

## Arts-based palliative care training, education and staff development

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# Arts-based palliative care training, education and staff development: A scoping review

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## Abstract

**Background:** The experience of art offers an emerging field in healthcare staff development, much of which is appropriate to the practice of palliative care. The workings of aesthetic learning interventions such as interactive theatre in relation to palliative and end-of-life care staff development programmes are widely uncharted.

**Aim:** To investigate the use of aesthetic learning interventions used in palliative and end-of-life care staff development programmes.

**Design:** Scoping review.

**Data sources:** Published literature from 1997 to 2015, MEDLINE, CINAHL and Applied Social Sciences Index and Abstracts, key journals and citation tracking.

**Results:** The review included 138 studies containing 60 types of art. Studies explored palliative care scenarios from a safe distance. Learning from art as experience involved the amalgamation of action, emotion and meaning. Art forms were used to transport healthcare professionals into an aesthetic learning experience that could be reflected in the lived experience of healthcare practice. The proposed learning included the development of practical and technical skills; empathy and compassion; awareness of self; awareness of others and the wider narrative of illness; and personal development.

**Conclusion:** Aesthetic learning interventions might be helpful in the delivery of palliative care staff development programmes by offering another dimension to the learning experience. As researchers continue to find solutions to understanding the efficacy of such interventions, we argue that evaluating the contextual factors, including the interplay between the experience of the programme and its impact on the healthcare professional, will help identify how the programmes work and thus how they can contribute to improvements in palliative care.

## Keywords

Art, staff development, education, learning, communication, empathy, palliative care, scoping review

### What is already known about the topic?

- The experience of art has been used as a conduit for palliative care staff development methods in both academic and practice settings.
- Researchers continue to find solutions to evaluating the efficacy of arts-based staff development programmes, while understanding contextual factors, and the 'how' programmes work (or not) are largely being ignored.
- The evidence for the long-term impact of arts-based learning programmes is sparse.

### What this paper adds?

- As far as we are aware, this is the first scoping review to provide a systematic approach to understanding the advancement of palliative and end-of-life care practice through the experience of art.

- We provide a typology of the proposed impacts and experiences of aesthetic learning interventions on healthcare professionals.
- By mapping the interplay between the experience of art and the impact on the healthcare professional, we begin to uncover how the programmes work and thus how they might contribute to improvements in palliative care.

#### Implications for practice, theory or policy

- The findings will help to guide training for education programme providers on how to tailor and implement aesthetic learning interventions.
- We have used the findings to develop a realist synthesis of aesthetic leaning interventions used in palliative and end-of-life care staff development.

## Background

The Economist Intelligence Unit<sup>1</sup> ranked 80 nations on the quality of their palliative care. Only 34 of those nations were deemed to provide ‘good’ palliative and end-of-life care.<sup>1</sup> Palliative care is the practice of improving ‘the quality of life of patients and their families facing the problem associated with life-threatening illness’.<sup>2</sup> The United Kingdom ranked as the leading nation ‘due to comprehensive national policies, the extensive integration of palliative care into the National Health Service, a strong hospice movement, and deep community engagement on the issue’.<sup>1</sup> UK policy and guidance,<sup>3–6</sup> which influence the global vision of palliative care, propose that all staff providing palliative care should have undergone ‘appropriate training’. Organisational efforts and continued advancements in the healthcare arena may help to improve practice. However, evidence suggests that many healthcare professionals feel inadequately prepared to administer proficient palliative care.<sup>7–10</sup> Understandably, even the top ranking nation fails to meet all of the palliative care needs for all of its citizens, but a recurring theme within Ombudsman casework is inadequate palliative care.<sup>11</sup> A recent investigation<sup>11</sup> identified distressing examples of people’s suffering which could have been avoided or reduced by better care and treatment.<sup>11–13</sup> This disparity between policy and practice raises doubts over the phenomenon of ‘appropriate training’. Compounding issues including the ageing population and an increasing incidence of malignant and chronic diseases<sup>14</sup> contribute to a pressing need to find ways to positively influence palliative care and the patient and family experience.

In recent years, healthcare education has included the development of humanistic aspects of healthcare including empathy, compassion and communication. Proponents of the humanities in healthcare practice development claim that a wide range of clinical and holistic skills associated with palliative care can be improved through the participation in and/or observation of art during the learning experience.<sup>15</sup> However, synthesis of various art forms that evaluate the connection between the experiences of art, learning and palliative care are largely absent. This review

maps healthcare staff development interventions that use art as experience to disseminate learning associated with palliative care. We refer to this process as aesthetic learning. Such interventions included the production, participation or observation of *works of art*. We have grouped healthcare professionals as individuals who provide preventive, curative, promotional, palliative or rehabilitative healthcare services in a professional context, including both registered staff and students.

Art serves as a means to communicate thought and emotion and acts as a radical stimulus influencing the perceiver.<sup>16</sup> Academics and practitioners have long maintained this notion when referring to elements of the ‘art of nursing/medicine’, whereby the *art* is positioned as the way in which the patient is imbued by the practitioner during their activities.<sup>17–26</sup> For example, by employing a sensitive adaption of movements and tone of voice, the healthcare professional can express security, empathy and calm, a positive state that is potentially passed onto the patient. However, *art*, in the context of this review, is the production, participation or observation of *works of art* used as a means to disseminate learning. *Aesthetic learning* can occur when a work of art resonates within the lived experience of an individual.<sup>27</sup> If the arts can articulate existential themes within individuals who are also healthcare professionals, then this evocative and emotive approach can potentially influence ‘the art of healthcare practice’. Within this context, art could be judged by its ability to produce an aesthetic learning experience, for example, to be intelligible, evocative and comprehensible to the healthcare provider.

The current evidence base<sup>28–30</sup> suggests that many learning methods that use art to facilitate staff development are inadequately tested and refined. Data relating to efficacy are lacking, and reported impacts often rely on participants’ opinions. However, the complex nature of such interventions mean approaches to test the programmes are difficult, comparisons between successes may not be valid and implementation strategies largely unknown.<sup>31</sup> In this review, we used an established scoping

review methodology.<sup>32,33</sup> This approach facilitated the inclusion of primary studies from different methodological backgrounds and allowed us to investigate components within the evidence to explore these complex interventions.

## Aim and objectives

The aim of this review was to map the activity of aesthetic learning programmes used in palliative and end-of-life care staff development. The objectives were to identify and explain

- The range of programmes;
- Reported impacts of these programmes;
- Common features that contribute to the workings, learning and experience of these programmes;
- Research gaps in the literature.

## Methods

### Design

The review design drew on published methodological guidance of scoping reviews.<sup>32,33</sup> Unlike a systematic review, a scoping review does not attempt to assess the ‘weight’ of evidence. For this reason, the quality appraisal of evidence was not a requirement.<sup>32–38</sup> Instead, the review adopted an inclusive, narrative approach to synthesis, so that the review was populated with a range of literature. Thematic analysis<sup>39</sup> was chosen as an appropriate method to categorise and code the identification of themes from the literature. Data extraction and charting were divided into two phases in order to maintain an iterative process of discovery, an approach promoted in the scoping review methodology.<sup>32,33</sup> The initial phase allowed the researchers to familiarise themselves with the literature and refine the objectives, research questions and data charting tables, and then continue in a deliberate approach to populate a framework which is described under section ‘Data extraction and charting’:

1. Develop the primary research question/s and identify the required data
2. Search strategy
  - a. Identify the relevant literature/terminology
  - b. Inclusion/exclusion criteria
3. Data sifting
  - a. Title
  - b. Abstract
  - c. Full text
  - d. Initial data extraction/charting
4. Refine objectives and research questions
  - a. Data extraction/charting
5. Collating, summarising and reporting the results

### Primary research questions

1. What forms of art have been used as aesthetic learning interventions in the development of healthcare professionals’ palliative care practice?
2. What are the common features of arts-based staff development programmes?
3. What are the associated impacts of aesthetic learning interventions which have been used to develop palliative care skills in the healthcare workforce?

### Search methods

Articles were collected from three major social, health and welfare databases: CINAHL/EBSCO (nursing and allied health, 1997–2015), MEDLINE via Ovid (biomedical sciences, 1997–2015) and ASSIA (Applied Social Sciences Index and Abstracts, 1997–2015). In order to achieve an inclusive scope of the literature, overarching search terms were drawn from relevant theories and Cochrane groups (Table 1). The terms ‘Palliative’, ‘Arts or Aesthetics’ and ‘Staff Development’ were segmented into the aspects of which they are contextually constructed. Relationships of terms were connected with OR, and each of the three groups of terms were connected with AND.

Citations were directly imported from the databases into the bibliographic manager RefWorks<sup>40</sup> and duplicates were removed. No exclusions were made regarding the quality of the evidence or methodological approach. Studies were selected if they met the following PEO<sup>41</sup> criteria (Table 2).

### Data sifting

Data selection consisted of screening titles, reading abstracts and if relevant, reading full texts. Once the databases were exhausted, reference lists were scanned for additional publications (Figure 1).

### Initial data extraction and charting

Care was taken to create a narrative of re-analytical data (and not simply a collection of short summaries) by extracting data in reference to the broad research questions.<sup>42,43</sup> Consistency was achieved by organising the narratives onto data tables. The data tables provided a framework subdivided into columns to chart key impacts, issues and themes. The completion of initial rows of data shaped the focus of subsequent data collection.

### Refinement of research questions

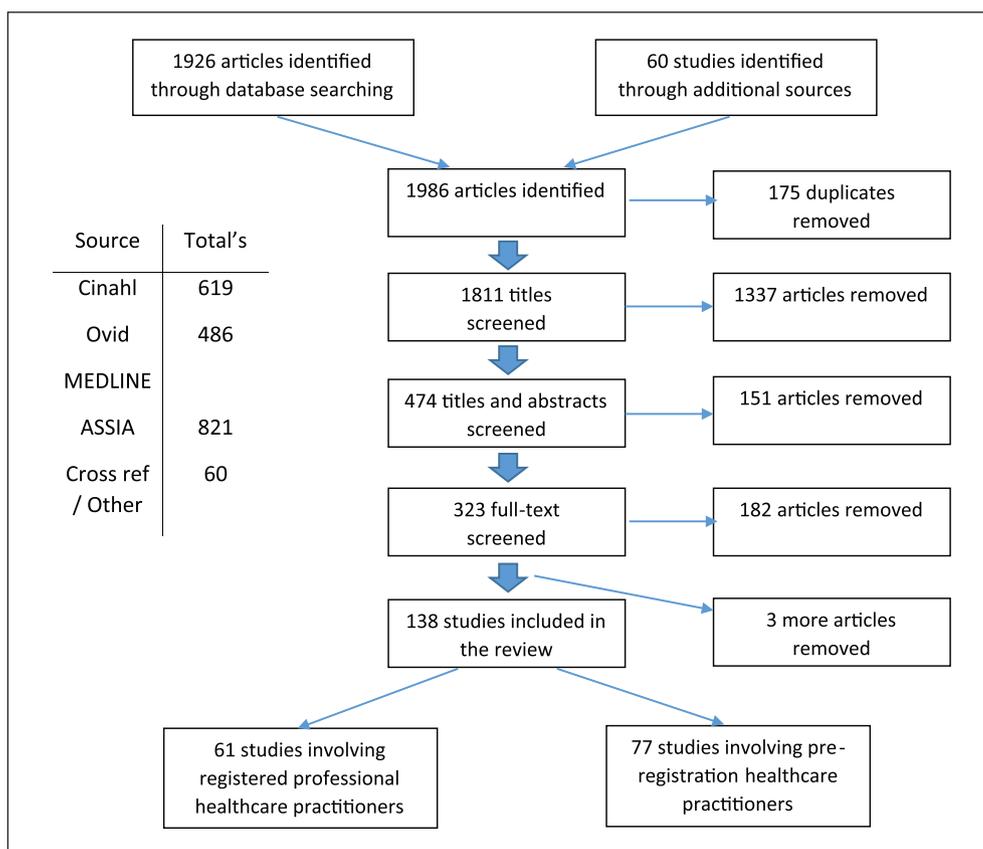
The iterative process helped secure a wide collection of data. Initial data extraction offered refinement of the study objectives and research questions.<sup>32,33</sup> The second

**Table 1.** Search terms.

Staff Development	AND	Palliative Care	AND	Art
medical education or nurse training or nursing education or professional growth or staff development		advance care planning or bereavement or communication or compassion or empathy or end of life or grief or family or palliative or quality of life or relative or spiritual or symptom or terminal		actor or actress or art or artist or artist or camera or cartoon or cinema or comic or dance or drama or film or illustration or improv or improvisation theatre or language art or movie or music or narration or paint or pathographies or performing artists or performing arts or photo or photography or poem or poet or poetry or puppet or puppetry or role play or role-play or sculpture or shadow play or singing or dancing or stories or story or theater or theatre or theatric

**Table 2.** Inclusion criteria.

P	Population and their problems	Medical, nursing or allied health professionals (including trainees) who are likely to participate in palliative care and end-of-life care
E	Exposure	An aesthetic learning intervention
O	Intended outcomes or themes	Developing the skills used in palliative care (e.g. prognostic communication or empathy), and practitioner well-being (e.g. confidence or coping with loss)



**Figure 1.** Data sifting.

research question regarding the common features of the staff development programmes was expanded into a set of sub-questions:

- What was the stated approach, for example, voluntary?
- How was the art disseminated, for example, are participants actively involved in the creation of art or are they passive viewers?
- What was the stated or proposed intent, for example, unthreatening or evocative?

- How was the intervention perceived/experienced (by those taking part), for example, anxious or enjoyable?
- What was the intended learning style, for example, peer engagement?
- What was the stated or proposed strategy, for example, feedback?

### Data extraction and charting

Once the review had been adequately refined, the descriptive-analytical data populated a standardised table. Each study was charted under the specific categories designed to organise data with regard to the research questions. This aided efficient comparisons of emerging data to develop categories and themes.

### Collating, summarising and reporting the results

Studies were collated, summarised and results were reported in this stage of the review. As we were not assessing the weight of evidence, this was not a necessary stage of the scoping review.<sup>33</sup> The intention here was to present an inclusive representation of primary studies.<sup>33</sup> Results were organised under the three review questions:

1. What forms of art have been used as staff development tools in the development of palliative care skills?

Intervention types were counted, listed, categorised and displayed in the data table. Some programmes contained more than one type of art. In these circumstances, the types of art were documented individually, but in later analysis of impacts, they were categorised as multiple interventions.

2. What are the common features of arts-based, staff development programmes?

The common features which included the intent, participation, experience and strategy of the interventions were re-analysed from the data tables through a process of thematic analysis.<sup>23</sup> We focused on how these themes relate to one another and the overall impacts of the programmes on healthcare professionals.

3. What are the associated impacts of the aesthetic learning programmes?

The proposed associated impacts of the interventions were drawn from the data table, coded, listed and divided into five impact categories. The occurrences of associated impacts were displayed in the form of radar diagrams with reference to their corresponding type of art category.

## Key findings

The evidence reported in this review

- Displays the types of aesthetic learning interventions relevant to palliative and end-of-life care staff development;
- Identifies the proposed impacts of the interventions and the correlation between specific intervention categories and patterns of impacts;
- Identifies and explains the common features shared between the programmes.

The key findings are documented here under the headings of the three review questions:

1. 'What forms of art have been used as staff development tools in the development of palliative care skills?'

The review identified a wide pool of aesthetic learning interventions, 138 studies were reviewed and these contained 60 different types of art. Many of the individual intervention types shared common characteristics and the authors were able to categorise the 60 types of art into 8 groups (Table 3).

The staff development programmes often used more than one type of art to produce the aesthetic learning experience. The most common type being role play which featured healthcare professionals with trained actors, ex-patients, carers or family members (Figure 2).

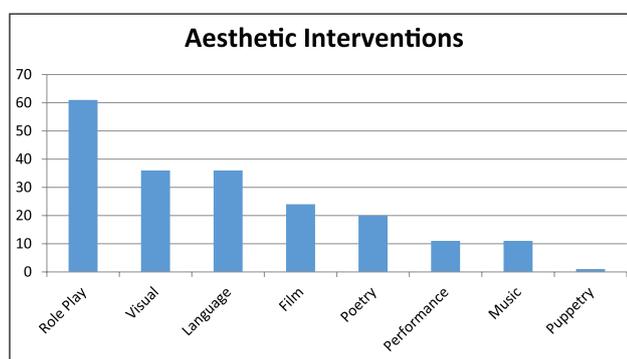
2. 'What are the common features of arts-based staff development programmes?'

Exploration of the features of the aesthetic learning programmes provided some contextual understanding of what was happening during the implementation of interventions. Particular attention was on the documented experiences of healthcare professionals during the interventions.

The 138 reviewed studies drew participants from pre-registration students ( $n=77$ ) and registered professionals ( $n=61$ ) and were composed of nursing ( $n=64$ ), medical ( $n=57$ ), allied health professions ( $n=2$ ) and multidisciplinary combinations ( $n=15$ ). One article reported on a film intervention that was being disseminated to 12,500 staff employed within one hospital.<sup>44</sup> This example was used to widen the understanding of the experience of a person with a diagnosis of dementia in the hospital environment. It highlights how applicable certain aesthetic learning interventions can be to the resource needs of the organisation and the variety of audiences.<sup>44</sup> The range of interventions targeted both specialist professionals, for example, oncology staff, and mixed groups. Some interventions included service users. In cases where service

**Table 3.** Aesthetic intervention types.

Category	Aesthetic intervention
Role Play	Role play, readers theatre, forum theatre, theatre style role play, interactive video, theatre games, clown workshop, body sculptures, simulation, interactive theatre, psychodrama, sociodrama
Visual	Expressive art, mask design and creation, images, fine art, contemporary art, box design, visual images, photography, painting, drawing, sculpture, visual metaphors, cartoons, college art, story boarding
Language, narratives and stories	Reading plays; reflective writing; folk stories; fiction; short stories; children's stories; letters to death; narrative stories – patient, physician, carer; vocal stories; story writing; life stories
Film	Film, feature film, television shows, video production, video review
Poetry	Poetry reading, poetry writing, poetry listening, tanka poetry
Drama Performance	Drama (both active and passive involvement), dramatising works of art, acting, drama production from patient stories
Music	Musical performance, song writing, instrumental, song, dance, mantras, music
Puppetry	Puppets

**Figure 2.** Frequency of art categories.

users were featured, the healthcare professionals were less sceptical about the value of aesthetic learning, and described the method as more realistic, and less simulated and hypothetical when comparing the programme to prior educational experiences. For example, healthcare professionals used words such as ‘humbling’,<sup>45</sup> ‘honour’,<sup>46</sup> ‘privilege’<sup>47</sup> and ‘intimate understanding’<sup>48</sup> to describe the experience.

Logistically, the characteristics of programmes varied in participation and location. Participation in programmes was either mandatory, including curricular components for students and clinical requirements for staff, or voluntary, including curricular electives and participation in research studies. A reservation of voluntary participation in aesthetic learning interventions was that the method may have ‘preached to the converted’.<sup>49</sup> Commonly, mandatory programmes were met with initial scepticism.<sup>50–55</sup> For the majority of participants, however, this could be resolved as the healthcare professionals engaged in the activities:

most people had serious reservations about this compulsory creativity ... the ‘jack the lad’, known for throwing paper planes from the back of lectures, stood and delivered a mournful and poignant poem about sibling love and loss of

innocence. It soon became apparent that while everyone was pretending not to care, they had been secretly and ferociously painting, drawing and composing.<sup>55</sup>

The reviewed studies were implemented in a variety of settings relating to the healthcare professionals, including internal venues (64%), such as hospitals, educational institutions and participants’ homes; and external locations (36%) such as conference centres, patient’s homes and arts venues (theatres, galleries and museums). Studies featured the following methods of analysis: qualitative (61%), quantitative (23%) and mixed methods (16%). The focus and impacts of the studies were relevant to a variety of overlapping domains from the following list: the collective (facilitators, researchers and participants), participants, research, teaching and education, and the specified staff development issue (e.g. breaking bad news).

### *Proposed or stated intent of the interventions*

Each of the reviewed studies attempted to use art to transport the participant into an aesthetic learning experience that could be reflected in the everyday experience of healthcare practice. In many cases, the evidence described how intervention planners adopted a process of active learning to help participants learn about often-sensitive material from a safe distance. The following themes were produced to further explain the intent of the programmes. Each contains examples from the reviewed studies.

*Imagining.* While the studies set out with varied objectives, the majority were contingent in how they sought to achieve their desired impacts. The overarching intent for all studies was to provide an aesthetic learning experience that mirrored (be it vicariously, emotionally, intrinsically, morally, socially, psychologically, consciously or unconsciously) the story of an actual experience that would be too complex, harmful, unattainable, unknowable and/or unethical

to represent through a 'real' experience; and that is too complex to imagine through scientific explanations of phenomena. Participants were able to access layers of the experience through an immersive state that arises when an individual engages with a work of art, leading to a clarity of insight, depth of understanding or new perspective. The experience opened opportunities for emotive and abstract philosophical discussion, which incorporated both historical lived experiences and the aesthetic experience.<sup>56–59</sup> The philosophical discussions were particularly significant when phenomena could not be represented by a real experience (e.g. there is no empirical representation of the subjective experience of death). Additionally, abstract thought was compelling when facing the interpretive nature of the more ambiguous art interventions.

**Safety.** Healthcare professionals accessed palliative and end-of-life care experiences through the 'story world' of art as experience. In this way, they were present at safe distance from actual practice, where they could manoeuvre through alternate layers of events that might not be seen in actual practice. This included the wider narrative,<sup>60,61</sup> intrinsic nature,<sup>62,63</sup> and physical, psychosocial and spiritual impact.<sup>64,65</sup> Many studies reported that safety was a primary intention, specifically with regard to psychological, emotional and social well-being. Topics were sensitive and often participants were moved to tears; however, the evocative impact of the learning experience on both participants and facilitators was held in positive regard.<sup>44,66,67</sup> In this way, safety focused not by avoiding or detaching participants from their emotions but through creating safe and non-judgemental atmosphere in which participants were free to feel and express personal and vicarious emotional stories.<sup>68–71</sup>

**Interaction.** Interaction with others played a key role in the process of the learning experience and it featured at various stages during the programmes:

- While actively involved in the art, participants worked in collaboration with each other towards a common goal;<sup>72,73</sup> or they were required to work alone and feedback to the group through presentation and/or discussion of their art and the experience of it.<sup>71,74</sup>
- While participating in the arts in a passive way, such as viewing a play or visiting an art gallery, the healthcare professionals would have an active role in feedback including group discussion with peers and artists.<sup>58,60</sup>
- During role play and interactive theatre interventions, the audience would work together as an active audience to shape the trajectory of the interventions at various stages of the drama<sup>75,76</sup> and/or contribute to post-event debriefing and discussion.<sup>59,77</sup>

### *How the intervention was perceived/experienced (by those taking part)*

The learning experience incorporated the healthcare professionals' points of view, values, beliefs and philosophies. This created an authenticity that gave way to a degree of participant autonomy by enabling the healthcare professionals to internally shape their learning experience at personal, emotional and professional levels. Healthcare professionals were able to contemplate wider aspects of palliative and end-of-life care at the level of the objective professional and empathically as 'ordinary people'. This included the effect that the practitioner has on others and the emotional impact of a given situation. This notion was expressed eloquently by Gillis:<sup>68</sup> 'We had not ceased to be physicians, nurses, Hospice staff, literary critics, historians, artists, or philosophers; but we had engaged together in a process of imagining'. As participants interacted, reflected and discussed 'in' and 'on' the aesthetic learning experience, they were able to process their thoughts and feelings while justifying their relationship to the portrayed events, themes, characters and plots. This is in contrast to didactic learning and algorithmic teaching methods in which participants may be distanced from addressing their emotions, values and beliefs through adopting the authoritative facts and standardised steps of others. The notion of authentic learning emerged and was categorised under the following inter-linked themes: enjoyment and engagement, dissonance and awareness.

**Enjoyment and engagement.** Healthcare professionals engaged in the programmes through creative participation and observation of the arts. Where stated, all studies contained a majority of positive participant feedback. A key theme supporting this was enjoyment. One way in which people experience enjoyment from art as experience is when the experience of art resonates with an individual at an emotional level.<sup>22</sup> This concept was mirrored in studies where a range of emotions were expressed during the interventions. Within positive psychology, enjoyment is achieved through the fulfilment of three intrinsic needs, each of which relates to psychological well-being: autonomy, competence and relatedness.<sup>78</sup> This was evident in the literature which documented threats to personal well-being.<sup>79,80</sup> For example, healthcare professionals who had low expectations of aesthetic learning interventions and those who had concerns over their ability as a practitioner, as an artist and a performer often experienced difficulties engaging with the programmes.<sup>51,80</sup> In most cases, participants overcame their preconceptions to engage in and enjoy the learning experience.<sup>54,55,71</sup> However, a few examples included statements whereby participants remained sceptical.<sup>51,53</sup> The impact of well-being on engagement led to a further theme: dissonance.

**Dissonance.** Cognitive dissonance may occur when people receive new information that challenges their beliefs, ideas and values. A range of emotions were expressed during the interventions. Dissonance was a powerful contributor to the impact of emotions on the healthcare provider. Dissonance occurred in two ways with opposing effects:

- a. *Vicarious dissonance.* The emotional connection that healthcare professionals experienced when empathising with the characters and plots had a positive impact on enjoyment and engagement. This understanding of how others experience palliative and end-of-life care issues increased their awareness of the wider narrative around palliative and end-of-life care issues. It also enabled them to think about the self in relation to those narratives. This helped form, reinforce and justify what the issues, events and plots mean and how the individual relates to them.<sup>81,82</sup>
- b. *Affective dissonance.* Feelings of vulnerability and inadequacy when partaking in arts threatened participant well-being and constructed a barrier to engagement. Examples include fear of judgement (particularly from peers) and the general anxiety associated with performing outside of participants' comfort zone and expertise.<sup>76,83</sup>

**Awareness.** Each of the studies focused on the human experience of healthcare, illness or death and dying. As healthcare professionals entered a vicarious relationship with characters and plots, they became more aware of how others including patients, patient's families and carers experience palliative and end-of-life care. The healthcare professionals' perceptions of this was influenced by their own lives and challenges, including the subjective view of themselves ordinary complex people, and as healthcare professionals with a plethora of relevant scientific, historical, moral and ethical knowledge and experiences. In this way, the healthcare professionals could relate to the experience of art at affective and cognitive levels. Healthcare professionals' tacit knowledge, emotions, experiences and expertise influenced their subjective and objective judgements in a domain that relates to actual practice but presents outside of it. Shifts in the awareness of self and others were related to the above themes of *dissonance* and *engagement*, which affected confidence levels. For example, in cases where healthcare professionals had underestimated the impact of the experience of palliative and end-of-life care issues, or overestimated their ability to deliver best palliative and end-of-life care, the aesthetic learning experience presented an opposing view that displayed a new complexity of care with regard to the participants' relationship in it. In some cases, this caused anxiety.<sup>45,84</sup> However, such states of existential discord may prove beneficial as awareness of what the individual

does not know may motivate better preparation for future practice. Where confidence levels were investigated, studies described a positive correlation between confidence and the aesthetic learning experience, with participants feeling better prepared to face future engagements.<sup>85,86</sup> However, the studies did not demonstrate whether participants had the confidence to apply their newfound knowledge to practice. Likewise, it is unknown whether the deeper awareness of portrayed situations resulted in improved actions in actual practice.

### *What was the intended learning style?*

The studies used cognitive, psychomotor and affective learning methods. They were facilitated by peers, specialists, academics, professionals, researchers, service users and/or artists. Facilitators aided the acceptance of programmes for the healthcare professionals by legitimising the learning experience and increasing cognitive congruence. Evidence of adult learning theories appeared throughout the programmes and were displayed with reference to the degree of participant autonomy within the programmes, and the inclusion of participants' historical experiences and knowledge in learning. Additionally, participants were able to reflect 'in' and 'on' action regarding the experience. However, the studies do not demonstrate whether these learning styles, in conjunction to the aesthetic learning experience, result in professional behaviour change.

3. 'What are the associated impacts of aesthetic learning interventions'?

The studies contained a diverse range of impacts. The primary intention of many studies was to improve communication skills and empathy. Other studies looked to increase the participants' awareness of others, including the wider narrative surrounding palliative and end-of-life care issues, personal development and to enable participants to feel better prepared to deal with future situations. The stated impacts were categorised under five themes: practical and technical skills; personal development; self; awareness of others; and compassion and empathy. These themes often overlapped and interlinked. For example, active listening as a practical communication skill requires a degree of empathy. Many studies adopted methods to justify the learning, including: feedback, coaching, self-evaluation, pre/post-tests (including empathy scales and communication prompts), Likert scales, discussion, presentations and reflections in an attempt to prove whether or not the interventions achieved the desired effect. While these methods displayed a positive correlation between learning the interventions, no study proved whether or not their newfound knowledge was applied to actual palliative and end-of-life care practice. The five impact themes drawn from the

primary studies are examined further and expressed in the radar diagram (Figure 3).

**Impact 1: practical and technical skills.** Almost half (49%) of the studies addressed practical and technical skills relating to clinical and communication skills. Role play was the most commonly used intervention, and it was predominantly geared towards addressing these skills:

- We associated practical and technical skills with practice, observational, care planning and diagnostic skills including: clinical skills, advanced care planning and advanced directives, bereavement, clinical services, end-of-life practice, pattern recognition, team working, biopsychosocial-spiritual care and breaking bad news.
- Communication skills, which looked to the way healthcare professional communicate addressed: listening skills (such as active listening), eye contact, body language, truth telling, displaying empathy, empathic responses, prompting, silence, questioning, follow-up questions, information giving, congruence, displaying emotions and electing patient preferences.

**Impact 2: personal development.** Personal development was a key impact with 58% of the studies reporting positive shifts in: affiliation, production and interpretation of art, assertiveness, attitude change, comfort, confidence, critical thinking, emotional intelligence, endurance, interpersonal skills, reflection, relationships, resilience, self-exploration, spirituality, stress reduction and well-being.

**Impact 3: self awareness.** The presence of the healthcare provider immersed in the learning experience contributed to a reported deeper insight into the self, 40% of studies addressed self in relation to: a good death, complexity, culture, philosophy, spirituality, role and responsibility, personal emotions, relation to environment, ethics, grief, law, meaning and meaninglessness, shared understandings, psychological impact and spiritual impact.

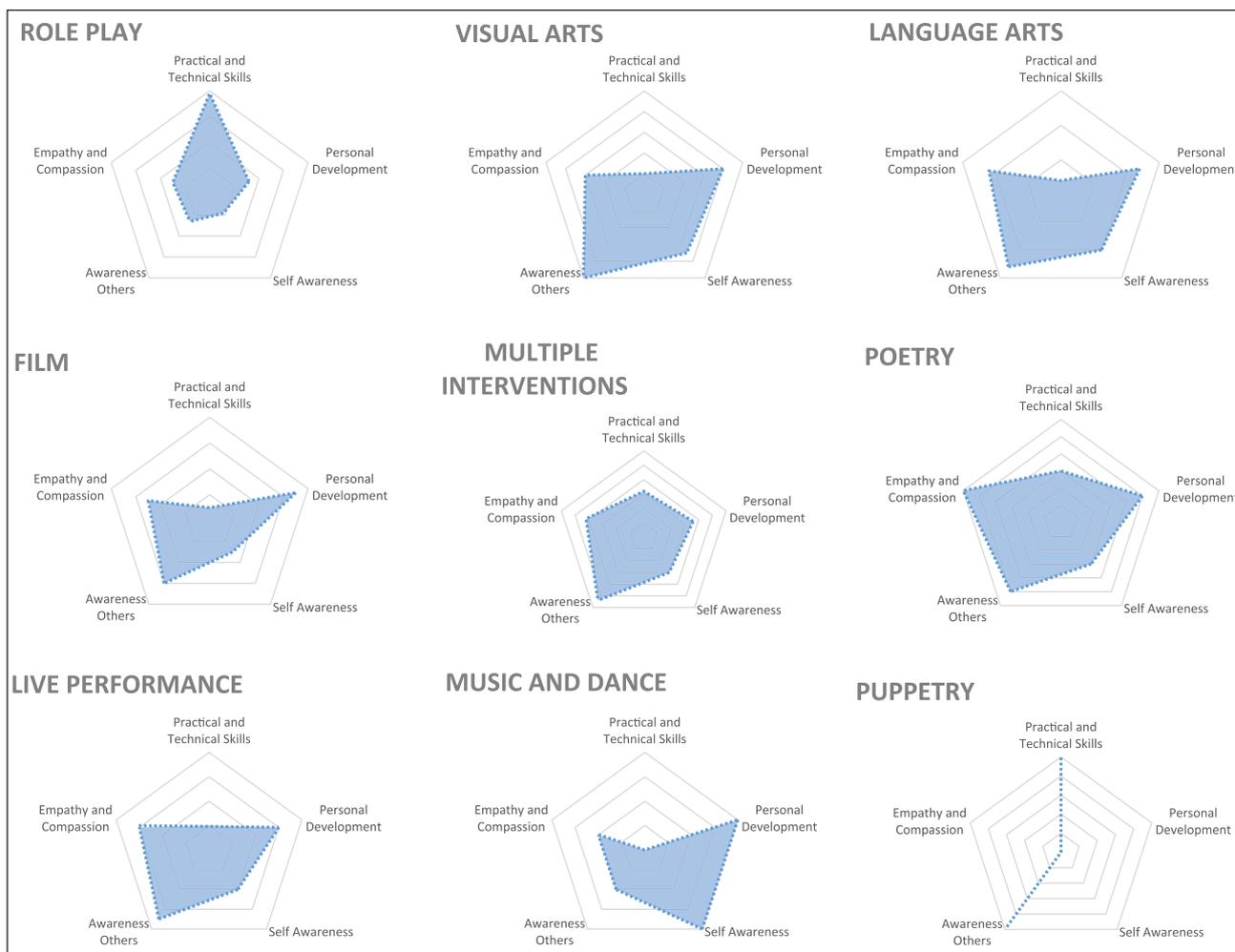
**Impact 4: awareness of others.** One of the key offerings of learning from the experience of art was the accessibility of empathic understanding of characters and plots. The majority (64%) of studies reported that healthcare professionals gained a deeper understanding into the experience of others including patients, peers and carers. This included a wider awareness of: what a good death means; complexity of death and dying; cultural influences; emotional impacts on the patients, loved ones and peers; environmental impacts on death and dying; grieving, loss and bereavement; meaning and meaninglessness; patient narratives; shared understanding of illness; social impacts; psychological impacts; spiritual impacts;

spirituality; suffering; dying trajectories; experiences; and wider narratives.

**Impact 5: compassion and empathy.** The arts allowed space for the humanistic qualities of care, and half of the studies reported compassion and empathy development, including improvements in compassion, compassion fatigue, empathy, dignity, loss, morality and loneliness. Once the impacts were categorised into the five themes, they were examined in association with the art that produced the impact. The following radar diagrams (Table 3) illustrate the overall correspondence between the associated impacts and the intervention categories. Significantly, *language art, film* and *live performance* (which often centred on a script) display similar patterns of impacts, while role play and music, which share little in common, have opposing patterns of impacts. These diagrams map the intervention types and their impacts; however, they are not necessarily predictive as to whether or not one method is better than another in producing a particular outcome. Further research would be required to evaluate such claims.

## Conclusion

The use of the arts in palliative and end-of-life care staff development is relatively uncharted territory. This review serves as an important step in collating and understanding this process. The review identified the types of art that have been used as aesthetic learning interventions in palliative care staff development programmes and the proposed impacts which correlate to them. Additionally, we have mapped the common features of the programmes including participant experiences. The review enabled us to adopt a broad method of investigation to pull data from a wide range of evidence. The scoping review methodology enabled us to investigate in ways a systematic review would not.<sup>32,33</sup> First, by sourcing a comprehensive list of studies obtained from a variety of methodological backgrounds, and second by allowing space to review some of the prominent qualitative features of the programmes, and importantly, to produce a narrative of the results. In order to map the range of interventions, we had to categorise large numbers of intervention types and their proposed impacts. In doing so, we have displayed patterns of impacts which are associated with certain intervention types. This offers a historical picture of what has been done in the field. The mapping of the primary studies could prove useful to educators and training providers considering aesthetic learning programmes in palliative and end-of-life care. However, our results which tell a story of what has happened are not necessarily predictive as to what can be done in the future. While the reviewed literature suggests that the arts-based learning interventions produced impacts within the training environment, the vast majority of



**Figure 3.** Intended outcomes.

primary studies did not look at the long-term impact on actual practice.

Undertaking this scoping review enabled us to look beneath the proposed impacts of interventions. We have mapped the documented features of the programmes and provided contextual data including insight into the health-care provider's experience of these programmes. This is particularly evident in the contingent themes around imagination, enjoyment, safety, dissonance, awareness and interaction. The interplay of these themes contributed to a state of authentic learning, which warrants further investigation. Deeper analysis into the causal factors which produce and sustain the impacts of the individual interventions, within the programme environment and daily practice, would help identify and explain how these programmes work (or fail to work), for *whom* and in *what circumstances*.

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