

University of Klagenfurt/IFF Vienna, Austria were invited to participate in a group discussion. They were asked which changes they experienced in connection to their masters degree in Palliative Care. A secretary took notes during the interview. Based on the notes categories were established by the two authors. Methods used were qualitative description and qualitative content analysis.

Results: The qualification which the participants gain during their studies led both to changes in the professional and private surroundings. Participants described the following changes as results of the masters degree in Palliative Care: change of workplace; better career opportunities at their workplace; increased salary; offers to work as lecturer; teamwork and networking becomes central; use of more time to reflect on professional and private themes; a broader view („a kind of multiperspectivity“); organisational structures and routines are questioned; increased self-confidence (both in private and professional life); better reputation, a better ability to assert oneself and increased public authority.

Conclusion: The graduation in Palliative Care leads to both private and professional changes. Changes include increased career options and authority, but possible conflicts in the workplace too. The participants have an increased will to multidisciplinary / interprofessional cooperation, team-working, networking and reflect more. An ongoing study shall investigate the experiences of a higher number of graduates from universities with master degrees in Palliative Care using a questionnaire.

The results have been presented as a poster presentation in German on the 8th congress of the German Association for Palliative Medicine (DGP) 2010.

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Abstract type: Poster

Dying, Death and the Newly Qualified Doctor

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Background: Dying and death form an integral part of the hospital experience, yet newly qualified doctors are frequently poorly prepared to deal with this particular patient cohort.

Objectives: To ascertain from the prospective of a newly qualified doctor, almost one year post qualification from an Irish medical school; if they felt that undergraduate training had prepared them for managing a dying patient, what training they had received since qualification to manage death and dying, their own individual experience of managing a dying patient and their perception of whether their competence had ameliorated since qualification after working in a hospital setting.

Method: Thirty doctors, all eleven months post qualification, working in a tertiary referral centre, were asked to complete a questionnaire, comprising twenty-four questions exploring the doctor's self-perceived competence and experiences regarding death and dying.

Results: Eighteen questionnaires were returned. All respondents felt ill-prepared on qualification to manage dying patients, describing it as 'awful', 'scary' with only half of the respondents, a year later, feeling competent. Ten had had to diagnose dying themselves with many finding their first experience a traumatic event. The Palliative Care Team and senior medical colleagues offered support, with all respondents requesting more undergraduate training.

Conclusion: Newly qualified doctors feel wholly unprepared to manage death and dying, due to a lack of training at both undergraduate and postgraduate level. Both patient and doctor suffer from this lack of training, reinforcing for the newly qualified doctor that death is seen as a medical failure, as opposed to recognising it as part of the normal process. It is imperative that adequate training be instigated both for undergraduates and newly qualified doctors to better equip them to manage this vulnerable patient group.

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Development and Configuration of the Training Offer in Palliative Care in Portugal

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The concept of palliative care has been changing over the years along with the increase in chronic and terminal illnesses and scientific developments. In 1990 the WHO emphasized the extent of this type of curative care and in 2002 they redefined the concept envisaging it as an approach that improves the quality of life of patients and families facing problems associated with diseases that are life threatening, by preventing, relieving any kind of suffer and by early identification, assessment and rigorous treatment of pain and other symptoms, integrating psychosocial and spiritual support. Being a special area with regard to medical procedures, nursing care and other specific training is required.

This communication aims to analyze the development and configuration of the training offer in palliative care in Portugal. We opted for a qualitative and quantitative methodology. We privileged the literature search, website consultation and phone contacts with entities that offer training in this area as well as interviews with key informants. We built a database with the following variables: year of the beginning of training, organization, training theme, target audience, type of training, characteristics of training, the sector develops, duration and location.

The training offer includes brief preparation in the workplace and especially in palliative care units. In recent years the training was part of the university context with post-graduate and master's degrees. The training is integrated into public and private higher education but with some specificity.

We conclude that this is a very important and growing area due to the paradigm shift of health/illness and societal transformations. The technology and scientific advances in health and investment in public policies (social and health) have allowed the training in this area to be ever more intense and specialized and improve the quality of care.

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Therapeutic Pact: Does the Education in Palliative Care Improve the Knowledge about Strategies to Improve That?

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Aim:

- To analyse if the education in palliative care improves the knowledge about the strategies to promote the therapeutic pact
- To identify factors that may influence the knowledge about the strategies to promote the therapeutic pact.

Methods:

- We developed one list with 8 strategies and we asked the subjects to choose which the strategies they thought should be necessary
- We created 2 groups of subjects: one with 27 students of the Master Course in Palliative Care (group 1) to study the evolution the answers during the course and other group with 26 students of others Masters Courses (group 2) to compare the answers
- In the group 1 we asked in the begin (T1) of the course, at the final of the classes about Principles and Philosophy of Palliative Care (T2) and at the end of the course (T3)
- We analyse if the gender, the profession and the work in palliative care affected the answers.

Results:

- In the three times of the group 1, and in the group 2, only one strategy ("not be compliant") wasn't chosen for the majority of the subjects
- The group 1 increased the number of strategies chose during the course with differences between T1 and T2. (p< 0.05)
- The group 1 chose more strategies (6.6±1.3) than the group 2 (5.5±1.7)
- Joining the two groups we only found differences between physicians (7.5±1) and the nurses (5.7±1,5)[p< 0.05].

Conclusions:

- The specialized education in palliative care seems to improve the knowledge about the strategies to promote the therapeutic pact
- In this study the physicians knew more strategies to promote the therapeutic pact.

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Golden Opportunity: Educating the End of Life Workforce across a Whole Hospital

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Background: Within the local acute trust where the Liverpool Care Pathway for the Dying had been part of the culture for 9 years, a programme of end of life education already included Advanced Communication Skills for all ward managers as well as all Cancer MDT members, the 6 day palliative care education programme for all band 6 and above ward nurses, a 2 day HCA course, and various other teaching. The hospital had a Rapid End of Life Transfer pilot project, an accompanied transfer home provided by hospice at home, developing recording of preferred place of care and Advance Care Planning was already being introduced.

However the hospital has been the missing link in the Gold Standards Framework. Because the acute environment has had no understanding of the Framework rolled out in Primary Care 10 years ago, then the vocabulary of GSF is unfamiliar to hospital staff. Consequently patients recognised to be on the GSF register in primary care are unrecognised when they cross the hospital doorway.

Aims: To introduce the concept of GSF to hospital staff, to continue the GSF pathway into and out of the hospital, to reduce inappropriate hospitalisation and empower patients who understand their GSF status.

Methods: The entire hospital trust (as part of the GSF working group) embraced the GSF Pilot and was the only whole hospital to do so. The End of Life workforce is huge and consists of almost every clinical and a fair number of non clinical staff. The methods used for educating staff in large numbers to ensure that all had an overview of the GSF programme and the aims of the pilot project are described.

Results: In all 551 staff from 45 wards and departments attended education regarding GSF.

Conclusions: The term GSF has become part of the hospital vocabulary and is familiar to all staff and information about it is being freely transferred in handover. Ward clerks have become integral to the process of registration and administration.

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Palliative Care in Undergraduate Teaching in Germany: Development since 2006 and Current Status Report

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Introduction: In August 2009, a law was passed by the German Parliament introducing Palliative Care as a mandatory core curriculum subject for all German medical schools. The law has to be implemented by the year 2012. Our survey reports current