was shown to improve student preparedness to work in the field and enhanced self-efficacy in palliative care (Mason & Ellershaw, 2010).

Clinical placements sit alongside curriculum as a means of consolidating learning, helping students to develop the skills needed in talking with patients and their families about life-limiting illness (Barclay et al., 2014). However, palliative care is an especially difficult area for students to undertake a placement in due to the high level of grief and loss encountered, as well as the complexity of symptom management and skilled communication required of therapists. A supportive clinical environment is an essential part of ensuring a positive learning experience on placement (Chan, 2003), and the importance of support, supervision and integrating theory with practice for effective practice learning is also clear (Parker, 2007). Furthermore, there is a strong link between strength of self-efficacy, one's belief in one's ability to succeed in specific situations or accomplish a task (Ormrod, 2006) and clinical practice (Mason & Ellershaw, 2010).

Interventions that were identified to improve student experiences in palliative care included input on emotional aspects of care and sharing of personal feelings (Cooper & Barnett, 2005). There is evidence that the confidence and skills of health professionals can improve with experiential learning and strategies that facilitate reflection on these experiences, and that self-directed learning strategies, positive learning environments and feelings of acceptance and belonging contribute to a successful placement in palliative care (Cairns & Yates, 2003).

With this in mind, the aims of this study were to investigate the attitudes, behaviours, perceptions and personal challenges faced by allied health students in palliative care, and to explore how to best prepare students for a palliative care clinical placement, so as to improve and develop their learning experience.

Methods

Sampling

Consecutive eligible allied health students were invited to participate while attending a clinical placement in palliative care at Prairiewood in New South Wales, Australia, between 2011 and 2013. Participants were from the disciplines of social work, occupational therapy and physiotherapy. To be included in the study, the placement had to continue for at least 4 weeks, with a minimum of 3 days a week attendance. All participants were volunteers and provided written, informed consent.

The determination of an appropriate sample size in qualitative research is a key component of the legitimacy of analysis and conclusions drawn (Merriam, 2009). Content was assessed after each interview, with consideration of newly emerging themes (Carlsen & Glenton, 2011). The sample ceased once it was determined no new information was being revealed from the interviews, i.e., at the saturation threshold (Fossey, Harvey, McDermott, & Davidson, 2002).

Interviews

Two sets of semi-structured, face-to-face interviews (Figure 1) were conducted with the participants, at the start and the end of their placement, by MB, who was independent of the participants' supervision process. The goals of the interviews were to explore participants' perceptions and attitudes in relation to undertaking a placement in palliative care, the impact of self-efficacy on placement experience in palliative care and opportunities for improving the placement experience.

All interviews were digitally recorded and transcribed verbatim. As recommended by Miles, Huberman and Saldana (2013), transcripts were reviewed against audio recordings to maximise integrity and trustworthiness of data. Initial analysis of qualitative data, undertaken independently by two investigators, included the eliciting of preliminary themes and data reduction and display to organise subject matter into preliminary categories (Sandelowski, 2010). QSR's NVivo qualitative analysis software (QSR International, 2010) was utilised to electronically manage data. During subsequent analysis, categories were merged into larger groups, culminating in the finalisation of major and sub groups, and the drawing and verification of conclusions (Mayring, 2000; Miles et al., 2013).

Pre-placement interview
1.   What is your understanding of palliative care?
2.   Do you have any anxieties or concerns about your placement?
3.   Have you referred to any resources in order to help you prepare for this placement?
4.   Have you received any support from your field work coordinator to help you prepare for this placement?
5.   Has your supervisor provided you with some resources to help you prepare for your placement?

Post-placement interview
1.   Did this placement improve or change your understanding of palliative care? If so, how?
2.   Did you utilise any strategies to manage your anxieties during this placement?
3.   Did you refer to any resources or participate in any activities that assisted in building your confidence to work in this setting?
4.   Have you learnt anything from your time in palliative care?
5.   Is there anything you think we should change before or during your placement to improve the learning experience for future students in palliative care?

Figure 1. Semi-structured interview guide.

Scales

At the beginning and end of their placement, participants were asked to complete the Self-Efficacy in Palliative Care Scale (SEPC), assessing efficacy in communication, patient management and multi-professional teamwork (Barrington & Murrie, 1999). They also completed the Thanatophobia Scale, assessing attitudes towards palliative care (Merrill, Lorimor, Thornby, & Woods, 1998). These scales have been validated for use within a medical student population by Mason & Ellershaw (2004) and were deemed suitable for the purpose of this study in the absence of validated scales for allied health students. Minor adjustments were made to reflect the disciplines in question, and a question in the SEPC was excluded as it related specifically to medical management.

Ethics approval to undertake the study was obtained from St Vincent's Hospital Human Research Ethics Committee (File number 11/080).

Results

Eleven allied health students were invited to participate, and all consented to participation in the study. Five social work, four occupational therapy and two physiotherapy students participated. All students were in the third or final year of their degree and were supervised by a discipline-specific therapist for the duration of their placement. There was a mix of voluntary and involuntary placements, i.e., some students self-selected to attend the placement while others were allocated to attend by their tertiary institution. Placement length varied from 5–16 weeks, with a mean length of 7.5 weeks.

SEPC and Thanatophobia Scale

The results of the SEPC and the Thanatophobia Scale are presented in Tables 1 and 2, respectively, and despite the small sample size, many of the results were of statistical

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Table 1
Results From the Self-Efficacy in Palliative Care Scale

Communication	Pre-placement: mean (range)	Post-placement: mean (range)	*P*-value
1. Discussing effects of cancer with patient	2.1 (1–3)	3.7 (3–4)	< 0.05
2. Discussing effects of cancer with family	2.2 (1–3)	3.7 (3–4)	< 0.05
3. Discussing issues of death and dying	2.2 (1–4)	3.7 (3–4)	< 0.05
4. Discussing patient's own death with patient	2.0 (1–4)	3.5 (2–4)	< 0.05
5. Discussing patient's death to occur with the family	2.1 (1–4)	3.4 (3–4)	< 0.05
6. Discussing patient's death with family or bereavement	2.4 (2–4)	3.4 (3–4)	< 0.05
7. Answering patient's question: How long do I have to live?	2.3 (1–4)	3.1 (2–4)	< 0.05
8. Answering patient's question: Will there be much suffering or pain?	2.1 (1–3)	3.3 (2–5)	< 0.05
Patient management			
1. Your ability to assess patient needs	3.0 (1–4)	3.8 (2–4)	< 0.05
2. Knowledge of aetiology/palliative symptoms	2.5 (2–4)	3.5 (3–4)	< 0.05
3. Ability to manage palliative symptoms	2.6 (2–4)	3.6 (2–4)	< 0.05
4. Ability to prescribe pain control	N/A	N/A	
5. Knowledge of analgesic agents	1.9 (1–2)	2.6 (1–4)	0.11
6. Ability to provide psychological care	2.8 (2–4)	3.0 (2–4)	0.17
7. Ability to provide social care	3.0 (2–4)	3.5 (3–4)	< 0.05
8. Ability to provide spiritual care	2.8 (2–3)	2.9 (2–4)	0.35
Multidisciplinary teamwork			
1. Working in a multi-professional team	3.5 (2–4)	4.2 (3–5)	< 0.05
2. Referring palliative care patients for physiotherapy	3.1 (2–4)	4.0 (2–5)	< 0.05
3. Referring palliative care patients for occupational therapy	3.1 (2–4)	4.0 (2–5)	< 0.05
4. Referring palliative care patients for complementary therapies	2.9 (2–4)	3.8 (2–5)	< 0.05
5. Referring palliative care patients for lymphoedema service	2.6 (2–3)	3.3 (2–5)	< 0.05
6. Referring palliative care patients for psychiatric evaluation	2.8 (2–4)	3.0 (2–4)	0.17
7. Referring palliative care patients to a spiritual advisor	2.8 (2–4)	3.4 (2–4)	< 0.05

Likert scale: 1 = very anxious, 2 = anxious, 3 = neutral, 4 = confident, 5 = very confident

Table 2
Results From the Thanatophobia Scale

	Pre-placement: mean (range)	Post-placement: mean (range)	*P*-value
1. Dying patients make me feel uneasy	4.1 (2–6)	2.4 (1–6)	< 0.05
2. I feel pretty helpless when I have a terminal patient on my ward	3.6 (2–5)	2.4 (1–6)	< 0.05
3. It is frustrating to have to continue talking with relatives of patients who are not going to get better	2.2 (1–4)	1.9 (1–7)	0.31
4. Managing dying patients traumatises me	3.2 (1–6)	2.5 (1–7)	0.07
5. It makes me uncomfortable when a dying patient wants to say goodbye	3.5 (1–7)	3.3 (1–6)	< 0.05
6. I don't look forward to being the SW/OT/PT of a dying patient	3.0 (1–4)	3.3 (1–7)	0.17
7. When a patient begins to discuss death, I feel uncomfortable	3.5 (1–7)	3.1 (1–7)	< 0.05

Likert scale: 1 = strongly disagree to 7 = strongly agree

significance. The results show that participants experienced the greatest anxiety in relation to communication issues pre-placement. However, results across both scales demonstrated significant increases in confidence and understanding in the areas of communication, patient management and interdisciplinary teamwork.

Pre-placement interview

Participant responses to the pre- and post-placement interview varied greatly in regards to the participants' understanding and expectations of a placement in palliative care. The key points have been categorised under separate headings, with participant quotes that captured the essence of themes also included.

Understanding of palliative care

Before their placement, participants displayed varying degrees of understanding regarding the nature of palliative care. Some saw it as limited to end-of-life care, while others discussed the care of patients with an incurable condition or life-limiting illness. Some participants reflected on their limited knowledge and understanding of the specialty and the generally negative perception of it amongst students:

> When we did talk about it at the university … not many people were interested. I think it's because it's depressing and not what (students) want to do, as they are looking to do something for the progression and improvement of things. It was very much that sentiment. (SW1)

After their placement, participants consistently spoke of an improved understanding of the philosophy of palliative care:

> It seems to me after a couple of months that it is not about dying but living, … and that people's goals go beyond just getting home to die. I think that is the biggest change in my understanding. (PT1)

They increasingly recognised its scope outside of the last days of a patient's life. They also discussed a more positive opinion of palliative care, and appreciation of the specialty and what it had to offer:

> A lot of people have a preconception that everything is sad and dreary and that palliative care is not a great environment to work in. But it is really different; the patients are much more open and willing to share and talk. … It is not sad and not that scary. (OT2)

Participants also reported an increased understanding of the role of their specific disciplines within palliative care, as well as that of the individual members that made up the interdisciplinary team.

Anxiety and the palliative care placement

Some participants spoke of the apprehension and anxiety of both themselves and their fellow students when the option of a placement in palliative care was raised at university. Issues of anxiety related to one's role in palliative care, being able to do the job properly and having to talk about death and know what to say. One of the participants spoke of her anxiety upon receiving the news that she had been allocated to a placement in palliative care:

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> *It was a bit of a shock … the first thing that jumped through my head was: I am going to see people die. I don't know how I will deal with that, what I am going to say to people and their families. How do I talk about death? What am I going to do when I see someone die?* (SW2)

However, in direct contrast to this, other participants said they had no anxiety about undertaking a placement in palliative care. When questioned further, these participants, generally, had personal experiences around death and had elected to undertake a palliative care placement rather than it being an involuntary option.

After the placement, participants who had identified anxiety as an issue prior to commencing listed a number of strategies used to manage these anxieties during their placement. These included speaking with their supervisor, support from other team members, mental preparatory talks, breathing exercises and a focus on supporting patients with their issues rather than on their illness. One participant spoke of her "transition" in learning how to deal with the grief of family members:

> *It wasn't easy to deal with at first, and supervision with my supervisor helped out at the beginning. I didn't know how to accurately respond to … grief and what to do when patients cry in front of you. That kind of stuff struck me in the beginning [but] I got more comfortable in dealing with that by the end.* (SW4)

Another participant spoke of the importance of supporting patients with their goals rather than focusing on their illness:

> *I can't stop people from grieving. The best I can do is to offer support, focus on their issues at the time and not feel helpless at not being able to make patients feel better. That was my strategy; just reminding myself I can't do anything for this person physically.* (SW3)

The placement as a learning experience

Participants referred to a variety of resources that assisted them in preparing for their placement. Resources included online research, journal articles, orientation packages, resources provided by their supervisor and their own personal experience. There was a variance across disciplines in regards to the amount and type of information available prior to placement commencement, with no real established patterns. One participant spoke of information and resource overload prior to and at the beginning of his placement, making it difficult to take everything in, while others stated that they didn't refer to any resources prior to commencing their placement.

Participants mentioned a variety of resources and activities that assisted in building their confidence while on placement in palliative care. Observation on the job, participating in case and family conferences, and reading journal articles and books were all offered as examples.

Overall, the participants identified that they enjoyed the placement, were actively engaged by the interdisciplinary team and had positive interactions with their supervisors. All expressed general satisfaction with the placement experience and only offered a few individual suggestions for improvements. Some suggested having more time before

taking on their own caseload, while others were satisfied with patient allocation in this regard. Again, some participants suggested a broader exposure to different settings within palliative care, while others felt they had a great experience in this area.

Discussion

A palliative care placement is challenging for students, both from a clinical and emotional perspective. It requires well-developed communication skills and, at times, may raise past unresolved issues and anxiety around dealing with death. In addition, attitudes and beliefs of students may be affected by the mindsets of the wider society, which discourages people from talking about death and palliative care. The learning and development of a student's clinical skills can be hindered by these issues (Mason & Ellershaw, 2004). The results of this study demonstrate that a clinical placement in a palliative care setting can have a positive effect on student attitudes in regards to care for the dying. Students undergo a process of transformational learning in that, over the course of their placement, they are challenged to change their previously held beliefs and assumptions regarding palliative care, and are able to reinterpret and give new meaning to their experience. They also develop confidence in communication, patient management and interdisciplinary teamwork in the palliative care setting. Change occurs as a result of participants rejecting their old beliefs and embracing their new learning and beliefs (MacLeod, Parkin, Pullon, & Robertson, 2003). Participants felt actively engaged and experienced positive interpersonal interactions within the palliative care setting, conditions shown to be conducive to optimal learning (Connell, Yates, & Burrell, 2011).

It is important that university and field educators work together to build confidence and self-efficacy in students undertaking a clinical placement in palliative care, to encourage positive self-regulation and performance (Bouffarda, Boucharda, Gouleta, Denoncourta, & Couturea, 2005). The results of this study point to a positive link between a clinical placement in palliative care and an increase in student self-efficacy in the delivery of palliative care services. As demonstrated by their improved understanding of what palliative care entailed, and more positive attitudes towards palliative care, students were seen to progress in this area over the course of their placement. Variance in suggested improvements possibly reflected the different learning needs and styles of individual students. This reinforces the need for supervisors to understand the students' learning needs and styles in order to tailor approaches to individual students accordingly, and the need to provide specific feedback.

It is important that field supervisors and universities are aware of the stress and anxiety students may feel when undertaking a placement in palliative care, and the factors that may contribute to variations in this area. When considering resilience and suitability for palliative care placements, our results suggest there may be a link between voluntary selection of a palliative care placement and less anxiety, and between involuntary selection and greater anxiety. The latter may be compounded for students who do not have a personal experience around death (Simons & Perk-Lee, 2009). It is important that tertiary institutions that send students to palliative care placements without self-selection provide targeted education sessions and resources encompassing self-care and related issues. Placement supervisors should also be aware of these processes, and of

the personal experiences of their students at the commencement of their placement to better tailor their orientation program to the individual.

Self-care is an important element for ensuring a successful placement. Students need to have an awareness of any personal triggers that bring on stress and anxiety, and to have thought through ways of dealing with stressful situations that may arise when dealing with patients and their families (Miller, Kovacs, Wright, Corcoran, & Rosenblum, 2005). These should be discussed with the placement supervisor on commencement. Supervisors need to be aware of each student's individual experiences and needs, and should model effective self-care and coping skills throughout the placement (Parker, 2006).

Study limitations

The study was conducted at a single site, which may limit the generalisability of its findings to other settings. Only social work, physiotherapy and occupational therapy students participated, which may affect translation of findings to other allied health disciplines. The study focused on understanding student perspectives. If it had also included the perspective of hospital and university staff, their insights may have allowed for triangulation of ideas to more thoroughly examine the topic. Considering the practicality of recruiting adequate numbers of allied health students, the sample size was set by the qualitative elements of the study, limiting the ability to statistically analyse the quantitative data.

Conclusions

As the population ages, it is important that the general health workforce has skills and confidence in caring for palliative care patients. Considering the importance of an interdisciplinary approach to end-of-life care, the limited exposure of allied health professionals to palliative care in their undergraduate training is an area that requires attention (Hegarty et al., 2010; Palliative Care Australia, 2010). Along with a more structured delivery of palliative care training through tertiary institutions, these results show that a palliative care placement has the potential to address this deficit. It also provides some insight into ways of making the learning environment in the palliative care setting more attractive, appropriate and accommodating for allied health students.

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