Non-Physician Hospice and Palliative Staff:
How Do They Describe Their Role in Medical Education?

BY

AMY MARGARET WESTCOTT
MD, American University of the Caribbean, 2003
BS, University of Richmond, 1998

THESIS
Submitted as partial fulfillment of the requirements
for the degree of Master of Health Professions Education
in the Graduate College of the
University of Illinois at Chicago, 2017

Defense Committee:
Janet Riddle, MD, Chair and Advisor
Carol Kamin, MS EdD
Daniel Wolpaw, MD, Penn State College of Medicine
This thesis is dedicated to my son, Patrick David, who motivates me.
ACKNOWLEDGMENTS

I would like to thank my thesis committee – Janet Riddle, Carol Kamin, Daniel Wolpaw – for their unwavering support and assistance. They provided guidance in all areas that helped me accomplish my research goals and enjoy myself in the process. I would also like to acknowledge, Sarah Kagan, who oversaw the development of the proposal and made contributions important to the conduct of the study.

A number of individuals in the data collection site were extremely helpful to me during data collection, and I would like to thank them as well – at Penn State Hershey Medical Center – Michelle Farnan, Greg Larsh, Nancy Parson, David Simmons, Erica Smeltz; and at the Hospice of Central Pennsylvania – Susan Resavy. Others who were helpful were Woodward Center of Excellence in Health Sciences Education colleague – Jennifer Meka.

Finally, I would like to acknowledge the financial support for transcription of the interviews through the assistance of a Woodward Grant.
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>A. Purpose</td>
<td>1</td>
</tr>
<tr>
<td>B. Objectives</td>
<td>2</td>
</tr>
<tr>
<td>C. Background and significance: conceptual frameworks</td>
<td>2</td>
</tr>
<tr>
<td>1. Interprofessional Education</td>
<td>2</td>
</tr>
<tr>
<td>2. Interprofessionality and Interprofessional Learning</td>
<td>3</td>
</tr>
<tr>
<td>3. Teaching/Role-modeling</td>
<td>4</td>
</tr>
<tr>
<td>II. METHODS</td>
<td>6</td>
</tr>
<tr>
<td>A. Context</td>
<td>6</td>
</tr>
<tr>
<td>1. Clinical-educational experience</td>
<td>6</td>
</tr>
<tr>
<td>2. Role of investigator</td>
<td>7</td>
</tr>
<tr>
<td>B. Educational rotations/experiences</td>
<td>7</td>
</tr>
<tr>
<td>C. Participant recruitment</td>
<td>7</td>
</tr>
<tr>
<td>D. Study approach</td>
<td>8</td>
</tr>
<tr>
<td>1. Design</td>
<td>8</td>
</tr>
<tr>
<td>2. Interview guide</td>
<td>8</td>
</tr>
<tr>
<td>3. Procedure</td>
<td>9</td>
</tr>
<tr>
<td>4. Analysis</td>
<td>9</td>
</tr>
<tr>
<td>III. RESULTS</td>
<td>11</td>
</tr>
<tr>
<td>A. Demographics</td>
<td>11</td>
</tr>
<tr>
<td>B. Major themes</td>
<td>11</td>
</tr>
<tr>
<td>1. Finding a Teaching Role as an “Informal Teacher”</td>
<td>11</td>
</tr>
<tr>
<td>2. Using Professional Identity as a Foundation for Teaching</td>
<td>13</td>
</tr>
<tr>
<td>3. Teaching Through Experiential Learning, Debriefing, and Role-Modeling</td>
<td>14</td>
</tr>
<tr>
<td>4. Teaching to Perceived Gaps in Physician Training</td>
<td>15</td>
</tr>
<tr>
<td>5. Understanding the Learning Needs for Physician-in-Training</td>
<td>16</td>
</tr>
<tr>
<td>IV. DISCUSSION</td>
<td>18</td>
</tr>
<tr>
<td>A. Informal/workplace learning</td>
<td>18</td>
</tr>
<tr>
<td>1. Participation in group activities</td>
<td>19</td>
</tr>
<tr>
<td>2. Working alongside others</td>
<td>19</td>
</tr>
<tr>
<td>3. Tackling challenging tasks</td>
<td>19</td>
</tr>
<tr>
<td>4. Working with clients</td>
<td>20</td>
</tr>
<tr>
<td>B. Limitations</td>
<td>21</td>
</tr>
<tr>
<td>V. CONCLUSION</td>
<td>22</td>
</tr>
<tr>
<td>VI. CITED LITERATURE</td>
<td>23</td>
</tr>
<tr>
<td>VII. VITA</td>
<td>25</td>
</tr>
</tbody>
</table>
SUMMARY

Purpose

Hospice and palliative teams are typically composed of chaplains, nurses, physicians, social workers, and others who provide interdisciplinary holistic care. These non-physician staff may teach and role-model aspects of patient care. This study explored how non-physician hospice and palliative staff describe their role in teaching physicians-in-training.

Methods

Semi-structured interviews were conducted of non-physician hospice and palliative staff. All interviews were audio recorded and transcribed verbatim. Initial open coding by two researchers (AW, JR) identified the codes and then the constant comparative method was used to find patterns by axial coding, categories and themes within the data. Coding discrepancies were resolved through discussion. Member-checking was conducted by asking all participants to review the final list of themes.

Results

Six hospice and palliative medicine staff members participated in interviews. Participants included chaplains, nurses, a social worker, and a physician assistant. All of the participants have practiced their discipline for many years (14-35), yet were newer to the field of hospital and palliative medicine. Four of the participants are women. Five major themes were identified during content analysis: (1) finding a teaching role as an “informal” teacher, (2) using professional identity as a foundation for teaching, (3) teaching through experiential learning, debriefing, and role-modeling, (4) teaching to perceived gaps in physician training, (5) understanding the learning needs of physicians-in-training.

Conclusion

The non-physician staff interacted with physicians-in-training guided by their disciplinary skills and perspectives on patient care. Although they did not feel that they have formal teaching roles, they direct their teaching towards perceived gaps in physician training using reflection, dialogue and role modeling through. The rich learning environment provides for good informal learning through interprofessionality. Based on these results, we would argue that these non-physician staff should be considered teachers albeit informal and as such be targets of professional development. Future studies could explore the educational roles and perspectives of non-physician professionals in other specialties and across diverse academic institutions.
I. INTRODUCTION

A. Purpose

Medical education and training has traditionally focused on using the Biomedical Model to heal body and mind. Over the last 20 years we have witnessed an increasing focus on a broader view of wellness and disease, including the importance of a “good death”. Medical educators, in recent reviews, have highlighted the importance of effectively preparing physicians-in-training (medical students, resident physicians, and subspecialty fellows) to provide end-of-life care (Case, Orrange, & Weissman, 2013; Horowitz, Gramling, & Quill, 2014; Schaefer et al., 2014; Shaw et al., 2010).

In parallel with this paradigm shift to a more holistic perspective of the role of physicians at the end of life, we are also seeing the rapid evolutions of collaboration and interdisciplinary teams as important vehicles for healthcare delivery in diverse clinical microsystems (Lucey, 2013). Based on a literature review of hospice and palliative medicine education, physicians-in-training often work with non-physician preceptors during hospice and palliative medicine experiences (Carmody, Meier, Billings, Weissman, & Arnold, 2005; Case et al., 2013; Schaefer et al., 2014; Shaw et al., 2010). Hospice and palliative teams are typically composed of chaplains, nurses, physicians, social workers, and others who work together to provide patient-and family-centered care. These non-physician staff may teach and role-model aspects of patient care that are not typically taught in medical school or residency, such as communicating with patients/families facing life-limiting illness as well as collaborating with other members of the healthcare team. This study explored how non-physician hospice and palliative staff describe their role in teaching physicians-in-training.
B. Objectives

The specific aims of this study were to:

1) Explore the extent to which non-physician hospice and palliative medicine staff perceive they have a responsibility to teach physicians-in-training;
2) Explore the qualities and teaching skills non-physician hospice and palliative medicine staff feel are important for effectively teaching physicians-in-training about hospice and palliative medicine;
3) Explore non-physician hospice and palliative medicine staff perceptions of barriers or enablers to teaching physicians-in-training;
4) Describe the training and support non-physician hospice and palliative medicine staff would find helpful in teaching physicians-in-training.

C. Background and significance: conceptual frameworks

1. Interprofessional Education

Interprofessional education (IPE), defined as “two or more professions learn[ing] with, from, and about each other to improve collaboration and the quality of care”, is widely discussed in healthcare and health professions education (Cuff et al., 2014). The Association of American Medical Colleges (AAMC) co-sponsored an expert report by the Interprofessional Education Collaborative in which professional organizations that support the training of physicians, nurses, pharmacists, dentists, and social workers, developed core competencies for Interprofessional Collaborative Practice (Schmitt, Blue, Aschenbrener, & Viggiano, 2011). The competency domains included in this report are: (1) values/ethics for interprofessional practice, (2)
roles/responsibilities, (3) interprofessional communication, and (4) teams and teamwork (Cuff et al., 2014). The main goal of formulating these core competencies was to encourage the development of curricula and educational experiences that will allow health professions students to learn how to work together to provide high quality healthcare. Unfortunately, evidence supporting the impact of IPE on patient/family-centered outcomes (i.e. satisfaction, length of stay) is limited (Hammick, Freeth, Koppel, Reeves, & Barr, 2007; Reeves, Tassone, Parker, Wagner, & Simmons, 2012; Zwarenstein, Goldman, & Reeves, 2009).

2. Interprofessionality and Interprofessional Learning

Hospice and palliative teams are prototypical interprofessional teams in that they are commonly composed of bereavement staff, chaplains, nurse’s aides, nurses, social workers, pharmacists, physicians, and volunteers. The typical hospice and/or palliative care experiences for physicians-in-training are not technically IPE because the ‘student’ learner is paired with a working health professional. During these rotations, physicians-in-training learn through observation of and experience with interprofessional teams in workplace settings. These educational experiences are more accurately characterized as emphasizing ‘interprofessionality’. Interprofessionality is the “…process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population” (D'Amour & Oandasan, 2005). Interprofessionality arises from patterns of communication and practice within interdisciplinary teams. Interdisciplinary team meetings allow physicians-in-training to explicitly learn the team approach to caring for patients and families requiring hospice and palliative care. Other curricular experiences, such as reflective writing exercises, allow learners to reflect on practice with other professionals. But learning in
these settings would also be more opportunistic and unstructured (Eraut, 2004). This study proposed to explore the teaching and role-modeling skills used by non-physician hospice and palliative staff that results in interprofessional informal learning.

3. Teaching/Role-modeling

In my review of the literature on instructional methods for hospice and palliative care teaching, there were no papers that described the teaching skills used by non-physician staff. Recent literature on the attributes and behaviors of effective physician teachers has contributed to the design of the proposed study. This literature highlights the importance of non-cognitive characteristics and behaviors. Sutkin and colleagues (Sutkin, Wagner, Harris, & Schiffer, 2008) in their review and analysis of the literature identified both cognitive and non-cognitive characteristics that define the good teacher. Examples of cognitive characteristics include content knowledge and communication skills. Non-cognitive characteristics include being supportive and inspiring, and demonstrating enthusiasm. Similarly, Fromme and colleagues (Fromme et al., 2010) identified skills, such as clinical teaching and patient care, as well as personal qualities and role-modeling that are thought to be linked to being a successful pediatric hospitalist educator. Based upon a review of the literature and expert consensus, Hatem and colleagues (Hatem et al., 2011) developed a list of attitudes and attributes, knowledge, and skills of competent medical teachers. As with the other studies, Hatem and his collaborators found that promoting a positive learning climate and role-modeling contributed to being an effective teacher. It is unclear how this literature translates to the non-physician experience as a teacher. Given the different educational backgrounds, experiences and cultural context of the non-physician teachers from different disciplines, this study explored the extent to which non-
physician teachers’ perspectives on being an effective clinical teacher are similar to or different from physician teachers’ perspectives.

Social-cognitive theory has been used by other investigators to explore physicians’ experiences and perceptions of their educational role in precepting physicians-in-training (Mann et al., 2001). Physicians-in-training join a hospice and palliative care community of practice or micro-community – and learn through legitimate peripheral participation (Lucey, 2013). From that perspective, the learners are learning about the clinical content (i.e. how to care for patients) but they are also learning about other disciplines and the contributions those other healthcare disciplines make to patient care. Because of the social nature of learning in this setting and the interprofessional informal learning that occurs, the conceptual framework of social cognitive learning, specifically vicarious learning (Bandura, 1986), works well to elucidate hospice and palliative care preceptors’ role as teachers of physicians-in-training. Physicians-in-training are the observational/experiential learners who learn from observations and interactions with hospice and palliative staff. We also assume that the physicians-in-training are influenced vicariously by the healthcare interdisciplinary team-based approach, the holistic patient care environment, and the interactions between hospice and palliative staff and patients. In addition, during this experience, physicians-in-training learn about the roles of other healthcare professionals comprising the hospice team (chaplains, nurses, nurses’ aides, social workers, etc.).

In summary, to provide patient and family-centered care within our current healthcare system, we need to better understand the role of hospice and palliative medicine staff as teachers. The underpinning concept of interprofessional informal learning is an integral part of how educators should be thinking about how to train physicians in the care of patients with life-limiting illness.
II. METHODS

A. Context

1. Clinical-educational experience

The study setting included both the Penn State Palliative Care Team and the Hospice of Central Pennsylvania. The Penn State Palliative Care Team was composed of the following members: 1 administrative coordinator, 2 chaplains, 1 nurse coordinator, 1 nurse practitioner, 1 pharmacist, 4 physicians, and 1 physician assistant. This team covers an average daily census of approximately 25 inpatients served in an academic medical center hospital and approximately 50 outpatients served through the Cancer Institute. Patients were predominately seen for advanced cancer and symptom management issues; however, increasingly we were asked to assist with complex medical decision-making for both cancer and non-cancer care.

The Penn State Palliative Care Team works closely and collaborates on educational efforts with a local non-profit hospice, Hospice of Central Pennsylvania. This hospice has an average daily census of approximately 200 patients cared for at home or residential long-term care communities. The hospice also has a hospice residence which is licensed as a personal care home and has 6 beds. Patients enrolled in hospice have a prognosis of six months or less and care would be provided by an interprofessional team. There are three hospice teams based on geographic location and each includes a chaplain, nurse, social worker, physician, and other disciplines as needed.
2. **Role of the investigator**

I participated in all phases of the research including recruitment, interviewing the participants, transcribing the interviews, and data analysis. At the time of the investigation, I served as one of the attending physicians who would round for one week at a time on the inpatient consult team. Since the study started, I have also launched the Hospice and Palliative Medicine Fellowship and serve as the Program Director. My primary role is now supervising the half-day outpatient clinic experience of the fellow.

**B. Educational rotations/experiences**

Each week there is a third year Penn State College of Medicine medical student and 2 resident level physicians-in-training from various programs (Internal Medicine, Medicine-Pediatrics, Family and Community Medicine, Pain Fellows, Hematology/Oncology Fellows, etc.). These rotations are electives and each learner spends 2 weeks with the palliative care team. On this two-week rotation, physicians-in-training have daily interaction with the other members of the team during morning sign-out rounds and then sporadically throughout the day. Each week there is a different physician attending who supervises the various learners, triages all new consults, completes bedside rounds, and teaches. In addition, every Thursday there is an Interdisciplinary Team meeting that the entire team attends to discuss patient care.

**C. Participant recruitment**

Non-physician hospice and palliative medicine staff on the Penn State Palliative Care Team and Hospice of Central Pennsylvania were recruited via e-mail in fall 2014 to participate in face-to-face interviews. At this time there were approximately 10 non-physician palliative
medicine staff who had interactions with physicians-in-training regularly. All of the interviews took place within 2 months of the recruitment e-mail. A second email request was sent a few weeks after the first email. Each of the 6 volunteers participated in a verbal consenting process prior to the interview. There was no compensation for participation in the study. The Penn State Internal Review Board (IRB) and the University of Illinois-Chicago IRB approved the study.

D. Study approach

1. Design

We designed and conducted a qualitative study using semi-structured in-depth interviews to explore non-physician hospice and palliative medicine staff perceptions of their roles and their experiences teaching physicians-in-training.

2. Interview guide

The interview guide was developed by the authors (AW, JR, DW) based on review of the literature and their experiences as health professions educators. Initially, the interview guide was piloted with a hospice nurse and adjusted to focus on the objectives of the study. Demographic information regarding gender, professional discipline, highest degree, years in practice, and years practicing hospice and palliative medicine were obtained at the end of the interview. The interview questions were:

- What are your roles and responsibilities [in your hospice and palliative medicine organization] for educating physicians-in-training (i.e., medical students, residents, and fellows)? How long have you been in that role?

- Think about the best experience you have had in teaching or supervising physicians-in-training – when you felt that you were able to teach that learner something valuable and important about hospice and palliative medicine. Please describe that experience to me.
What did you do that made that experience so effective for learning?

Based upon your experiences, what qualities and skills are important to being an effective teacher of physicians-in-training?

What do you view are the most important things associated with effective teaching hospice and palliative medicine?

What makes it easier in teaching the learners who are physicians-in-training?

To what extent, if at all, does the fact that you are a [profession] influence your teaching and supervision of physicians-in-training?

What are some of the challenges in teaching learners who are physicians-in-training?

Are there characteristics of the learner that make the educational experience more productive?

What types of information, activities, or staff development would you find helpful to make you feel more prepared to teach or precept learners who are physicians-in-training?

3. Procedure

Face-to-face interviews, lasting 45-60 minutes, were conducted by one of the authors (AW) in the interviewer’s office or study participant’s office, depending on availability. All interviews were audio recorded then transcribed. All digital recordings and transcriptions were stored on a secure password protected server at Penn State College of Medicine. Each interview was given a number and letter code to keep it anonymous when recorded and transcribed.

4. Analysis

A conventional content analysis incorporating the constant comparative method associated with grounded theory was used to analyze the interviews (Hsieh & Shannon, 2005). Two coders (AW, JR) independently read each transcript to create initial codes. Coding discrepancies were resolved through discussion. Using the constant comparative method coders found patterns, categories and themes within the data with saturation. Both coders have been trained in and have experience in qualitative research and are physicians. One of the coders
(AW) is an attending physician on the Penn State Palliative Care Team. Given the small sample size, all interviews were coded. Member-checking was conducted by asking all participants via email to review the final list of themes and provide any feedback on discrepancies. One study participant responded and reported that the themes were appropriate, no one responded with discrepancies.
III. RESULTS

A. Demographics

Five staff from the Penn State Palliative Care Team and one staff from the Hospice of Central Pennsylvania participated in the interviews. Participants included chaplains, nurses, a social worker, and a physician assistant. The social worker is from the Hospice of Central Pennsylvania. The Penn State Palliative Care Team does not have a social worker on their team. All of the participants have practiced their primary discipline for many years (14-35), but are newer to the field of hospital and palliative medicine (1-27 yrs.).

Table I. Non-physician Participants

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Gender</th>
<th>Highest Degree</th>
<th>Years in Practice</th>
<th>Years Practicing Hospice and Palliative Medicine</th>
<th>Respondent Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaplain</td>
<td>Male</td>
<td>Doctor of Ministry</td>
<td>23</td>
<td>3</td>
<td>A1</td>
</tr>
<tr>
<td>Chaplain</td>
<td>Male</td>
<td>PhD</td>
<td>23</td>
<td>6</td>
<td>C3</td>
</tr>
<tr>
<td>Nurse</td>
<td>Female</td>
<td>Masters</td>
<td>14</td>
<td>5</td>
<td>B2</td>
</tr>
<tr>
<td>Nurse</td>
<td>Female</td>
<td>Masters</td>
<td>26</td>
<td>1</td>
<td>F6</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>Female</td>
<td>Bachelors</td>
<td>21</td>
<td>4</td>
<td>D4</td>
</tr>
<tr>
<td>Social Work</td>
<td>Female</td>
<td>Masters</td>
<td>35</td>
<td>27</td>
<td>E5</td>
</tr>
</tbody>
</table>

B. Major themes

Five major themes were identified:

1. Finding a Teaching Role as an “Informal” Teacher

Although most non-physician members of the hospice and palliative care staff interviewed reported that they did not have a formal role in education of the learners, they spoke about their role as the health professionals who focus on non-medical issues. This lack of formal role, actually allowed the staff to teach learners in a different way and teach the things that they
think are important. For example, one staff commented on the ability to think beyond the medical issues - “So helping them (physicians-in-training) to think beyond the medical to what non-medical interventions are available to our patients...” (A1) Other staff felt able to teach humanistic medicine, taking a more holistic approach to patients - “...when called upon to address psychosocial or spiritual issues, history, family dynamics, my contribution, I think, aids in the student’s education as well...” (C3) and “A humanistic medicine, you know...understanding that patients suffer holistically and wholly in terms of how they face it individually and collectively.” (C3) The informal role that these hospice and palliative medicine staff found themselves in also allows them to be viewed as easier or safer to approach –

“...over the years I’ve noticed I’ve been this kind of, more of an approachable person on the team for what they may perceive as stupid questions, although they’re not or just little questions that they don’t want to talk with the attending with or something like that so I think I do a lot more indirect education...”(B2)

Staff truly feel that they do not have a formal role and unfortunately, this leads the staff to feel that they are at the periphery of the physician-in-training’s experience. For example, one staff described having an ‘ancillary’ role -

“So my role is ancillary. I believe in when we have learners here on the team, certainly during morning rounds, I have an opportunity, to perhaps talk about my patients a little more in depth and to maybe explain why I’m making the recommendations that I am making.”(D4)

Another staff described waiting to be approached by learners –

“At this point I don’t really have any (role in teaching). As part of the interdisciplinary team, there are times that our director of education might ask me to come in and speak briefly with a medical student that might be going out to spend a day with a staff person, but it’s very limited.” (E5)

And another staff characterized his/her teaching role as being a “resource”- to “...serve as a resource for the medical students, residents and fellows.” (F6) Within the boundaries of an
informal role, some staff found opportunities to engage students. While other staff take a more passive stance, waiting until they are approached by learners to initiate teaching.

2. Using Professional Identity as a Foundation for Teaching

Most of the hospice and palliative staff interviewed discussed their training and areas of strength as playing a role with their interactions with learners. These staff teach from a position of special expertise and disciplinary skills. Learners are in the position of learning at work as well as learning through work.

A nurse practitioner commented on sharing her areas of strength and interest with learners through working through a challenging patient care situation -

“...I like pain management, that’s probably one of my favorite parts of what I do. So just to be able to sit down with residents (physicians-in-training) and work out a complex regimen or do the rotation, those are the little things that I think are the wins.” (B2)

While a chaplain reflected similarly when he was called upon for his expertise to assist the team and in doing so was teaching through doing work to care for a patient and family –

“So, we had a young patient who was waiting for a transplant and in the morning we got a call. They said we think we have a heart for you. So I got a page from one of the directors of the Heart and Vascular Institute, asking me ... what do you think might be helpful...I have conversations with the patient and family, listened to some of his concerns. I shared a story that involved hope in the midst of scary times...” (C3)

And a physician assistant with years of experience felt comfortable facilitating family meetings and invites this as an opportunity for learning at work –

“...it’s through participation in family meetings...being able to provide a role model, for those physicians-in-training that are also at the meeting...how to interact with these families who are under great stress...how to present information in a manner that is not overwhelming to these families and to follow up with appropriate questions and to solicit from the families their understanding...” (4D)
Staff from each discipline are knowledgeable in their field and welcome the opportunity for learning through work in caring for patients. This day-to-day interaction in caring for patients provides a rich forum for teaching.

3. Teaching Through Experiential Learning, Debriefing, and Role-Modeling

This group of hospice and palliative medicine staff felt that physicians-in-training learn best from them through experiential learning, debriefing, and role-modeling. These approaches to teaching reflect, in part, how these non-physicians learned.

Many staff who work in healthcare completed parts of their training through clinical experience or internships, and this social worker highlights her thoughts on why this is important.

“I think it was more of the experiential piece. I mean he (physician-in-training) had medical training, you know, he was going to know how to probably respond to a symptom question or pain question, but it was more the family dynamic issue. You know the experiential and ‘how to’... that’s what I could offer him so I think that, that’s always helpful.” (5E)

Chaplain training involves reflection and debriefing, hence their comfort with this type of teaching method. One staff observed, “…I think it was the time we took afterwards for him (physician-in-training) to debrief and to talk about what he experiences...” (A1) And this same staff member commented on “…the action of reflection, allowing them (physicians-in-training) to attempt it and then having some immediate feedback in reflection…” (A1) By using this method learners are able to talk through their thoughts and emotions to help solidify what they learned.

Similar to experiential learning, role-modeling is another common training method in healthcare. This quote highlights how this can be valuable for physician-in-training - “…it’s
more being a role-model, it's not a didactic, you know, read this article or do that, but it's showing them appropriate ways to professionally interact with these families.” (4D) These staff role-model communication skills with patients, families, and other healthcare professionals by having physicians-in-training participate with them in a family conference to discuss goals of care and complex medical decision-making.

4. Teaching to Perceived Gaps in Physician Training

The hospice and palliative medicine staff perceived skills in interprofessional collaboration and improved communication skills as important learning outcomes from their interaction with physicians-in-training. This is where these staff feel that they have a role in “filling in the gaps” through teaching physicians-in-training.

This staff perceived a gap being able to participate in interprofessional work - “

…this is the first time he (physician-in-training) witnessed conversations between disciplines...he didn’t realize what he was missing...he said that [it] was really neat to hear the perspective of the chaplain and to hear the perspective of the social worker who knew the family and how our physician was the patient’s physician and didn’t know some of that stuff...how he (physician attending) needed to be able to incorporate that in his care of the patient. That you need to understand the context in which people live and just because I think this medicine and it probably could be effective, if the wife doesn’t buy in, there’s an issues. If there’s finances that could be an issues, if there’s a spiritual reason why I should suffer versus take the pain medicine.” (E5)

She highlights how the physician-in-training didn’t realize how the members of the healthcare team work together. She hoped that the learner also realized the important role the other members of team play and how the patient/family needed to be included in the plan of care for it to be successful.

One staff felt that physicians are so trained to treat the disease that they often forget about the human being aspect of the care, potentially depersonalizing patient care. He felt that by
bringing the physician-in-training into contact with another discipline it would open their minds as in the concept of interprofessionality. He stated –

“My sense is that students (physicians-in-training) are about data, information, lots of it, memorization and umm the whole concept of being observed and assessed and evaluated and so when you bring them into context someone who is not a physician, but who understands and contributes and is embraces by the collective medical team, I think that acceptance creates permission or creates, yea, a sense of permission to, for the students to listen and to hear from another different vantage point how, how to practice holistic or whole-person medicine.” (C3)

Additionally, a staff perceived a gap in the communication skills training of physicians and so hope to model that - “Modeling the quiet and silence that we have to employ in our communication skills in our interactions with families and patients.” (A1). Many hospice and palliative medicine staff, such as social workers and chaplains, have robust communication skills training. This participant hoped that by working with another discipline, through role-modeling, that the physician-in-training is exposed to their professional approach and expertise.

5. Understanding the Learning Needs for Physicians-in-Training

The hospice and palliative medicine staff interviewed commented on how they wish to gain a better understanding of the needs for physicians-in-training in order to have a more formal role or to be a better teacher. First comes the acknowledgement that each discipline has a unique training - “...the way I learn as a chaplain is very different then the way a medical student (physician-in-training) learns...” (A1) Next comes the notion of feeling comfortable with their own skills and what topics they feel able to teach - “I think I could effectively teach about communication because those skills run across all professions.” (F6) Followed by thinking through the readiness of the learner and how to ensure that they are in the right frame of mind to learn –
“...their (physicians-in-training) openness to learning about how the spiritual part impacts people...a lot of them don’t come with a lot of preconceived notions because they probably never thought they would experience a chaplain on a team anyway...they have preconceived notions about religion itself not necessarily about professional clergy being part of the team...” (C3)

As part of this understanding, the staff also felt that they needed more background and approaches that would be helpful for physicians-in-training. One way is to have more education on the curriculum and expectations for physicians-in-training. For example, one staff member shares –

“...what would help me, I guess, I would need to know more about what they (physicians-in-training) need to know, more about what they need to successfully complete residency or medical school, like I don’t know ACGME criteria.” (B2)

This could be followed by skill building on teaching methods and instructional design for staff to arm them for this more formal role. A staff member felt it would be helpful to have -

“...some education about how to appropriately prepare for this (teaching physicians-in-training)...” (D4) Another staff acknowledges the importance of the instructional design being outside the classroom and more experiential - “...I think when they come here (hospice), they’re receptive versus going to them in their setting they may not. They usually come because they’re interested...” (E5) Here learner readiness and teaching context play a role in promoting learning. This theme shoes the value in formalizing the role of the non-physician as a teacher through orientation to teaching physicians-in-training and providing teaching skills development.
V. DISCUSSION

A. Informal/workplace learning

How do non-physician hospice and palliative medicine staff describe their role in teaching physicians-in-training? They do not consider themselves teachers per se, but rather as members of a team who incorporate the physicians-in-training into learning that happens in those teams. Interprofessionality arises from patterns of communication and practice within interdisciplinary teams. Interdisciplinary team meetings allow physicians-in-training to explicitly learn the team approach to caring for patients and families requiring hospice and palliative care. These informal teachers are part of the team with the physicians-in-training and engaged in workplace learning by using day to day work opportunities as opposed to formal learning that occurs in the classroom.

Eraut provides a conceptual framework of informal learning in the workplace that seems appropriate to apply as a framework for understanding interprofessionality as experienced by the study participants (Eraut, 2004). In his model, learning in the workplace occurs as a result of interactions between the individual worker, the work itself, and relationships at work. Informal learning occurs within the social context of work and in the absence of a teacher and formal instruction. Eraut describes four main types of work activity that give rise to learning – participation in group activities, working alongside others, tackling challenging tasks, working with clients. During each of these activities learning occurs through processes such as observing, reflecting, practicing, and feedback.
1. **Participation in group activities**

   The staff commented on the importance of the team and working towards patient/family-centered outcomes. The focus on a common goal/purpose provided physicians-in-training a meaningful experience. In some clinical situations physicians-in-training were observing while in others they were participating. These teams all have a common purpose to provide care for those with life-limiting illness. For example, when these informal teachers had learners join family meetings and interdisciplinary team meetings, they were working towards a common goal set in motion by a patient and/or family managing healthcare challenges.

2. **Working alongside others**

   In working alongside their teachers, learners get to observe and listen to how others think and participate in clinical activities. This type of role-modeling can lead to learning new perspectives and clinical practices by expanding their exposure to different expertise and knowledge. The staff in the study often commented on the perception that role-modeling during patient care was one of the most crucial ways to approach teaching physicians-in-training. The teaching skills of experiential learning, debriefing, role-modeling most closely parallel the literature for effective physicians in training (Sutkin, Wagner, Harris, & Schiffer, 2008) (Fromme et al., 2010) (Hatem et al., 2011) (Cruess, 2008).

3. **Tackling challenging tasks**

   The challenging tasks faced by hospice and palliative medicine staff may be outside the comfort zone for many physicians. Hospice and palliative medicine providers often break bad news to patients and families, plan for a ‘good death’, or creating a care plan for refractory pain
and the symptoms faced by those suffering from life-limiting illnesses. Such situations get at the patient experience and suffering at the end-of-life which may elicit emotional reactions by learners. These are scenarios that we want physicians-in-training to experience and participate in. Education in hospice and palliative medicine settings allow for the creation of “desirable difficulties“. Learners are guided through these challenges by experts who are not physicians and can speak to how to manage the emotional issues that arise from within when aiding patients/families struggling with complex decision-making or symptoms.

4. Working with clients

Each of the disciplines mentioned the importance of learning ‘special’ information about the patients/families that allowed them to address the non-medical issues. These staff are the informal teachers filling out a broader, biopsychosocial perspective of the patient and family that are often missing from medical education and residency training. Learning a broader assessment of the patient care is really a systems-thinking process and encourages a team-based approach to patient/family care. The ‘non-medical’ pieces are often crucial in addressing the medical issues, thus are important for learners to grasp. Many of these informal teachers are teaching to the perceived gaps in physician training related to addressing the non-medical issues that come up in caring for patients and families.

The educational experiences hospice and palliative medicine staff have with physicians-in-training are characterized as emphasizing ‘interprofessionality’ (D'Amour & Oandasan, 2005) through workplace learning. The fact that the study participants have talked about values for interprofessional practice and teamwork within the context of their roles as teachers can also be linked to the interprofessional core competencies for health professionals which we strive to
address in medical education. The observing, reflecting, practicing, and feedback provided by the workplace learning with these informal teachers deserves further attention.

B. Limitations

I had a small group of participants. Participants may have stated socially desirable answers that they ‘think’ are appropriate. Each discipline faces different professional pressures within both their discipline and institutional contexts in which they work. These cultural or contextual factors may contribute to results that may not be present in all hospice and palliative medicine care settings. The interviewer (AW) was also a new member of the hospice and palliative medicine interdisciplinary team which may have altered responses. To minimize these limitations, the instructions reiterated the anonymity of the project and encourage open honest answers.
VI. CONCLUSION

In order to advance our educational goals to align with evolving care delivery systems focusing on teamwork and patient/family-centered care, we need to better understand the role of non-physicians as teachers. Our qualitative data leads us to the concept of interprofessional informal learning that clarifies important opportunities to advance the training of physicians. This group of non-physician hospice and palliative medicine staff interact with physicians-in-training guided by their areas of expertise and perspectives on patient care. Although they do not feel that they have formal teaching roles, they direct their teaching towards perceived gaps in physician training using reflection, dialogue and role-modeling. Based on these results, we would argue that these staff should be considered informal teachers and as such be offered professional development which could enhance what they already do with learners. This study also served as foundational work for providing a new educational experience. In 2016 we launched a Hospice and Palliative Medicine physician fellowship. Acknowledging the role of staff will help with staff self-perception of their potential roles and impact on all levels of physicians-in-training. Future studies could explore the educational roles and perspectives of non-physician professionals in other specialties (i.e. surgery) and across diverse academic institutions.
VII. CITED LITERATURE


professionals' education. *Acad Med, 86*(11), 1351. doi: 10.1097/ACM.0b013e3182308e39


VIII. VITA

Amy Margaret Westcott, MD CMD FAAHPM

Name: f.k.a. Amy Margaret Corcoran

Work Address: 500 University Drive, H106
Hershey, PA 17033 USA
awestcott@pennstatehealth.psu.edu
(717) 531-6263

Education:

1998 BS University of Richmond (Honors Biology)
2003 MD/MS American University of the Caribbean, School of Medicine
(Medical Science)

Postgraduate Training and Fellowship Appointments:

2003-2006 Internal Medicine Residency, University of Connecticut,
Farmington, CT
2006-2007 Geriatric Medicine Clinical Fellowship, University of
Pennsylvania, Philadelphia, PA
2007-2008 Palliative Medicine Fellowship, University of Pennsylvania,
Philadelphia, PA
2008 Palliative Care Education Program, Harvard University,
Boston, MA
2008 Clinical Teaching Course, Stanford University, Palo Alto, CA
2010 Core Curriculum, American Medical Directors Association,
New Brunswick, NJ
2011 Scholar, Duke University Mini-Fellowship in Long-Term Care
Education, Durham, NC
2011-present Master in Health Professions Education, University of Illinois
at Chicago

Faculty Appointments:

2007-2008 Clinical Instructor in Medicine, University of Pennsylvania
School of Medicine
2009-2014 Assistant Professor of Clinical Medicine, University of
Pennsylvania School of Medicine
2014-present Associate Professor of Medicine, Penn State University,
College of Medicine, Milton S. Hershey Medical Center

Hospital and/or Administrative Appointments:

2007-2008 HUP Ethics Committee Member, University of Pennsylvania
2008-2014 Associate Medical Director, Penn-Wissahickon Hospice
2008-2011  Director of Geriatrics and Long-term Care Program, Penn-Wissahickon Hospice
2009-2012  Associate Director, Hospice and Palliative Medicine Fellowship, University of Pennsylvania
2010-2012  Associate Program Director, Geriatric Fellowship, University of Pennsylvania
2011-2014  Director of Medical Education, Penn-Wissahickon Hospice
2012-2014  Program Director, Hospice and Palliative Medicine Fellowship, University of Pennsylvania
2015-present  Consultant, Office of Interprofessional Collaborative Education & Training (ICE&T)
2015-present  Program Director, Hospice and Palliative Medicine Fellowship,
2015-present  Penn State College of Medicine, Hershey Medical Center
2015-present  Woodward Center for Education Task Force Director of Educator Development in Teaching and Learning (present), Faculty Development Co-Director (2015), Office for
2015-present  Support in Learning and Teaching Excellence (SLATE) LCME Self-study Task Force Subcommittee, Standard 3:
2015-present  Academic and Learning Environments (subgroup Chair) Member and Post-Acute Care Hospitalist, Hershey Medical Center/Manor Care Re-admissions Quality Improvement Committee

**Other Appointments:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-2014</td>
<td>Faculty Sponsor, Aging Interest Group, Perelman School of Medicine, University of Pennsylvania</td>
</tr>
<tr>
<td>2008-2014</td>
<td>Fellow, Institute on Aging, University of Pennsylvania</td>
</tr>
<tr>
<td>2011-2014</td>
<td>Faculty Sponsor, Student Healthcare Alliance at Penn (SHAPE), Perelman School of Medicine, University of Pennsylvania</td>
</tr>
</tbody>
</table>

**Specialty Certification:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006/2016</td>
<td>American Board of Internal Medicine</td>
</tr>
<tr>
<td>2007</td>
<td>Geriatric Medicine</td>
</tr>
<tr>
<td>2008</td>
<td>Hospice and Palliative Medicine</td>
</tr>
<tr>
<td>2011</td>
<td>Certified Medical Director (CMD)</td>
</tr>
</tbody>
</table>

**Licensure:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Licensure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-Present</td>
<td>Pennsylvania</td>
</tr>
</tbody>
</table>

**Awards, Honors and Membership in Honorary Societies:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Honors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Member, Alpha Omega Phi Medical School Honor Society</td>
</tr>
</tbody>
</table>
2002  Most Outstanding Medical Student Award at Yale University-Affiliated Griffin Hospital
2006  American Medical Directors Association Futures Program Recipient Award
2008  American Academy of Hospice and Palliative Medicine CPC Year-Long Mentoring Program Award with Mentor Laura Hanson, MD MPH of the University of North Carolina
2010  Outstanding Leadership in Doctoring, Perelman School of Medicine Class of 2013 at the University of Pennsylvania
2011  Quality and Safety Award for Improving Pain Assessment in the Hospice Dementia Patient, University of Pennsylvania Health System
2012  Outstanding Professor in Differential Diagnosis, Perelman School of Medicine Class of 2015 at the University of Pennsylvania
2013  Nominated for the Provost's Award for Distinguished Teaching
2013  Palliative Care Champions Award, University of Pennsylvania Health System
2014  Fellow, American Academy of Hospice and Palliative Medicine
2014  Professor Inductee, Alpha Omega Alpha Honor Society, Perelman School of Medicine at the University of Pennsylvania
2015  Special Recognition Award for Outstanding Service on the Education Committee, American Geriatrics Society
2015  Inspire Award for Creating an Extraordinary Patient Experience
2015  Scholarship in Education Award from Office of Scholarship in Learning and Education (OSLER)
2016  Medical Group Dean’s List for the First Quarter of FY17

Memberships in Professional and Scientific Societies and Other Professional Activities:

<table>
<thead>
<tr>
<th>National:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995-present</td>
</tr>
<tr>
<td>Delta Delta Delta (Richmond Chapter Panhellenic Delegate 1996-1997)</td>
</tr>
<tr>
<td>1999-2003</td>
</tr>
<tr>
<td>American Medical Student Association (Chapter President 2000-2001)</td>
</tr>
<tr>
<td>2006-present</td>
</tr>
<tr>
<td>American College of Physicians</td>
</tr>
<tr>
<td>2006-present</td>
</tr>
<tr>
<td>American Geriatrics Society (Junior Faculty Task Force 2011-2013, Education Committee 2013-present, Teachers Section Chair 2016-present)</td>
</tr>
</tbody>
</table>
2006-present AMDA The Society for Post-Acute and Long-Term Care Medicine (Education Program Committee 2011-2015, Annual Conference Poster Judge 2016-present)

2008-present American Academy of Hospice and Palliative Medicine (Co-Chair Long-term Care Special Interest Group 2009-2010)

2010-2015 John A. Hartford Foundation, American Federation for Aging Research (Scholar Advisory Committee 2012-2013)

Local:
2006-2014 Eastern Pennsylvania Geriatric Society (Education Committee Chair 2011-2012, Executive Board Member 2010-2012)

2009-2011 Pennsylvania Hospice and Palliative Care Network (Executive Board)

2015-present Supportive Older Women's Network (SOWN) (Board of Advisors)

2015-2016 Safe and Effective Prescribing Practices and Pain Management Task Force’s work group for the PA Department of Health

Editorial Positions:
2008-present Ad hoc reviewer, The American Journal of Nursing
2010-2014 Ad hoc reviewer, Journal of Palliative Medicine
2012-2014 Ad hoc reviewer, Health Policy
2014-2015 Reichel's Care of the Elderly: Clinical Aspects of Aging
2016-present Geriatric Review Syllabus (GRS), Editorial Board

Academic and Institutional Committees at the University of Pennsylvania:
2007-2014 Member of the Geriatric Education Center Planning Committee
2007-2014 Member of the Geriatric Interdisciplinary Planning Committee
2009-2014 Individual Medical Student Mentor for Elizabeth Blackwell Society
2010-2014 Member of the School of Medicine Curriculum Committee
Major Academic and Clinical Teaching Responsibilities at the University of Pennsylvania:

2006-2014

Undergraduate Medical Education:

1. Aging Theme Leader for Reynolds-funded Penn CARES (Community and Academic Resources for Education about Seniors)(2008-present).


3. MD 306 Introduction to Clinical Medicine faculty preceptor annually for history portion. Also participate in 'round robin' and deliver the geriatric assessment station (2006-present).

4. MD305 Differential Diagnosis Course Geriatric Case, "Cognitive Decline". Annually, co-lead plenary and participate in small group discussion differential diagnosis presentation to medical students (2008-present).


6. Palliative Medicine Frontiers Course Director (2009-present).

7. Faculty participant in the Careers in Medicine Luncheon (2010-present).

8. Faculty participant in the Medicine Mentoring Program (2010-present).


11. Older Adult Transitions visit to a long-term care setting as part of the Acute Care for the Elderly (ACE) Unit rotation. Create, coordinate and piloting (2012-present).

12. Faculty Advisor for Medical Education Scholarly pursuits (2012-present).

2006-2014
Graduate Medical Education:
2. Geriatric Interdisciplinary Fellows' Conference. Coordinate and teach the palliative care theme and teaching themes (2008-present).
3. Penn CARES Reynold's Chief Resident Immersion Training (CRIT) Annual Retreat. Participate as core faculty and facilitate small group case-based discussions. Cover material related to teaching small groups and approaching the challenging or reluctant learner (2009-present).
4. Resident Interprofessional Hospice Elective. Coordinate and review all reflective narratives as well as provide supervision and bedside teaching (2010-present).
5. Internal Medicine Residents Clinical Teaching Skills Sessions offered during the Clinical Investigator Toolbox Resident Elective (2010-present).
7. Interprofessional Communication Education Workshop including medicine, nursing, social work, physical therapy, occupational therapy, chaplaincy, and pharmacy learners (Fall 2012).

2006-2014
Continuing Medical Education:
2. Annually facilitate the Stanford Clinical Teaching Course for Geriatric Faculty and/or Faculty Affairs and Professional Development (FAPD) (2009-present).

2008-2014
Other Educational Activities:
1. Adult Nurse Practitioner Course: Cancer as a Chronic Illness. "Ethical Issues at the End of Life: Advance Care Planning" facilitated annually.
2. School of Nursing Principles of Palliative Care Course. Annual guest lecturer.
3. Dental Students: Geriatric Dentistry Course in the Penn School of Dentistry, "Caring for Older Adults at Life's End: An Introduction to Geriatric Palliative Care" (2008-2010).
4. Penn Undergraduate Reading Project Faculty Preceptor (2008-2010).
Major Academic and Clinical Teaching Responsibilities at the Penn State University, College of Medicine:

2014-present  
**Graduate Medical Education:**
1. Palliative Care Consult Rotation. Facilitate I-SMART and reflections.
2. JEMS. Mentor and coach 4 Internal Medicine Residents longitudinally until graduation.
3. Hospice and Palliative Medicine Fellowship Program Director. 
   Received ACGME-accreditation. Will be recruiting for July 2016.
4. Faculty Development Co-Director focusing on GME teaching skills and Residents as Educators for Office for Support in Learning and Teaching Excellence (SLATE)
5. Preceptor for Family and Community Medicine Residents longitudinal long-term care experience.

2016-present  
Undergraduate Medical Education:
1. Kienle Humanism Stripe. Facilitate small group discussion with students regarding various topics.
2. Department of Medicine Student Mentorship Program. Mentor 2 students interested in pursuing careers in Internal Medicine.
3. Medical Student Navigator Program. Faculty Preceptor for 2 students navigating long-term care residents.

2016  
**Other Educational Activities:**
College of Nursing. NURS 824. Palliative Care Elective. “Post-acute Palliative Care”. Webinar.

---

**Lectures by Invitation:**

- **Mar, 2009**  
  "Palliative Care Communication: Advance Directives, Goal Setting, and Family Meetings", American Medical Director Association Annual Meeting, Charlotte, NC

- **Mar, 2009**  
  "Hospice and Palliative Care in the Skilled and Long-term Care Communities: Challenges and Opportunities for Physician and APN Providers", American Academy of Hospice and Palliative Medicine, Austin, TX

- **Apr, 2009**  
  "Living with Advanced Dementia: End-of-Life Care". Penn-Wissahickon Hospice Living with Dying Series. Bala Cynwyd, PA
April 2009  "Palliative and hospice care in the nursing home - how to create a successful collaboration!" co-lead with Joan Weinryb, MD, CMD, EdM. Annual Penn Palliative Care Conference. Bala Cynwyd, PA

May 2009  "Serving the Underserved Special Needs Population: A Collaborative and Experiential Journey to Create a Unique Care Model", Pennsylvania Hospice Network, Erie, PA

May 2009  "The Physician's View of End of Life Discussion and Role of Hospice", Southern New Jersey Ethics Society, Pomona, NJ


March 2010  "Hospice and Nonhospice Models of Palliative Care Delivery in Long-term Care", American Academy of Hospice and Palliative Medicine, Boston, MA

March 2010  "Effective Communication Strategies in Long-term Care: bringing together the long-term care, hospice and families", Penn Future of Hospice & Palliative Care Conference, Philadelphia, PA

March 2010  "ELNEC Module 3: Nonpain assessment and management", Penn School of Nursing, Philadelphia, PA

May 2010  "Improving Your Clinical Teaching: A Systematic Approach", American Geriatric Society, Orlando, FL

September 2010  "Pain: What You Need to Know to Advocate", Kairos Health Systems, Inc., Lancaster, PA

March 2011  "Palliative Care Part I: Clinical and Ethical Considerations - Goals of Care", American Medical Directors Association, Tampa, FL

May 2011  "Approach to Caring for the Hospice Patient with an Implantable Cardioverter Defibrillator", Pennsylvania Hospice Network, Hershey, PA

September 2011  "Stanford Clinical Teaching Course: Learning Climate", Drexel University School of Medicine, Philadelphia, PA

September 2011  "Pain: What You Need to Know to Advocate", Geriatric Education Center of the University of Rochester Conference, Rochester, NY

March 2012  "Ways to Effectively Communicate Challenges Surrounding Opioid Use", American Medical Directors Association, San Antonio, TX

March 2012  Palliative Care Part I: Clinical and Ethical Considerations - "Palliative Care Communication: Goals of Care", American Medical Directors Association, San Antonio, TX

November 2012  "Palliative Medicine's Approach to Advanced Dementia", Watermark At Logan Square, Philadelphia, PA

March 2013  "Palliative Care I: Communication", American Medical Directors Association, Washington D.C.

March 2013  "Teaching in Long-term Care", American Medical Directors Association, Washington, D.C.

March 2013  "Junior Faculty In the Trenches", American Medical Directors Association

May, 2013  "Model Geriatric Programs: Medical Student Educational Materials and Methods Swap" Moderator, American Geriatric Society, Grapevine, TX

May, 2013  "A Longitudinal Senior Faculty and Peer Mentoring Program for Junior Investigators and Educators", American Geriatric Society, Grapevine, TX

Jun, 2013  "Interprofessional Geriatric Education and Practice Institute: Solving Challenges in Dementia Care - Caring for Patients with Dementia at the End of Life", Eastern Pennsylvania-Delaware Geriatric Education Center of Thomas Jefferson University, Philadelphia, PA

Feb, 2014  "Palliative Care Part I: Clinical and Ethical Considerations. Communication Core Curriculum", American Medical Directors Association, Nashville, TN

Feb, 2014  "Communicating Effectively with Families, Caregivers, and Health Professionals in Long Term Care: A Skills Building Workshop", American Medical Directors Association, Nashville, TN

May, 2014  "Model Geriatric Programs: Geriatric Materials and Methods Swap" Moderator, American Geriatric Society, Orlando, FL


Jun, 2014  "Piloting the Interprofessional Team Assessment Program (ITAP): students observing teams in action", All Together Better Health VII, Pittsburgh, PA

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan, 2015</td>
<td>“Implicating End of Life Choices: Practical Implications in Geriatric Palliative Care” The Closure Initiative Series, Pinnacle Community General Osteopathic Hospital, Harrisburg, PA</td>
</tr>
<tr>
<td>April, 2015</td>
<td>“Palliative Pearls in Caring for Older Adults” Pennsylvania Hospice Network, Harrisburg, PA</td>
</tr>
<tr>
<td>Oct, 2015</td>
<td>“Post-Acute Palliative Care in the Long-Term Care Setting” Institute for Healthcare Improvement Expedition. Webinar.</td>
</tr>
<tr>
<td>Dec, 2015</td>
<td>“Informational Meeting on Hospice and Palliative Care” House Aging and Older Adults Services Committee, House of Representatives, Harrisburg, PA</td>
</tr>
<tr>
<td>Mar, 2016</td>
<td>“Enhancing Leadership for Women in Post-Acute Care” AMDA – The Society for Post-Acute &amp; Long-term Care Medicine, Orlando, FL</td>
</tr>
<tr>
<td>April, 2016</td>
<td>“Managing Expectations and Goals of Care” Pennsylvania Hospice and Palliative Care Network, Harrisburg, PA</td>
</tr>
<tr>
<td>May, 2016</td>
<td>“Post-Acute Palliative Care: Managing Expectations and Goals of Care” Butler Hospital, Providence, RI</td>
</tr>
<tr>
<td>March, 2017</td>
<td>“Post-Acute Palliative Care: team-based approach to challenging cases.” Dickenson College, Carlisle, PA.</td>
</tr>
</tbody>
</table>

**Organizing Roles in Scientific Meetings:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Role and Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar, 2012</td>
<td>Program Planning Committee Member, American Medical Directors Association Long-Term Care Medicine, &quot;A Mission From the Heart&quot; San Antonio, TX</td>
</tr>
<tr>
<td>May, 2012</td>
<td>Program Planning Committee Member, Association of Directors of Geriatric Academic Programs (ADGAP): American Geriatrics Society Pre-conference Seattle, WA</td>
</tr>
<tr>
<td>Mar, 2013</td>
<td>Program Planning Committee Member, American Medical Directors Association Long-Term Care Medicine, &quot;Monumental Steps for Quality&quot; Washington, D.C.</td>
</tr>
<tr>
<td>Feb, 2014</td>
<td>Program Planning Committee Member, American Medical Directors Association Long-Term Care Medicine &quot;Creating Harmony in Long-Term Care&quot; Nashville, TN</td>
</tr>
</tbody>
</table>
May, 2014  Co-chair, Education Committee Subcommittee on Annual Conference Events, American Geriatric Society  
Orlando, FL  
May, 2015  Co-chair, Education Committee Subcommittee on Annual Conference Events, American Geriatric Society  
Baltimore, MD  
May 2016  Co-chair, Education Committee Subcommittee on Annual Conference Events, American Geriatric Society  
Long Beach, CA  
May 2017  Co-chair, Education Committee Subcommittee on Annual Conference Events, American Geriatric Society  
San Antonio, TX  

Bibliography:

Research Publications, peer reviewed (print or other media):

1. Topham R, Tesh S, Cole G, Mercatante D, Westcott A(maiden name), Bonaventura C.:  


4. Kumar P, Casarett D, Corcoran A, Desai K, Li Q, Chen J, Langer C, Mao JJ:  


Research Publications, peer-reviewed reviews:


Contributions to peer-reviewed clinical research publications, participation cited but not by authorship:
Abstracts:


Editorials, Reviews, Chapters, including participation in committee reports (print or other media):


**Alternative Media:**


Grants:

Ongoing Research Support

No Grant # (McGillen) 4/1/2017

Hatt Award

Title: Hospitalist as Educator Pilot: Can Peer-to-Peer Observation Enhance Teaching Skills

The aim of this pilot is to improve the quality of education provided by the hospitalists through faculty development, individual goal setting and peer-to-peer observation.
Title: Non-physician Hospice and Palliative Staff: How do they describe their role in medical education?

The goal of the pilot study is to explore the qualities and skills non-physician hospice and palliative staff feel are important for effectively teaching physicians-in-training; explore the perceived facilitators and barriers that non-physician hospice and palliative staff experience in teaching physicians-in-training; and describe the preferred training and support non-physician hospice and palliative staff would find beneficial as related to their role in teaching physicians-in-training.

Geriatric Academic Career Award

Title: Effective Inter-Professional Aging Education.

Project goal: Dr. Corcoran’s career development focused on developing expertise and skills in the following areas: (1) educational approaches and products (lectures, workshops, seminars, and full curricula) for teaching geriatrics and aging aspects of palliative care to physicians and interdisciplinary groups of trainees, (2) techniques of formative and summative evaluation of educational approaches and products, and (3) dissemination of educational approaches and products for diverse audiences. As a consequence of the award, Dr. Corcoran impacted the quality of care of older adults, particularly around geriatric palliative care issues and those residing in long-term care.

HRSA

Title: Geriatric Training Program For Physicians, Dentists, And Behavioral And Mental Health Professions

Project goal: This grant funds the Geriatric Interdisciplinary Fellowship (GIF) which prepares fellows for roles as leaders in geriatrics within the academic medical center setting in geriatric medicine, psychiatry and dentistry, with particular expertise in interdisciplinary and culturally competent practice. Through a core, integrated curriculum, this program will provide shared educational content and learning experiences among the fellows from medicine, psychiatry, and dentistry.

Role: Core Faculty
Title: Practice Change In Geriatric Care
Project goal: This grant funds the Geriatric Education Center of Greater Philadelphia (GEC-GP) Consortium focuses its educational program on the care of the growing number of older patients with cognitive impairment, and on the interdisciplinary care of elders at the end of life. In conjunction with a faculty development program on health literacy and equity, the GEC-GP incorporates training in addressing issues of health equity and literacy at all levels in its approach to these two central issues. The GEC-GP also addresses identified needs in the professions of medicine, nursing, dentistry, pharmacy, chaplaincy, and social work.
Role: Core Faculty

Role: Faculty Scholar

Role: Implement SOM Aging Theme

Role: PI