·缓和医疗和安宁疗护专栏·

三级医院主导的社区安宁缓和医疗培训模式探索及效果分析

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【摘 要】 **目的** 探索三级医院主导的社区安宁缓和医疗培训模式,并对其效果进行分析。**方法** 回顾性分析2021年1月至5月参加北京协和医院主导的社区安宁缓和医疗培训的37名学员的资料。采取自主学习、知识点讲解与案例讨论相结合、线上线下相结合的模式进行培训。采用自制量表对学员的培训效果及满意度进行问卷调查。采用SPSS 26.0统计软件进行数据分析。配对二分类资料采用McNemar检验,2组配对有序分类变量采用Wilcoxon秩和检验。**结果** 培训时间持续4个月,共进行2次线下教学,线上学习总时长为3 524 min。其中,线上自主慕课学习总时长为1 834 min;线上带教14次,总时长为1 690 min。学员平均出勤率为96.5%。与培训前相比,培训后"在与患者及其家属讨论缓和医疗的选择时,我的许多同事(医生或护士)都感觉不舒服"[(2.43±0.93)和(2.78±0.85)分]、"缓和医疗支持医师协助自杀(即安乐死)的行为"[(1.54±0.96)和(2.03±1.07)分]方面得分显著降低,"为使临终患者免于疼痛困扰,我通常会开(或要求开)足量的镇痛药"[(3.32±1.08)和(2.57±0.93)分]、"一旦知道根治性治疗不再有效,我通常会告知患者"[(3.46±0.87)和(2.95±0.85)分]方面得分显著增加,差异均有统计学意义(均$P<0.05$)。培训后各项缓和医疗知识回答正确率均高于培训前。在"病程决定了疼痛治疗的方法"[64.9%(24/37)和40.5%(15/37)]、"辅助疗法对于疼痛控制很重要"[100.0%(37/37)和86.5%(32/37)]、"长期使用吗啡镇痛面临的最主要的问题是药物成瘾"[45.9%(17/37)和24.3%(9/37)]及"缓和医疗的理念与积极治疗的理念是一致的"[81.1%(30/37)和43.2%(16/37)]方面比较,差异均有统计学意义($P<0.05$)。学员对课程整体满意度在97.6%以上,对课程设置、知识点讲解、案例讨论、教师对案例的讲解及个人收获等5个方面的评分分别为4.94、4.95、4.94、4.94及4.96分(满分5分)。**结论** 三级医院主导的多模式社区安宁缓和医疗培训提高了学员对安宁缓和医疗的认知水平和服务能力,可进行推广。

【关键词】 三级综合医院;社区;安宁缓和医疗;培训
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Exploration of training model of community hospice and palliative care conducted by tertiary hospitals and analysis of its effects

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【**Abstract**】 **Objective** To explore the training mode of community hospice and palliative care conducted by tertiary hospitals and analyze its effects. **Methods** A retrospective analysis was performed of the data from 37 participants who participated in the community hospice and palliative care training led by Peking Union Medical College Hospital from January 2021 to May 2021. Conducted online and offline, the training featured independent learning, knowledge explanation and case discussion. After the training, a questionnaire survey was conducted among the participants using self-made scale. SPSS statistics 26.0 was used for analysis, McNemar test for paired dichotomous data, and Wilcoxon signed rank test for paired ordered categorical variables. **Results** The training lasted for 4 months, totaling 3524 minutes of online learning (1834 minutes of self-study and 1690 minutes teaching for 14 times) with an average attendance of 96.5%. Two offline teaching workshops were held during the training. Compared with before the training, the scores after

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the training were significantly lower in "Many of my colleagues (doctors or nurses) felt uncomfortable when discussing palliative care options with patients and their families [(2.43±0.93) *vs* (2.78±0.85) points] and in "Palliative care support assisted suicide (*i.e.* euthanasia)" [(1.54±0.96) *vs* (2.03±1.07) points], and significantly higher in "I usually prescribe (or am asked to) a sufficient amount of analgesics to relieve the dying patients from pain" [(3.32±1.08) *vs* (2.57±0.93) points] and in "I usually inform the patient once I know that radical treatment is no longer effective" [(3.46±0.87) *vs* (2.95±0.85) points], the differences being statistically significant. The correct rate of responses to palliative medical knowledge after the training was higher than that before the training. There were statistically significant differences ($P<0.05$) between before and after the training in "The course of the disease determines the method of pain management" [64.9%(24/37) *vs* 40.5%(15/37)], "Adjuvant therapies are important for pain control" [100.0% (37/37) *vs* 86.5% (32/37)], "The main problem of long-term morphine analgesia is drug addiction" [45.9% (17/37) *vs* 24.3% (9/37)], and "The concept of palliative care is consistent with that of active treatment" [81.1% (30/37) *vs* 43.2% (16/37)]. The overall satisfaction of the trainees with the course was over 97.6%, and they scored, out of 5, 4.94 for the course setting, 4.95 for knowledge point explanation, 4.94 for case discussion, 4.94 for teachers' explanation of cases and 4.96 for personal gains. **Conclusion** Multi-mode community hospice and palliative care training led by tertiary hospitals enhances the trainee's cognition and service competence and can be popularized.

【Key words】 tertiary general hospital; community; hospice and palliative care; training

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安宁缓和医疗是指为生命末期患者提供包括身体、心理、社会及灵性照顾在内的全人照护,旨在提高患者生命质量,帮助患者舒适、安详、有尊严地离世的学科[1]。随着我国人口老龄化和癌症发病率的逐年增高,临终患者及其家属对安宁疗护的需求日益增加[2,3]。2017 年,国家卫生和计划生育委员会印发了《安宁疗护中心基本标准和管理规范(试行)》[1]及《安宁疗护实践指南(试行)》[4],并开始以试点的形式,推进安宁缓和医疗在全国各个地区的开展。至 2019 年,试点地区已经扩大到全国 71 个市(区)[5]。

国外调查显示,大多数患者希望在家中离世[6]。受中国传统"落叶归根"思想影响,国内越来越多终末期患者更倾向于在家中或社区接受安宁疗护服务。相比三级医院经常出现一床难求的情况,居家安宁疗护既尊重了患者及其家属的心愿,又缓解了医疗资源紧张[7]。

我国目前专业的安宁缓和医疗从业人员十分匮乏,社区安宁疗护人员及相关培训更是不足。因此,北京协和医院安宁缓和医疗组在 2020 年 6 月至 2021 年 5 月相继开展了 2 期社区安宁缓和医疗培训。本研究就 2021 年 1 月至 5 月第 2 期的社区安宁缓和医疗培训模式进行探讨,并对其效果进行分析。

1 对象与方法

1.1 研究对象

选取 2021 年 1 月至 5 月参加北京协和医院社区安宁缓和医疗培训班的 46 名学员作为研究对象。采用培训前后发放调查问卷的方法,对学员进行调查。共回收问卷 37 份,问卷回收率 89.1%,最终纳入 37 名学员。

1.2 方法

1.2.1 师资建设 培训共有 30 名教师,包括 13 名(43.3%)医师及 17 名(56.7%)护士。76.7%(23/30)的教师来自北京协和医院安宁缓和医疗组,23.3%(7/30)来自其他医院安宁团队。

1.2.2 学员招募 培训采取自主报名的方式招募学员。每个社区有≥2 名学员共同参加。

1.2.3 培训开展 培训在北京协和医院安宁缓和医疗组指导下开展,采取线上线下相结合的教学模式。学员以社区为单位分为 7 个学习小组,每个小组配备 4~5 名指导教师。每次线上由 3 名教师进行授课。教学内容:(1)线上教学。包括自主学习、定期案例讨论和专题讲座。自主学习采取慕课的形式,内容涵盖缓和医疗的发展和定义、症状处理、舒适护理、哀伤及心理灵性照顾等。课后学员轮流讲解自主学习知识点,每周结合具体临床问题进行案例讨论。针对学员提出的普遍性问题,邀请专家进行专题讲座。教师组在线上进行指导、点评和答疑。(2)线下教学。教师深入社区,带领学员进行门诊病例教学查房,居家上门访视,结合临床案例进行家庭会议及沟通示范教学。

1.2.4 培训后评价 通过问卷星方式对学员进行问卷调查。收集学员的性别、年龄、工作年限及既往实践经历等一般资料,了解培训前后学员面对末期

患者的感受、缓和医疗知识、对缓和医疗态度及行为变化等情况。培训效果采取学员自评的方式,共有“强烈不同意”“不同意”“一般”“同意”及“强烈同意”等5个选项,分别对应1分、2分、3分、4分及5分。培训后学员从课程设置、知识点讲解、案例讨论、教师对案例的讲解及个人收获等5个方面对培训进行满意度评价,满分为5分,分值越高满意度越高。

1.3 统计学处理

采用SPSS 26.0统计软件进行数据分析。计量资料以均数±标准差($\bar{x}\pm s$)表示;计数资料以例数(百分率)表示。配对二分类资料采用McNemar检验,2组配对有序分类变量,采用Wilcoxon秩和检验。$P<0.05$为差异有统计学意义。

2 结 果

2.1 一般资料

本研究纳入的37名学员。其中,男性3名,女性34名,平均年龄(39.1±6.3)岁。学员来自7家社区服务中心,医师占54.1%(20/37),护士43.2%(16/37),行政管理人员2.7%(1/37)。97.3%(36/37)的学员工作年限>5年。学员中83.8%(31/37)有“接触、管理末期患者或面对患者死亡过程”的经历,27.0%(10/37)此前参加过一次安宁缓和医疗培训,40.5%(15/37)既往从未参加过安宁缓和医疗培训,21.6%(8/37)既往从未参加过居家社区服务。

2.2 培训效果

培训持续4个月,共完成1 834 min的自主学习慕课、14次线上教学+案例讨论(每周1次,每次2~2.5 h,共1 690 min)及2次线下教学。学员平均出勤率96.5%。

2.2.1 学员对缓和医疗态度的变化 与培训前相比,培训后“在与患者及其家属讨论缓和医疗的选择时,我的许多同事(医生或护士)都感觉不舒服”及“缓和医疗支持医师协助自杀(即安乐死)的行为”的得分显著降低,“为使临终患者免于疼痛困扰,我通常会开(或要求开)足量的镇痛药”及“一旦知道根治性治疗不再有效,我通常会告知患者”的得分显著增加,差异均有统计学意义(均$P<0.05$;表1)。

2.2.2 培训前后缓和医疗知识的变化 培训后各项缓和医疗知识回答正确率高于培训前。“病程决定了疼痛治疗的方法”“辅助疗法对于疼痛控制很重要”“长期使用吗啡镇痛面临的最主要的问题是药物成瘾”及“缓和医疗的理念与积极治疗的理念是一致的”方面比较,差异均有统计学意义(均$P<0.05$;表2)。

2.2.3 培训满意度 学员对课程整体满意度在97.6%以上。培训后学员对课程设置、知识点讲解、案例讨论、教师对案例的讲解及个人收获等5个方面的评分分别为4.94、4.95、4.94、4.94及4.96分。

表1 培训前后缓和医疗态度的比较

Table 1 Comparison of palliative care attitudes before and after training ($n=37$, points, $\bar{x}\pm s$)

Item	Pre-training	Post-training	P value
Many of my colleagues (doctors or nurses) believed it a self-failure when the patient in their charge accept palliative care	2.14±0.82	1.92±0.89	0.146
Many of my colleagues (doctors or nurses) felt uncomfortable when discussing palliative care options with patients and their families	2.78±0.85	2.43±0.93	0.049
Physicians do not play a role in palliative care	1.73±0.73	1.68±0.88	0.790
Most dying elderly patients want doctors to decide the best way of care for them	3.54±0.96	3.27±1.22	0.188
Palliative care usually meets the needs of family members better than other treatments	3.46±0.90	3.65±0.98	0.430
Multidisciplinary team (composed of doctors, nurses, professional therapists, social workers, volunteers, *etc.*) interferes with the care of patients	1.89±0.88	1.84±0.99	0.772
I feel I have enough knowledge to discuss palliative care with patients and their families	2.03±0.76	2.14±0.71	0.448
Palliative care supports assisted suicide (i.e. euthanasia)	2.03±1.07	1.54±0.96	0.007
Most patients′ symptoms (such as pain, shortness of breath and nausea) are not better than the therapeutic treatment by palliative care	2.3±0.70	2.22±0.92	0.659
I usually prescribe (or am asked to) a sufficient amount of analgesics to relieve the dying patients from pain	2.57±0.93	3.32±1.08	0.001
I usually inform the patient once I know that radical treatment is no longer effective	2.95±0.85	3.46±0.87	0.017
Most elderly patients do not want to be informed of their imminent death	3.35±0.95	3.05±0.94	0.195

表 2 培训前后缓和医疗知识正确率比较

Table 2 Comparison of correct rate of palliative care knowledge before and after training [n=37, n(%)]

Item	Pre-training	Post-training	P value
Palliative care is only suitable for those patients whose condition worsens	26(70.3)	32(86.5)	0.146
Morphine is the reference standard of analgesic effect of other opioids	15(40.5)	21(56.8)	0.180
Course of the disease determines the method of pain management	15(40.5)	24(64.9)	0.035
Adjuvant therapies are important for pain control	32(86.5)	37(100.0)	0.027
Main problem of long-term morphine analgesia is drug addiction	9(24.3)	17(45.9)	0.039
Providing palliative care requires emotional separation	18(48.6)	25(67.6)	0.092
Concept of palliative care is consistent with that of active treatment	16(43.2)	30(81.1)	0.000

3 讨 论

本研究中,83.8%(31/37)的学员有接触、管理末期患者或面对患者死亡过程的经历,但40.5%(15/37)的学员未曾接受过缓和医疗相关培训,这体现了临终患者对安宁疗护需求日益增长与国内安宁疗护专业人员严重缺乏的矛盾[8]。当然,这也与国内缺乏针对安宁疗护专科人员的培训机构及认证机构有关[9]。目前,在社区开展安宁疗护工作的人员,大多并未接受过系统的安宁疗护专科培训,非常缺乏完整的专科知识体系[10]。与传统的医疗服务相比,照顾终末期患者及其家属需要医务人员更多的情感投入来进行共情和心理、灵性照顾。长期面对患者的离世、家属的哀伤,势必承受更大的压力[11],很容易产生无助感甚至职业倦怠。美国国家综合癌症网络实践指南要求对实施安宁缓和医疗的医护人员开展培训,使其具有专业知识[12]。世界卫生组织提出的缓和医疗公共卫生模式,也强调对决策者、医务工作者进行教育培训以及为民众、社区赋能[13]。三级医院疾病末期的患者很难在医院被照顾到生命最后,在离开医院后,需要有基层医疗机构可以完成专业的末期照顾。因此,在上级主管部门还没有开启足够范围培训的背景下,由有能力的三级医疗机构开设培训班,对基层人员进行安宁疗护培训是一个值得探索的教育培训途径,这对三级医院更好地照顾自己的患者以及发挥三级医院的社会责任都有非常重要的意义。

本次培训通过前期调研学员需求、参考权威课程和实践指南,制定课程内容,并基于学员需求进行困难案例讨论和专题讲座。学员将所学到的理论应用到实践中,并将学习和实践中遇到的问题和困难案例在培训中反馈、汇报,由教师引导进行讨论,发现并总结解决方案,再将反思学习的收获带入到新的缓和医疗实践中。这个过程遵循了 Kolb 反思循环的教育理论,即有效的学习来源于学习者构建和组织知识的过程中,包括从具体实践到反思、再到总结经验的循环过程[14]。学员在长达 4 个月的线上学习中平均出勤率为 96.5%,高出勤率可能与培训内容结合了学员的实际临床需要,对学员的临床工作提供了帮助以及学习受到社区领导的支持和重视等原因有关。

本研究结果显示,培训改变了学员对缓和医疗的态度。与培训前相比,培训后学员对“患者接受缓和医疗意味着医师的失败”有了新的认知,更多的学员认识到缓和医疗不是安乐死,同意开足量镇痛药使临终患者免于疼痛困扰,在根治性治疗不再有效后会选择告知患者(均 P<0.05)。学员对缓和医疗态度的转变,有助于其从被动面对问题发展到主动解决问题,有益于促进其行为的改变[15]。

缓和医疗的知识与缓和医疗服务利用率的提高呈正相关[16]。症状的管理和沟通是缓和医疗教育中的 2 个最为重要的主题,症状管理的重点是疼痛管理[17]。本研究结果显示,培训有助于提升学员的缓和医疗理念和知识,尤其是吗啡使用和疼痛治疗相关知识。此外,本研究中学员对课程的高满意率和良好感受,除了与课程内容有关,可能也与教学过程采取“以人为本”的教学理念有关。线上慕课学习让学员可以根据自己的时间自主灵活安排学习。

培训在实施过程中也发现了一些问题。首先是项目的可持续性。此类培训虽然有效,但对专业教师数量要求多,目前缓和医疗专业师资力量有限。其次是从理论到实践的困难。缓和医疗内容的学习不在医疗系统继续教育内容之列,社区学员需要利用工作之余参加学习,学习压力大。最后是授课形式。本次培训受新型冠状病毒肺炎疫情影响,线下带教受到限制。未来,还需要对培训效果进行持续追踪。可以通过对学员进行定期随访,基于科学的评价框架,将行为层与效果层评估相结合,进行远期培训效果的持续监测[18,19]。此外,结合本研究的经历和结果,建议有关部门从决策层面改变社区人员的工作内容,将缓和医疗服务和培训融入社区常规工作和继续教育,开发高效率、可持续、见成效的人

才培训体系。综上所述,带动北京市的安宁疗护中心和示范机构的现有师资力量成为讲师,通过自主学习、知识点讲解与案例讨论相结合,线上线下培训相结合,分区域带动周边所属二级医院或社区的教育模式,是一个值得探索的方向。

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