

## “Palliative Care: The Essentials”: Evaluation of a Multidisciplinary Education Program

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### Abstract

**Background:** Despite the world-wide growth of specialist palliative care services, the bulk of care and decision making at the end of life are delivered in general hospital, primary care, and aged care settings. Health workers of all disciplines therefore need to develop attitudes, knowledge, and skills required to deliver palliative care.

**Aim:** To develop, deliver, and evaluate a short multidisciplinary education program focusing on the core elements of palliative care.

**Method:** A 2-day program was developed by an expert panel comprising academics, policy makers, clinicians, and a caregiver representative. Evaluation consisted of a pretest/posttest questionnaire aimed at identifying participants' palliative care knowledge and confidence at three time points; prior to attending the program, at the conclusion of the program, and 1 month later. In addition a session evaluation questionnaire sought to determine whether the session was interesting, informative, and useful.

**Results:** The program was delivered four times in both metropolitan and regional areas of Australia to a total of 537 participants incorporating a range of disciplines and care settings. Participants reported significant improvement in key areas including; ability to identify patients likely to benefit from a palliative approach, communication skills, symptom management, family-centered care, legal and ethical issues, and grief and bereavement.

**Conclusions:** The majority of participants identified that the program increased their levels of interest, knowledge, and confidence in relation to palliative care. The findings demonstrate that multidisciplinary educational approaches of this type can be effective in the context of delivering palliative care education. The high demand to attend the program suggests the need for ongoing palliative care educational activities.

### Introduction

PATIENT AND FAMILY-CENTERED CARE, provided by a multidisciplinary team is a core component of palliative care practice.<sup>1,2</sup> Despite the desire of most people with life-threatening illnesses to die at home, more than 50% of people in developed countries die in general hospitals.<sup>3</sup> Moreover, many patients die without access to a specialist palliative care service. Palliative Care Australia Standards<sup>4</sup> and the World Health Organization<sup>5</sup> promote developing partnerships between specialist palliative care services and primary care providers, facilitating a palliative approach to the care of all people with a life-limiting illness.

The palliative approach to care promotes assessment and management of the psychosocial and spiritual realms, as well as the physical symptoms for people with advanced incurable disease.<sup>6</sup> All health care professionals, regardless of setting, provide occasional care to people with life-threatening illnesses. It is therefore essential to ensure clinicians working in a range of settings are provided with educational opportunities and resources to competently meet the needs of people diagnosed with life-threatening illnesses.

The advantage of providing education to a multidisciplinary audience is the opportunity for clinicians to gain awareness and appreciation for the skills and roles of disciplines other than their own. However, there is a paucity of sup-

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porting evidence related to the effectiveness of multidisciplinary education. One small pilot study that did explore the effectiveness of palliative care multidisciplinary education concluded that health professionals knowledge and attitudes toward dying patients improved after education, and the improvement was maintained over time.<sup>7</sup> However, given the small sample, results are not generalizable.

One education program that focused on the development of a train-the-trainer program was designed to provide nurse educators with a package to assist educating undergraduate nursing students in the care of dying patients and their families.<sup>8</sup> While the program appeared to be successful with nurses, it would be useful to explore its applicability to other disciplines. Several specialty areas within health care have explored the concept of multidisciplinary education, but they lacked comprehensive evaluation.<sup>9,10</sup> While there has been a shift in recent times toward integrating palliative care education into undergraduate health care programs, there is a lack of consistency regarding content and teaching method.<sup>9,11</sup>

Given that all health care professionals may be required to care for a palliative patient and their family, it is essential to consider optimal ways to educate and equip them with the necessary knowledge and skills. The purpose of the current project was to develop, deliver, and evaluate a short multidisciplinary education program focusing on the core elements of the palliative approach to care.

## Method

### Curriculum development

Given that the target education audience was to be multidisciplinary, an advisory group was formed to capture experiences from a range of disciplines and backgrounds in palliative care. The advisory group consisted of thirteen people representing clinical and academic palliative care fields. Specific disciplines included; medical academic (1), nurses (7; clinical, management, and academic), social worker (1), caregivers representative (1), project funding body representative (1), pastoral care (1), and palliative care administrator (1). Evidence from a literature review, combined with the collective clinical experience of the project team, the Australian Standards for Palliative Care (4) delivery and input from the advisory group provided the basis for a curriculum.

The program consisted of nine sessions presented by specialist palliative care clinicians from a range of disciplines. Program delivery consisted of mixed methods, including didactic, question and answer sessions, workshops and panel/case discussions. Resources, appropriate to each session, including relevant reading materials, websites, and reference lists were provided to the participants. Session presenters were requested to consider specific session learning objectives, grouped under the broad framework of "attitude," "knowledge," and "confidence" relevant to their subject. Session objectives were included on the participants' program outline. Table 1 provides a list of the session titles. The rationale for concurrent Sessions VIIIA and VIIIB (Table 1) was that previous project team experience suggested that doctors and nurses welcomed opportunities to learn about specific palliative physical symptoms and their management, including advice and information regarding relevant medications. Session VIIIB was designed to provide allied health team members with an opportunity to explore their role within the multidisciplinary care team.

The closing session for the program took the form of a panel discussion, during which the local palliative care services for each program were encouraged to participate as a way of facilitating introductions and highlighting the locally available services.

### Setting

The program was delivered in two regional and two metropolitan areas in the State of Victoria, Australia.

### Recruitment

The program was promoted via a flyer, which was distributed to all public and private hospitals in Victoria, the Divisions of General Practitioners, Palliative Care Victoria, and all residential aged care facilities (RACF). Enrollments were initially accepted from all health professionals with a university degree (or equivalent). However, due to the frequent requests received from personal care attendants (PCA), particularly those working in RACF, a decision was made to modify the inclusion criteria and invite them to attend. The PCA were individually advised of the program content and clinical focus prior to having their registration confirmed. Participants paid a small registration fee to cover cost of catering and materials.

TABLE 1. CURRICULUM CONTENT FOR "PALLIATIVE CARE: THE ESSENTIALS"

<i>Program Day 1</i>	<i>Program Day 2</i>
Session I. Clinical and public health approaches to palliative care	Session VI. Communicating with patients, families and colleagues
Session II. Decision making in palliative care: ethical and legal challenges	Session VII. Palliative care and nonmalignant disease
Session III. Assessing and responding to spiritual and cultural issues	Session VIIIA (Doctors and nurses). Frequently asked questions regarding symptoms
Session IV. Family centered care	Session VIIIB (allied health clinicians). "Multidisciplinary Team—Does it Work?"
Session V. Grief, loss, and bereavement	Session IX. Care of an imminently dying person and their family
	Panel discussion

## Data Collection

Participants were required to consent to evaluation data being used for any future publications or presentations. Data collection comprised the following:

1. A sociodemographic questionnaire was developed to capture data including; gender, age, professional role, care setting, and frequency of attending palliative patients, and was administered at the beginning of the program. Estimation of the level of financial burden/employer support was gained with the use of a brief questionnaire administered at the beginning of Day 2 of the program.
2. Despite an extensive literature search, no validated palliative care evaluation tools were identified that would capture data related to the program objectives. Therefore, a decision was made to utilize a questionnaire developed by a palliative care project officer from a Victorian regional palliative care service, who was not associated with the program. The generic questionnaire (61 items), was administered at the beginning and end of each 2-day program to explore participant perceptions related to importance, knowledge, and confidence with palliative care in broad terms over eight key areas. Each item was rated on a 5-point Likert scale where 0 represented "not important" and 4 represented "critical." One month after each program, participants were mailed the same questionnaire in a postage-paid return envelope, with the aim of identifying longer term benefit or otherwise from attending the program.
3. Immediately after each session, participants completed a session evaluation questionnaire (3 items), to ascertain any benefit in relation to level of interest, extent of new information learned, and perceived usefulness of the session. This scale is not validated and was designed specifically for the purpose of this study. A Likert scale, 0–4, was used to measure "interest," "information," and "usefulness," where "0" represented "not at all" and "4" represented "extremely."

TABLE 2. TOTAL SUBSCALE MEANS AND STANDARD DEVIATIONS FOR MEASURES OF IMPORTANCE, KNOWLEDGE, AND CONFIDENCE FOR ALL OF THE EIGHT AREAS TARGETED IN THE PALLIATIVE CARE TRAINING AT PRE AND POSTINTERVENTION ( $n = 345$ )

Measure	Time 1 $\alpha$	Time 1 ( $n = 345$ )		Time 2 ( $n = 345$ )		F (1364)	$\eta^2$ (sig.)
		Mean	SD	Mean	SD		
Identify patients for PC (2 items)							
Importance	0.60	7.11	1.07	7.38	0.91	16.12	0.04 <sup>a</sup>
Knowledge	0.79	5.29	1.44	5.89	1.33	57.41	0.14 <sup>a</sup>
Confidence	0.79	4.87	1.37	5.47	1.30	72.18	0.17 <sup>a</sup>
Relationships and roles (7 items)							
Importance	0.76	25.27	3.26	26.10	2.71	21.44	0.06 <sup>a</sup>
Knowledge	0.87	19.99	4.08	21.69	3.65	67.29	0.16 <sup>a</sup>
Confidence	0.90	18.75	4.15	20.29	3.90	58.02	0.14 <sup>a</sup>
Support services (9 items)							
Importance	0.93	33.15	4.08	33.82	3.59	9.90	0.03 <sup>b</sup>
Knowledge	0.93	25.36	5.83	27.78	4.96	73.37	0.17 <sup>a</sup>
Confidence	0.94	23.95	5.68	25.86	5.48	52.24	0.13 <sup>a</sup>
Communication skills (9 items)							
Importance	0.74	33.61	4.53	34.10	3.19	4.02	0.01 <sup>b</sup>
Knowledge	0.91	25.53	5.80	27.78	4.94	69.72	0.16 <sup>a</sup>
Confidence	0.83	23.90	5.81	25.71	5.25	47.83	0.12 <sup>a</sup>
Clinical management (14 items)							
Importance	0.60	50.13	8.50	51.10	7.63	7.54	0.02 <sup>c</sup>
Knowledge	0.79	37.74	10.77	41.52	9.27	75.20	0.17 <sup>a</sup>
Confidence	0.79	35.72	9.98	38.43	8.71	38.20	0.10 <sup>a</sup>
Legal & ethical issues (6 items)							
Importance	0.92	21.61	3.52	22.32	2.48	16.02	0.04 <sup>a</sup>
Knowledge	0.80	14.53	5.60	16.48	3.76	58.09	0.14 <sup>a</sup>
Confidence	0.91	13.67	4.40	15.37	3.70	71.22	0.16 <sup>a</sup>
Spiritual/cultural aspects (10 items)							
Importance	0.84	36.85	4.93	37.71	3.89	11.97	0.03 <sup>c</sup>
Knowledge	0.95	26.96	7.26	29.49	5.91	59.87	0.14 <sup>a</sup>
Confidence	0.95	25.18	7.27	27.66	6.04	65.19	0.15 <sup>a</sup>
Grief and bereavement (4 items)							
Importance	0.92	14.96	1.89	15.23	1.44	7.77	0.02 <sup>c</sup>
Knowledge	0.91	11.24	3.16	12.23	2.49	44.64	0.11 <sup>a</sup>
Confidence	0.92	10.57	3.10	11.49	2.56	41.02	0.10 <sup>a</sup>

<sup>a</sup> $p < .001$ ; <sup>b</sup> $p < .05$ ; <sup>c</sup> $p < .01$ .

Items measured on a 0–4 Likert scale. Note that subscales have varying numbers of items so scores on different subscales cannot be compared without first dividing the subscale mean by the number of items making up that subscale.

SD, standard deviation.

TABLE 3. PROFESSIONAL ROLE OF PARTICIPANTS PER PROGRAM

Program	Professional role				Total
	Allied health	Doctor	Nurse	Other staff (mainly PCA)	
1 Melbourne	17 (11%)	4 (3%)	115 (73%)	22 (14%)	158 (32%)
2 Colac	8 (9%)	1 (1%)	73 (78%)	12 (13%)	94 (19%)
3 Cranbourne	11 (12%)	2 (2%)	76 (83%)	3 (3%)	92 (19%)
4 Shepparton	8 (5%)	1 (1%)	138 (91%)	4 (3%)	151 (31%)
Total	44 (9%)	8 (2%)	402 (81%)	41 (8%)	495

PCA, personal care attendant.

- A total program evaluation was administered at the end of each program, with open-ended questions to encourage participants to provide comments not captured by the questionnaire. The questionnaire was developed by the project team to provide participants with an opportunity to describe strengths and weaknesses of the program, ongoing learning needs, and identify challenges in implementing change in their workplace.
- A focus group was conducted by one of the research team 1 month after the first program to provide the opportunity for additional qualitative data to be collected in order to consider recommendations for improvement. Questions to guide the discussion were developed by the research team and broadly aimed to explore the organization of the program appropriateness and relevance of the program content to practice, recommendations for improving the program and any concerns or issues as identified by the participants.

**Analysis**

Questionnaire data were entered into SPSS for Windows 14.0 (SPSS, Inc., Chicago, IL) for the purposes of analysis. The participants' pre-/postresponses to the generic questionnaire were analyzed using a repeated measures analyses of variance (MANOVA). Eight subscale scores were calculated for each of the eight key areas measured in the 61-item questionnaire. All eight subscales reported moderate to strong reliabilities (alpha scores were between 0.60 and 0.95) as shown in Table 2.

The participants' responses to three items measuring individual session evaluations on interest, information, and usefulness were analysed using several analyses of variance (ANOVA). To limit inflation of type I errors due to conducting multiple analyses, a more conservative  $\alpha$  limit was set at 0.001.<sup>12</sup>

Qualitative data were entered into an Excel spreadsheet (Microsoft, Inc., Redmond, WA) and underwent a thematic analysis. Data related to program cost to participants, including travel, professional development leave, and management support were entered into an Excel spreadsheet to undergo group analysis.

Focus group discussions were transcribed from the tapes. Data were analyzed using the thematic approach, identifying common themes and entering into an Excel spreadsheet.

**Results**

**Sociodemographic profile**

A total of 537 participants attended the four programs. Each program received maximum registrations, based on venue capacity. In addition, over 100 people registered for a waiting list. Evaluations were not received from 42 participants, therefore, results are based on feedback obtained from 495 participants over the four programs.

Numbers of participants from each discipline represented at each venue are provided in Table 3. The overwhelming majority of attendees were registered nurses and therefore not surprisingly, the majority were also female (96%). The age range of participants was between 20 years and "over 60 years", with the majority between 40-59 years (60%). Sixty-two percent of participants were from regional settings, compared to 24% from metropolitan settings. Fourteen percent of participants declined to identify their care setting. While only 2% of attendees were doctors and 17% allied health, the program was developed and delivered by a multidisciplinary team with the aim of being potentially appropriate for a multidisciplinary audience.

Allied health disciplines represented over the course of the programs included occupational therapy, physiotherapy, complementary therapy, social work, bereavement counseling, case management, speech pathology, welfare worker, pastoral care, PCA, volunteer, support worker, family therapy, diversional therapy, and art therapy. Strongest repre-

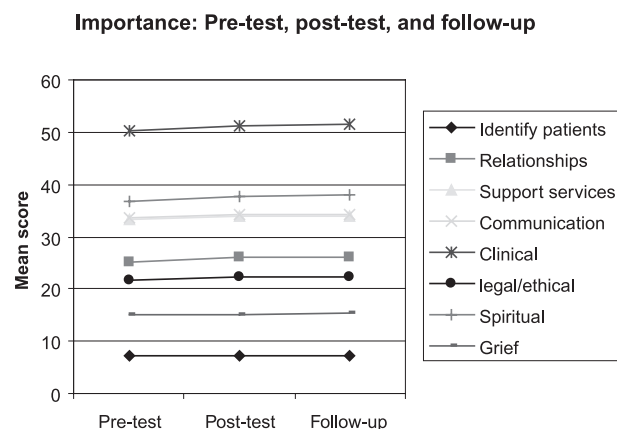


FIG. 1. Means for eight key areas for importance.

sensation was from social workers ( $n = 16$ ) and pastoral care/bereavement workers ( $n = 11$ ).

For the purposes of analysis the allied health participants were grouped together.

**Palliative care “importance,” “knowledge,” and “confidence” preprogram and postprogram**

A repeated MANOVA was performed on a total of 24 variables that included a measure of perceived importance, knowledge, and confidence for each of the eight areas: (1) identifying patients for palliative care, (2) relationships and roles, (3) providing support services, (4) communication skills, (5) clinical management (symptoms and pain management), (6) legal and ethical issues, (7) spiritual and cultural aspects, and (8) grief and bereavement. Two time periods were compared for the 345 participants who completed both preintervention and postintervention measures. The within-group factor was time and there was no between-group factor.

Using Pillai’s criterion, multivariate effects within groups was found for time,  $F(24,341) = 7.45, p < 0.001$ . The results showed moderate associations between time and the combined variables,  $\eta^2 = 0.34$ . Univariate analyses revealed significant difference between time periods on all 24 measures. As shown in Table 2, the intervention had a positive effect on importance, knowledge, and confidence, for all of the eight areas from time 1 to time 2.

The effect of the intervention had a stronger association for knowledge and confidence and weaker association for importance. This pattern was demonstrated across all eight areas. The majority of participants already rated themselves fairly highly on the pretest for importance of factors compared to self-ratings at pretest on knowledge or confidence.

**Follow-up questionnaire one month after program**

Only 84 participants responded to the follow-up questionnaire (response rate = 17%). Due to the poor response rate, the sample size was too small to repeat the analyses to examine for differences on importance, knowledge, and confidence on the eight areas targeted in the palliative care training sessions. However, the means for each of the eight areas for each time period have been graphed for importance,

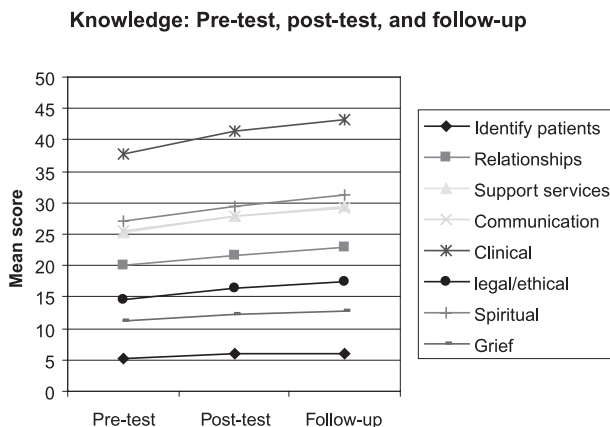


FIG. 2. Means for eight key areas for knowledge.

**Confidence: Pre-test, post-test, and follow-up**

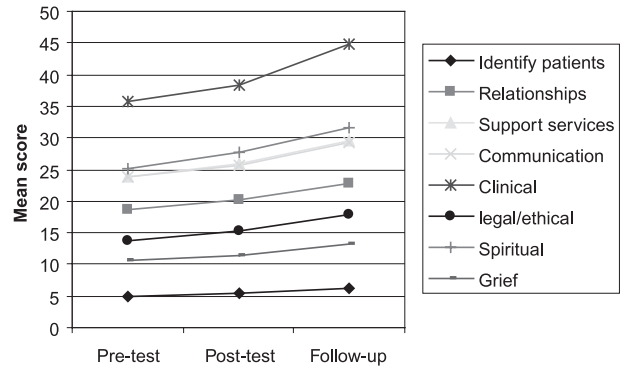


FIG. 3. Means for eight key areas for confidence.

knowledge, and confidence (Figs. 1–3). For most of the key areas, follow-up mean scores for importance, knowledge, and confidence remained stable from post-test mean scores, and in many cases there was a continual increasing trend.

**Individual session evaluation**

Overall, session evaluations were positive with mean scores for individual sessions ranging from 2.36 to 3.56 as shown in Table 4. Session V1 on communication and session VII on nonmalignant disease scored the highest on “interest,” “information,” and “usefulness.”

Several ANOVAs were conducted to examine for differences between groups (allied health, nurses, and PCAs) on scores for interest, information, and usefulness for each session, except the concurrent session. Doctors were excluded from the analyses due to small numbers. In total, 24 ANOVAs were conducted. Due to the high number of analyses, the  $\alpha$  limit was set at 0.001 to reduce type I errors.<sup>12</sup> There were no differences between scores on interest, information, and usefulness for each session between the three disciplines.

In relation to the concurrent sessions, independent  $t$  tests were conducted for the concurrent Session XIb to examine differences on interest, information, and usefulness between allied health professionals and PCAs. Analyses revealed a significant difference between PCAs and allied health professionals on interest,  $t(68) = -4.04, p < 0.001$ , information,  $t(68) = -4.83, p < 0.001$ , and usefulness,  $t(68) = -3.14, p < 0.001$ , for this session. PCAs reported higher levels of interest, information, and usefulness (means = 2.88, 2.85, and 2.76, respectively) for the session than allied health professionals (means = 1.86, 1.50, and 1.92, respectively).

**Qualitative results**

**At completion of Day 2 of the program.** Participants responded that the program strengths included the passionate conviction of the “excellent” speakers, who were regarded as highly motivating and knowledgeable in their field. Several comments were made about the well-balanced coverage of content in the program. The take-home resources were highly valued, as was the time allowed for questions.

Suggestions for program improvement included encouraging more group sharing and participation and consider

TABLE 4. MEAN VALUES FOR INTEREST, INFORMATION, AND USEFULNESS FOR PROGRAM SESSIONS I–IX

<i>Session</i>	<i>Session topic</i>	<i>Interest</i>	<i>New info.</i>	<i>Usefulness</i>
Day 1				
I	Clinical and public health approaches to palliative care	2.71	2.62	2.36
II	Decision making in palliative care: ethical and legal challenges	2.98	2.71	2.77
III	Assessing and responding to spiritual and cultural issues	2.76	2.62	2.77
IV	Family-centered care	<b>3.13</b>	2.91	<b>3.05</b>
V	Grief, loss and, bereavement	2.96	2.84	2.83
Day 2				
VI	Communicating with patients, families and colleagues	<b>3.56</b>	<b>3.35</b>	<b>3.46</b>
VII	Palliative care and nonmalignant disease	<b>3.45</b>	<b>3.32</b>	<b>3.35</b>
VIIIa	Concurrent session (nurses/doctors)—FAQs regarding symptoms	2.98	2.88	2.91
VIIIb	Concurrent session (allied health/PCAs) “Multidisciplinary Team—Does it Work?”	2.36	2.16	2.33
IX	Care of an imminently dying person and their family Panel discussion (no evaluation)	2.87	2.73	2.80

Note: Scores range from 0 (low)–4 (high). The bold figures indicate high participant responses. PCAs, personal care attendants.

ways of maintaining interest despite participant fatigue toward the end of each day.

**Focus group results.** A focus group with eight participants was conducted by one of the research team members, one month after the first program. Participants strongly recommended the program to colleagues and found it very applicable to their practice. Two participants described their motivation and confidence to make some practice changes in their workplace. Based on the positive feedback from program one, with no recommendations for improving the program delivery or content, no further focus groups were conducted.

### Discussion and Recommendations

Findings from the study indicate that the program increased levels of interest, knowledge, and confidence in relation to palliative care. The overwhelming majority of participants found the program to be of benefit to their practice, and empowered them to consider making changes in their care settings. Program evaluation results suggest that the majority of content remains core to a multidisciplinary audience with participants reporting the relevance and applicability to their practice. However, the low numbers of doctors and allied health professionals limits generalisability of results to those disciplines.

The sessions on communication skills and nonmalignant disease were rated by the participants as providing the greatest overall benefit with regard to interest, new information, and usefulness, which reflect the current focus of contemporary palliative care practice on those areas. Increasingly, advanced communication skills are viewed as essential to

providing optimal care for both the patient and their family.<sup>13</sup> Recent palliative care diagnoses statistics have demonstrated that referrals for non malignant disease are increasing, which is reflected in the demand from health professionals to gain knowledge related to this area, demonstrated by the strong demand for participation in the program.

PCAs did not benefit as significantly from attending the program as did the other participants; this may be reflective of PCA-specific needs not being met within the program content. However, given the number of enquiries received from PCA, it may be timely to consider developing a palliative care education program exclusively for them that addresses some of their identified needs. Allied health team members and PCA who attended Session B (exploring the role of a multidisciplinary team approach in palliative care and its application in practice) verbally and informally expressed some frustration at being excluded from the symptom session (Session A). Therefore, a recommendation for future programs is that participants be encouraged to select the session they consider to be most valuable, rather than being selected based on their discipline.

Given the attendance by a large number of palliative care health professionals, it would appear there is a need for ongoing education specifically targeting palliative care health professionals. Regional palliative care participants particularly welcomed the opportunity to attend education within their own region, as attested to by the very strong registrations for the two regional programs.

In recognition of the national shortage<sup>4</sup> of a skilled palliative care workforce, there is an urgent need to consider opportunities to develop a variety of innovative education programs that meet the needs of health professionals from

a range of care settings. Education programs similar to the one outlined has potential to influence practice confidence and satisfaction, while also serving as a potential recruitment tool to palliative care by promoting interest in participants not currently working in the field. It is recommended that future programs seek formal accreditation with each of the individual clinical disciplines' governing bodies, and also explore the option of recognition with university programs and linking with specific postgraduate programs.

The reality is that palliative care is predominantly delivered outside specialist palliative care inpatient services, with general practitioners primarily responsible for providing care. However, the low numbers of doctors who attended the program suggests promotion of the program could be improved, or perhaps the delivery may need modification to entice more doctors to attend. For example, 2 to 4 hours per week over several weeks may appeal, while a 1-week intensive program may better suit participants, particularly those from regional and rural areas. It may also be valuable to consider incorporating a period of clinical placement if support from appropriate sites can be arranged.

### Limitations

Despite the intent of the program to be multidisciplinary, there was, as expected, dominance by nursing, which is the largest component of the palliative care workforce. The project was funded, with only a small charge made for participants to attend. It is therefore difficult to predict whether participants would have been as willing to attend if the program cost was substantially higher. Another limitation is that the evaluation instruments were not validated prior to the program, although they showed good reliability. The response rate for the follow-up questionnaire was poor, prompting caution in making any comment regarding longer term benefit or otherwise from attending the program. Consideration could be given to exploring longer term benefit to participants, particularly in terms of impact on practice change within work settings. Ideally, a period of clinical experience would complement the program, but may be challenging to achieve in practical terms.

### Conclusion

The aim of the project was to develop, deliver, and evaluate a 2-day multidisciplinary palliative care education program, appropriate for generalist health professionals working in a variety of settings. The program content focused on providing participants with an introduction to palliative care principles and practice, identifying that the approach to care is holistic and multidisciplinary. In total, 537 participants (495 completed evaluations) attended the program in two regional and two metropolitan Victoria, Australia, sites. Although the overwhelming majority of participants were nurses, many other disciplines were also represented. Palliative care health professionals embraced the opportunity to attend the program, despite the target audience being generalist health professionals, which may suggest there is an urgent need to develop short courses specific to the specialty of palliative care as well as for generalist health professionals.

Evaluation of the program demonstrates the program was very well received, met the needs of, and improved the importance, knowledge, and confidence of palliative care for the large majority of participants, and had some impact on their practice. All sessions were rated by the participants as complementing their interest, new information, and confidence in each area, with communication skills and nonmalignant disease attracting the strongest improvement. Overwhelmingly, the participants supported the opportunity for programs such as "Palliative Care: The Essentials" be made available on an ongoing basis.

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### Author Disclosure Statement

No competing financial interests exist.

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