9 Terminal Care Education for Doctors
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INTRODUCTION

In common with other advanced industrial societies one of the features of modern Britain is the central role played by doctors and nurses in the ways in which death and dying are dealt with. Death and dying have become both institutionalised and medicalised as Blauner and other writers have noted (Ariès 1974; Blauner 1966; Illich 1977; Elias 1985; Field 1994a) and medical and nursing work with people who are dying and those close to them have important consequences for the ways in which members of our society experience the stresses and traumas of death, dying and bereavement. In the 1990s both medical and nursing hierarchies in the UK have seen this area of medical and nursing work as amenable to improvement via education. The Standing Medical Advisory Committee and the Standing Nursing and Midwifery Committee issued a joint report on ‘The principles and provision of palliative care’ (1993). Its first two recommendations are that all patients needing palliative care services should have access to them and that terminal care services for patients dying from diseases other than cancer should be developed. To achieve its recommendations the report sees education as ‘the most basic requirement which must be at undergraduate and postgraduate level in medicine’. The General Medical Council’s document aimed at improving the education of medical undergraduates (1993) also emphasises the importance of caring for dying people by including it as a topic in the ‘core curriculum’ for medical undergraduate teaching.

The inclusion of Terminal Care Education (TCE) as an explicitly taught part of the medical undergraduate curriculum is a relatively recent phenomenon. In medicine, the influential Todd Report on undergraduate medical education (1968) contained no reference to teaching about death and dying and it was not until 1980 that the Wilkes report on terminal care for the Standing Medical Advisory Committee recommended that a terminal care element should be included in undergraduate medical training.
The emergence of the speciality of palliative medicine in 1987 both reflected and gave further impetus to concerns within medicine about the adequacy of care for people who were dying. A working party set up in 1991 by the Association for Palliative Medicine of Great Britain and Ireland provided detailed guidelines for such teaching for medical students, general practitioners and hospital doctors and specialists in palliative medicine (1993). Similar importance is attached to TCE in Nursing education. It is a requirement that terminal care must be covered in both 'core' and 'branch' teaching programmes, but it is left up to each department and unit to decide how to do so. At the post-basic level there is a well established specialist course in terminal care (931) and nurses can gain a diploma qualification in terminal care.

This chapter considers the provision of education for terminal care in the undergraduate medical curriculum. It first outlines what currently constitutes education for terminal care. It then discusses the aims of such education and concludes by asking about the effectiveness of such education.

THE CONTENT OF EDUCATION FOR TERMINAL CARE

There are a number of difficulties in establishing exactly what constitutes education for terminal care in our medical schools. In part this reflects debates within the field about the nature and remit of the medical care of dying people and those close to them. Three inter-related terms are used to describe such care, each with a slightly different but nevertheless important emphasis. The modern hospices were originally developed to improve the provision of terminal care (James and Field 1992) – that is, the care of those for whom death is certain and not too distant. Hospice care has been very largely restricted to those suffering from cancer and there has been a long standing recognition of the desirability to expand the scope of hospice care to other conditions (Wilkes 1980). Palliative care developed from this focus and incorporates key features of the hospice approach. It can be defined as ‘the total (physical, emotional, social and spiritual) care both of patients with life threatening disease and of their families. The focus of care is both the quality of remaining life of the patient and the support of the family and friends’ (Higginson 1993). Although in practice still largely focused upon the care of cancer patients, palliative care has a wider remit. In theory at least (although not always in everyday practice) the principles of palliating symptoms in order to maximise quality of life should extend to the care of people dying from chronic respiratory or heart failure and other progressively deteriorating conditions. Palliative Medicine was