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Palliative care teaching for undergraduates: challenges and routes pointed by medical students and teachers

Ensino de cuidados paliativos na graduação: desafios e caminhos apontados por estudantes e docentes médicos

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ABSTRACT

Introduction: This study examined the challenges and factors that facilitate the integration of palliative care (PC) education into the medical curriculum of a public institution, emphasizing its significance for a humanized training aligned with current demands.

Objective: To identify challenges and contributing factors for including PC in medical education.

Methods: Descriptive and exploratory study with a quantitative-qualitative strategy.

Results: Data were grouped into three categories: 1) perception of professors of teaching and challenges, 2) strategies for structuring PC education, and 3) suggested pathways for improvement. Although PC is essential for humanizing medical practice, it faces limited actions and cultural barriers. Challenges include training in delivering difficult news and overcoming the model focused on therapeutic obstinacy. Pain management, family-centered care, and spirituality were prioritized.

Conclusion: The study highlighted the urgent need for curriculum changes to integrate PC, aligning with the National Curriculum Guidelines and improving medical and institutional training.

Keywords: Palliative Care; Medical Education; Undergraduate Studies.

RESUMO

Introdução: *Este artigo analisa os desafios e fatores que favorecem a integração do ensino de cuidados paliativos (CP) no currículo médico de uma instituição pública, destacando sua importância para uma formação humanizada e alinhada às demandas atuais.*

Objetivo: *Este estudo teve como objetivo identificar os desafios e fatores que contribuem para incluir CP na educação médica.*

Método: *Trata-se de um estudo descritivo e exploratório com abordagem qualiquantitativa.*

Resultado: *Os dados foram agrupados em três categorias: 1. percepção dos docentes sobre ensino e desafios, 2. estratégias para estruturar o ensino de CP e 3. caminhos sugeridos. Embora o ensino de CP seja essencial para humanizar a prática médica, enfrenta ações limitadas e barreiras culturais. Entre os desafios, estão a capacitação em comunicação de notícias difíceis e a superação do modelo focado na obstinação terapêutica. Manejo da dor, abordagem familiar e espiritualidade foram priorizados.*

Conclusão: *O estudo destaca a necessidade urgente de mudanças curriculares para integrar o ensino de CP, de modo a alinhar-se às Diretrizes Curriculares Nacionais e melhorar a formação médica e institucional.*

Palavras-chave: *Cuidado Paliativo; Educação Médica; Graduação.*

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INTRODUCTION

The aging population and increased life expectancy, combined with the growth of chronic diseases, significantly impact the healthcare network. However, palliative care (PC) education is not sufficiently addressed in the training of healthcare professionals and research in the medical field[1].

Currently, Brazil has about 32 million people aged 60 or older, a 56.0% increase since 2010, reflecting the inversion of the population pyramid and the increase in life expectancy[2]. In parallel, more than 700,000 new cancer cases are expected annually by 2025[3]. This situation, coupled with the growing prevalence of chronic diseases and their complications, has intensified the demand for continuous care[4]. Despite this scenario, the increased life expectancy is directly related to technological advances in health, which improve diagnosis and treatment and delay complications associated with these diseases.

The PC is fundamental in an interdisciplinary context for improving the quality of life for families and patients facing debilitating and potentially fatal diseases, whether acute or chronic, with or without possible reversal or curative treatment. The PC is based on values and guidelines, offering active and comprehensive care to the patient and their family, respecting the right to dignified assistance[5].

In the 2000s, around 662,068 people in Brazil required PC. Projections suggest that this number may double by 2040, accompanying a population growth of 31.0%, which highlights the growing demand for this care. However, PC availability in the country is limited. Only 234 services are available, with 52.6% belonging to the Brazilian Unified Health System, concentrated mainly in the Southeast region[7].

The absence of education in PC during medical training must be highlighted; less than half of the services offer activities for undergraduate students[7]. Furthermore, only 14.0% of Brazilian universities included PC education in their medicine curriculum[1], which reinforces the necessity to expand education on the topic.

Although PC education is essential for clinical practice, this topic is not adequately addressed in medical schools. Promoting a more solid integration between academic teaching and care reality is crucial to keep medical training aligned with Brazilian social demands. In 2022, the Ministry of Education recommended including the topic in the curriculum, aligning training with societal needs[8]. In 2024, a significant milestone was the creation of the National Palliative Care Policy within the Brazilian Unified Health System, resulting from the work of the Palliative Care Front for Brazil. This civil society initiative aims to facilitate access to essential medicines and supplies for patients under PC[8].

This study represents a joint effort between professors and students to investigate the challenges and factors that facilitate the inclusion of PC in the medical curriculum of a public teaching institution and to indicate pathways for its integration.

METHODS

This descriptive and exploratory study employed a quantitative-qualitative method suitable for the investigation of PC, which involves subjective and relational themes that are not quantifiable, such as death and human finitude. The qualitative approach enables an understanding of the dimensions of the educational process in the context of diseases, as it deals with subjective aspects of social reality[9].

First, the curriculum matrix of the academic unit was analyzed to identify PC-related competencies in the undergraduate medicine syllabi, enabling an analysis of the current scenario of PC education and contributing to the subsequent stages of the study. Additionally, studies published within the last five years were consulted using descriptors, such as "medical education", "palliative care", "bioethics", and "humanities", to support the development of the questionnaires.

Next, an online survey was conducted among students using Google Forms to verify whether they had prior contact with PC and how they believed this topic should be taught. Participation was voluntary, with the questionnaire disseminated via a message app and in physical spaces at the university. A total of 192 students participated, distributed across 1st to 6th year, corresponding to 30% of the student body. The responses of participants who had no previous academic contact with PC were included because their life experiences as students and involvement in care legitimize perceptions about PC-related topics. The compiled data was analyzed using descriptive statistics, considering the relative frequencies of responses to each question, to obtain a quantitative overview of student perceptions on the topic. The findings were discussed according to the institutional context of the study and compared with the current literature.

The findings from the first stage conducted with the students were essential for the continuation of the study, as they indicated which disciplines were considered most relevant for the insertion of PC education. The collected data established the 10 disciplines that were most likely to integrate PC themes into their curricula, with one professor from each discipline included in the next stage of the study.

Then, invitations were sent to the discipline coordination, and the departments indicated the professors responsible for answering the survey. Thus, an interview was developed to assess the background of professors, their perception of how and when PC education should

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be inserted, and themes that should be addressed. The interviews recorded were transcribed verbatim and discussed by the authors. Three categories were developed to analyze the interviews of professors: 1) the perception of professors concerning PC, 2) the pedagogical structure of PC education, and 3) pathways for integrating PC into the undergraduate medical curriculum. After categorizing the interviews, the core themes were identified within each category for analysis. These themes included "challenges of contact with PC" (category 1), "what should be taught in PC" (category 2), and "changes in institutional culture" (category 3). Last, the statements and their meanings were related to the institutional context and recent literature.

The study was conducted in accordance with the research ethics committee (CAAE: 1 84886018.7.0000.5259), and participants signed the informed consent form. The authors are academics and professors from the institution.

RESULTS AND DISCUSSION

The first phase of the study involved 192 students whose profiles are presented in Table 1.

Graph 1 shows the distribution of students according to prior contact with PC. Those with previous exposure reported multiple types of contact, including primarily lectures (50.5%), mandatory undergraduate courses (34.3%), participation in the academic league of PC (26.7%), and elective PC courses (15.2%). Other contacts (17.1%) included practical internships in Internal Medicine and Medical Emergencies, extracurricular internships, and teacher-recommended readings.

Graph 2 presents the disciplines identified by students with the most potential for integrating PC education, which highlights the possibility of incorporating PC throughout the curriculum and indicates pathways for its implementation.

In the second stage, an in-depth analysis was conducted on the perspectives of coordinator professors from the disciplines that were most likely to integrate the PC education, and the proposed methods for their integration. Based on the analysis, the results were categorized into three main groups, discussed below.

Perception of professors and challenges regarding PC education in undergraduate medical programs

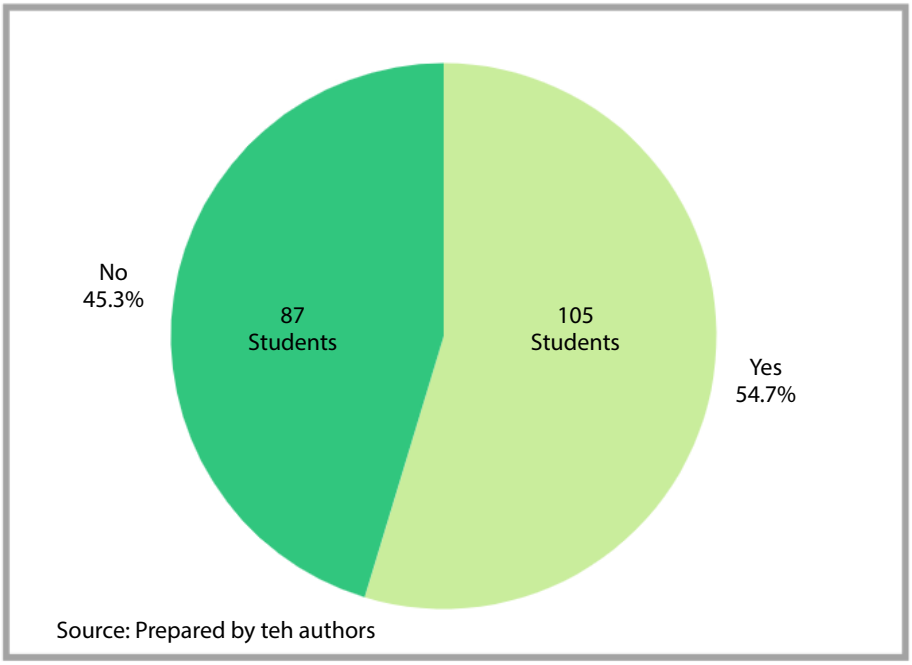
The professors highlighted cultural and demographic factors driving the need for PC, acknowledging population aging and the rise of chronic diseases. Despite aligning with

Table 1. Distribution of research participant students by academic year.

Academic Year	Quantity (%)
1st Year	41 (21.3%)
2nd Year	28 (14.5%)
3rd Year	30 (15.6%)
4th Year	28 (14.5%)
5th Year	27 (14.0%)
6th Year	38 (19.7%)
Total	192 (100.0%)

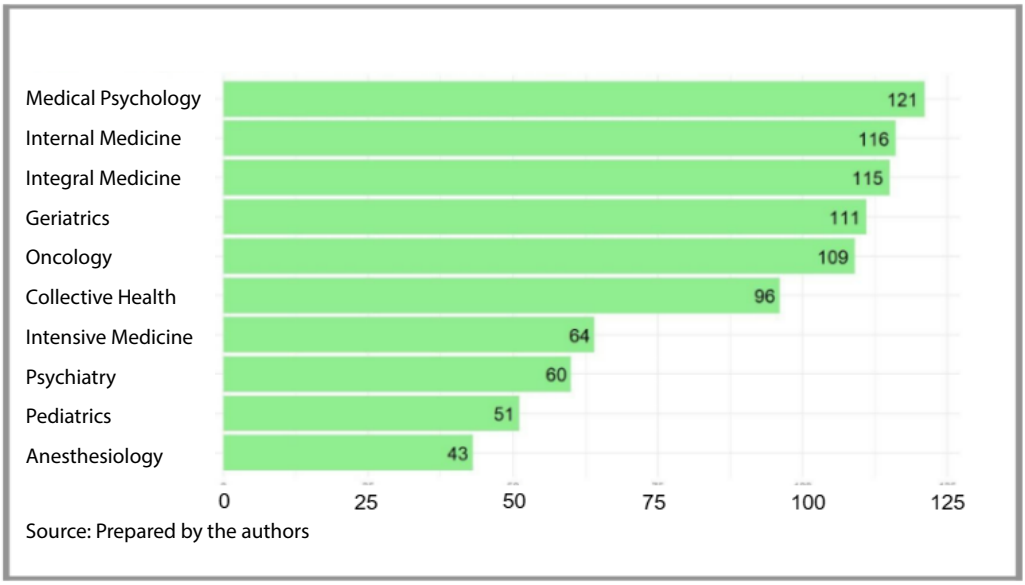
Source: Prepared by the authors.

Graph 1. Number of participating students who had contact with PC.



Source: Prepared by teh authors

Graph 2. Disciplines indicated by students as potential for the insertion of PC education.



Source: Prepared by the authors

national literature, current PC initiatives remain scarce and insufficient to meet the demand. Expanding PC using changes in health policies and medical training is urgently needed[10], a view corroborated by one interviewee:

> *"There's another issue, which is PC not being limited to just oncological patients. Longevity has increased in recent decades, and that's not being considered much. Now, when it comes to a terminal stage, where PC is fundamental [...], it's still very bad" (E10).*

The interviews evidenced the perception that PC is not limited to end-of-life care, and should include early interventions as soon as a life-limiting illness is diagnosed. The PC aims to enhance the quality of life for patients and their families when facing life-threatening diseases, emphasizing early initiation alongside treatment[11]. However, the interviews revealed that this modern concept of PC has not yet been assimilated into the care culture, highlighting the need for changes in this understanding and the practice of care.

> *"We need to intervene early, not wait until the end of life. So, with that in mind, I think there's a huge field of work here, and to be honest, I think that perspective is really missing" (E7).*

Another professor recognized that although PC extends beyond oncological, it is still mostly linked to this condition, justifying the need for transversal teaching of PC-related topics:

> *"To have more interdisciplinarity. To be addressed throughout the course, in everything. Because we think a lot about Oncology when we talk about palliative care, but there are other pathologies where the patient won't have the possibility of a cure and will reach a point where they'll need this treatment" (E4).*

The benefits and contributions of PC education to improve medical practice have already been recognized. However, this understanding is not effectively disclosed among healthcare professionals, perpetuating the traditional idea that PC is exclusive to terminal patients. The PC possesses competencies across diverse clinical areas, with its knowledge being essential for a more ethical and humanized medical practice[12]. This view can be observed below:

> *"Knowledge in PC is fundamental and indispensable for good medical practice; however, it's not the reality, and this greatly harms medical conduct regarding patient reception" (E3)*

The prevalence of chronic diseases in the pediatric age group has increased in recent years, which highlights the growing need for PC in this population[13] and aligns with the view of professors:

> *"Pediatrics is very distant, because when we think of PC, we think of sick adults dying or the older. Nobody thinks about children. And children die too; they need to have a dignified end of life" (E7).*

Thus, disseminating an expanded PC concept is crucial for changing paradigms, increasing PC availability, and enhancing generalist education. The inclusion of PC education in the curriculum has gained significant traction in recent medical education debates and was further encouraged by the National Curriculum Guidelines[14] recommendations. In this context, the mandatory PC education and its contact and influence on the training of professors were discussed as hindering factors, as reported by the interviewees.

> *"[...] most people, when they have a difficulty [...], like this thing about finitude, you avoid the subject because you don't know how to deal with it. So, if you don't know how to deal with it, how are you going to teach? [...] So it's easier to run away" (E9).*

A consensus exists on the need for PC education in undergraduate medical programs and how its deficiency manifests in practice and teaching, leading to topic avoidance and a lack of preparedness. The lack of specific training fosters negative professional attitudes, such as withholding support from patients and families or managing real-life situations. This approach hinders care and results in medical practice lacking humanism, which impacts medical education as students emulate the attitudes of the professors[15].

Professors consider the PC education important for medical training, linking it to modernization and humanization of medicine. They also acknowledge the need to make this education mandatory, a view corroborated by most students (63.1%) who believe PC should be a required discipline.

> *"I think it's super necessary (mandatory education). Medical students increasingly need to have a more humanistic education. And I think PC really provides that focus [...]. We need to modernize [...]" (E10).*

The topic of finitude and the dying and death process was addressed from the perspectives of the complexity of physicians in dealing with terminality and the difficulty of the professor in addressing this topic with students, as pointed out by the interviewed professor:

> *"Absolutely! A lot of difficulty [...] I had students who came through my classes during graduation, from cohorts before the pandemic, [...] they would call me desperate, crying to talk about it (death and grief), because they lost a patient. So, I think that's something that's really missing" (E9).*

When questioned about their feelings toward death, only 51 (32.2%) of the professors reported comfort, while the remainder expressed fear, insecurity, sadness, anxiety, unpreparedness, and frustration. In this context, negative personal attitudes about death and dying may influence the capacity of students to care for people at the end of life[16]. This result reinforces that education on finitude effectively prepares students to manage patient terminality. Interviews with other professors revealed similar concerns:

> *"I think the biggest limitation is with those who teach [...] The entire medical school, you're taught to be obsessed with saving lives" (E2).*

A significant gap in medical training is the insufficient discussion of death and finitude as an expected life process. This gap hampers students, who are taught to approach disease mechanically, from distinguishing between curable and incurable conditions[17]. Consequently, the absence of PC education in medical training perpetuates a cycle: physicians, apprehensive about addressing death and dying, lack the resources to discuss this topic with their students, who are similarly unprepared to manage human terminality.

Regarding challenges in PC education, a concern about student preparedness for communication stood out, especially regarding difficult news, which necessitates specific instruction, as evidenced below:

> *"Students don't have this preparation (to communicate bad news), and I believe they need theoretical understanding before engaging with families" (E3).*

Communicating difficult news is an indispensable skill in medical practice, yet it remains insufficiently addressed in undergraduate education. This difficulty causes hesitation in delivering bad news and promotes iatrogenic practices, potentially aggravating family grief during vulnerable times. Furthermore, professors and students emphasized inadequate preparedness, which hinders training and practice. Unpreparedness leads to less empathetic and efficient care, diminishing understanding of the emotional needs of patients and impairing their healthcare experience[18].

Another significant challenge involves the cultural aspects of clinical practice. Taboos and myths surrounding death and dying were identified as a major hindering factor for educational integration, as highlighted by an interviewee:

> *"Our society doesn't work on this at home; we're not prepared to talk about death in everyday life, about the end of life. So, for me, it would be strange if someone came to college dealing with this super well [...]" (E8).*

Traditional biomedical medicine focuses on curative approaches, struggling to manage patients whose therapy has not changed the disease course or yielded satisfactory responses. It often fails to consider therapeutic proportionality in individual patient care, a model that significantly influences student learning in practice. Cultural change was identified as a critical challenge for integrating PC education:

> *"The hospital culture has to change. The culture, especially the internal medicine part of the hospital, must change. Until that changes, you can put (the PC discipline) wherever you want in the undergraduate program, and he (the student) will hear one thing and see another in practice. What you learn is what you're seeing in practice" (E2).*

Therefore, the culture of strictly curative medicine in the practical training of students hinders the implementation

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of a care-based approach. This prevalent culture is associated with PC being a more contemporary field, posing a challenge for physicians trained in the biomedical model, who lack preparation and experience in this area to manage PC cases[17].

How to structure: what cannot be missed in CP teaching

The topics referenced by professors for inclusion in PC education encompass a family approach, spirituality, multidisciplinary teamwork, and pain and symptom management.

The professors recognize the importance of physicians possessing resources to support family members and for students to acquire this knowledge. Managing death is vital, requiring engagement with the family who seek explanations about the condition of the patient and suffering[19]. Students must learn to support family members and caregivers, understand and manage any conflicts that arise during the health-disease process, and actively inquire about the physical and psychosocial well-being of the caregiver, extending this support to the initial stages of grief[20]. The following statement illustrates this view:

> *"Because there are those questions, we have to ask ourselves, the patient, the family. How far do we go? How much will I intervene? But that's a decision that can't be made solely by the physicians. [...] It must be collegiately with the family. And for that, you need prepared people" (E9).*

The spiritual approach (understood beyond religiosity) is a fundamental principle for mastering communication skills, gaining relevance in alleviating suffering, and appropriately managing the dying and grief processes[12]. The perception of professors below aligns with the principles identified, which emphasize spiritual care as paramount for patients, confronting profound existential questions arising from life-limiting or life-threatening diseases:

> *"To understand palliation, it's important to understand the issue of spirituality. The person [...] must understand why they reached that point, understand the family context with the view of religion. Anyway, the suggestion I leave is to also consider the insertion of spirituality along with palliation" (E7).*

With adequate training, physicians must develop competencies for multidisciplinary teamwork, enabling the identification of responsibilities and skills of each member and the coordination of patient care across different clinical settings. This training is especially relevant in spiritual care, which should be provided by all team members[19,21]. Additionally, professors support the training of students capable of interdisciplinary work, as emphasized by one of the interviewees:

> *"I think PC, obviously, is multidisciplinary; it's no use for only physicians to have palliative training, otherwise we can't implement PC" (E5).*

Pain and other symptom management, utilizing relief and comfort measures, constitute mandatory competencies that must be acquired during medical training. Comfort is understood as paramount to the quality of life of the patient and family[12], an idea corroborated by the professors.

Regarding the structure of education, professors discussed how and when to incorporate PC. The professors mentioned formats, such as mandatory disciplines, integration into other disciplines (modules and outreach activities), and methodologies for teaching PC:

> *"So, I think maybe it would be a separate, individualized discipline, for the student to value it more, because sometimes, in the module format, the student is interested in the more technical part, [...] and palliative care, nobody studies [...]. So, diluting this theme might not be the best situation" (E10).*

The creation of a mandatory PC discipline was advocated. Thus, the students can study it individually, without diluting it in other disciplines. However, other professors emphasized integration as the best approach:

> *"I think it's a theme that permeates the axis of Collective Health, Integral Medicine, Family Medicine, Internal Medicine. [...] PC needs to be inserted into several disciplines for the student to gradually learn" (E4).*

According to Pieters *et al*. (2020) and Heath *et al*. (2022), the most effective way to teach PC education is by integrating it with other disciplines in the curriculum. Most physicians, regardless of their specialty, care for patients nearing the end of their lives. Therefore, many disciplines share the same learning objectives as PC education, which extend throughout the entire medical curriculum[10,16]. Another professor advocates that initially, integrating PC into other disciplines is advantageous to establish it as a standalone discipline later:

> *"I also wonder if it's not worth inserting it into several disciplines because I think each discipline has a different view. For example: pediatrics is a different world from oncology, so perhaps having a class on it in pediatrics could be a way to insert it into the curriculum, [...] start inserting a topic into each discipline so that in the long term it changes into a real discipline, to only talk about that" (E7).*

Regarding the best time for integration into undergraduate studies, responses of professors varied from the 4th year, during an internship, or throughout the six years of the medical program. Many statements evidenced the importance of addressing PC at various periods of

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undergraduate education in a transversal manner throughout the curriculum. The main determining factors for these positions proved to be the maturity of students, the beginning of contact with patients, and the theoretical foundation already acquired by the student:

> *"In the clinical cycle and during internship, for the student to mature both personally and in terms of health content" (E5).*

In New Zealand medical schools, PC is integrated vertically into the curriculum from the 2nd year of undergraduate studies[16], contrary to the opinion of most professors, who advocated for the insertion of PC only after the 3rd year.

Pathways identified by professors for the integration of PC education into medical training:

Professors highlighted pathways to strengthen PC in undergraduate medical education, addressing collaborations with university hospital service teams, external communities, and the students, with a focus on changing institutional culture. To engage with students and the external community, one professor reinforced the role of outreach activities and academic PC leagues:

> *"[...] perhaps a part of palliation shouldn't just be teaching physicians, but to have effective outreach activities. For family members, I think that's very, very important. [...], but the (PC) League itself can work by providing guidance to families who potentially have elderly individuals, or an oncology patient, and undoubtedly, I think there's even a more organized structure already" (E10).*

Academic PC leagues are valuable options when dedicated curriculum space is currently unavailable[19]. Students learn to comfort and reduce pain, recognizing that a cure is sometimes achievable[19]. These leagues facilitate the connection between professors and PC educational policies[19]. In the medical school where this research was conducted, the league is essential for uniting professors, students, and university hospital professionals in support of PC.

Changing the culture of medical education and practice is urgent. Other dimensions of care must be valued, as a purely pragmatic physician approach, lacking humanistic competencies, distorts medical practice[19]. Physicians must define their role when the technique aligns with other dimensions of their training and clinical practice[19]. The professors interviewed also emphasized the need to overcome the technocratic and curative view of medicine, fostering approaches focused on humanistic care and alleviating suffering:

> *"There's still a strong focus on curative measures, and it takes a while for it to click that they could already be doing something in parallel with palliative care. Another worrying issue is that often, because we rely so much on medicalization, on always wanting to investigate, we end up advancing medical iatrogenesis. And we must prevent that" (E4).*

Another aspect highlighted is the need for cultural change among professionals working in the university hospital who are directly responsible for teaching students and who form models that students emulate:

> *"It's no use talking to the student, and then they have someone in the ward or during internship who is completely different. So, we would have to train these preceptors a bit" (E10).*

Preceptors are professional models for students. From the perspective of students, the action of preceptors in situations involving communication with patients and families, family conflicts, and symptom management is important to teach PC competencies[22]. This modeling role highlights the importance of transforming the culture of medical education in classrooms and clinical settings. The role of the league in promoting the structuring and cultural transition within the medical school aligns with the statements of the professor:

> *"I think it still needs to be structured a bit more. Organized. [...] I think there needs to be a structured flow for everyone, like 'oh, a palliative patient appeared in my ward, how do we handle this again?' [...] it needs to be structured" (E9).*

Last, another pathway pointed out by professors includes the creation of Medical Residency programs in PC:

> *"[...] In 2015, a project was made to open a residency for this (PC). At that time, the hospital was in crisis. [...] The hospital today has a new economic reality. It will be a PC residency, led by family medicine. [...] We will be the precursors, that's how much importance we give to this. This is something that is really missing. I think it will be very cool" (E9).*

Thus, the identified pathways suggest the possibility of integrating education into internal and external communities, focusing on cultural change, especially within the undergraduate environment, but not limited to it, potentially expanding to specialization programs. Academic leagues and outreach projects proved to be important instruments for promoting this cultural change within the external community and institutions, being fundamental for structuring PC education.

CONCLUSION

The research revealed a concerning gap in medical training regarding the approach to PC. Despite its recognized relevance, acknowledged by most students as essential for pain and symptom management, many reported no exposure to PC during the graduation. The disparity between perceived importance and actual integration highlights the urgent need for curriculum reforms.

Results indicated a demand from students and professors for greater PC inclusion, especially in clinical disciplines, such as Internal Medicine and Geriatrics. Both populations of the present study expressed insecurity in addressing PC demands, particularly concerning dying and death processes. Furthermore, the PC perception of participants often limits it to end-of-life care and oncology patients. Previous studies corroborate this training insufficiency.

Given these findings, the study emphasized the urgency of curriculum reforms and developing teaching strategies to equip future physicians with skills for dignified and humanized care. The results of the present study, conducted with strict ethical and methodological rigor, contribute to the debate on the inclusion of PC in medical curricula. Future studies incorporating the perceptions of professors may offer new insights for implementing these changes.

AUTHOR CONTRIBUTIONS

AAC - Contributed to the preparation and review of the manuscript, responsibility, integrity of the research aspects, and approval of the final version of the manuscript for publication;

LROC - Contributed to the preparation and review of the manuscript, significantly participated in the study design, data collection, and data analysis/interpretation;

MRMAFSA - Participated in data collection and data analysis/interpretation;

SHM - Contributed to the preparation and review of the manuscript, significantly participated in the study design, data collection, and data analysis/interpretation;

KMR - Contributed to the preparation and review of the manuscript, significantly participated in the study design, data collection, and data analysis/interpretation;

TAS - Participated in data collection or data analysis/interpretation;

CONFLICT OF INTERESTS

We declare no conflict of interest.

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DATA AVAILABILITY STATEMENT

Research data is not available.

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