
Medical Education

Teaching terminal care at Queen's University of Belfast**I—Course, sessional educational objectives, and content**

W G IRWIN

Introduction

One of the features of the fourth year medical curriculum at Queen's University of Belfast is a programme of coordinated teaching of topics of common interest by the departments of community medicine, general practice, geriatric medicine, and mental health.¹ These departments are equal contributors to the integrated and interdisciplinary teaching sessions. The General Medical Council strongly advocates this type of combined teaching.² The group leaders and panel of tutors are able and carefully chosen. Student acceptance of the teaching appears to be high.¹ The joint course was developed six years ago and lasts for 12 weeks. Teaching is based largely on small group tutorials and seminars with a written combined course short answer assessment at the end.

Terminal care is one of the topics covered in the course, and for some years I have been responsible for planning and coordinating the teaching of this topic. This is the first of two teaching articles: here I discuss the content of what is taught and define the educational objectives; in the second article I will describe the format of the three hour teaching session on terminal care and the ways of imparting knowledge adopted by the tutors.

Many young students, and indeed doctors, do not cope adequately with their own reactions to death and do not fully appreciate the principles underlying care of a dying patient and his family. They are accustomed to seeing lives saved by resuscitation, surgery, readjustment of electrolyte balance, or antibiotic treatment. Science appears to have the answer to everything. When cure is impossible—for example, in the case of inoperable cancer—the words quoted by Sheila Hancock, "I'm afraid there's nothing more we can do,"³ are sometimes heard. Medical students must realise how important it is to provide high quality medical care and support at this stage.

The terminally ill patient is defined as one whose death is certain and not too far distant and for whom treatment has changed from the curative to the palliative (Leeds Oncology Working Party, 1973).

Even before the publication of the *Report on terminal care* (chaired by Professor E Wilkes)⁴ the heads of the respective departments at Queen's had decided that medical students in the fourth year course should be better informed about: (1) the identification of patients for whom treatment has changed from the curative to the palliative; (2) the principles underlying the management of the psychological aspects of dying and bereavement; (3) the principles underlying the physical management of terminal illness; and (4) the environment in which care is provided and what support is available. Specific educational objectives, content, teaching, and methods of assessment were then considered and defined. Basic factual knowledge about terminal care was to be imparted in a fourth year general practice students' handbook,⁵ in various handouts, and through reference to relevant books and other published material.^{3, 6-12} Teaching time was to be largely devoted to imparting appropriate skills and attitudes.

Educational objectives

These were divided into four parts. At the end of the course and with the benefit of further reading we agreed that students should be able to:

PART 1

(1) Describe the various disorders causing terminal illness.

PART 2

(1) Describe patients' fears about death and dying.
(2) Describe the different stages of dying.

- (3) Define their own attitudes to death and dying and having to care for the terminally ill and bereaved.
- (4) Describe why doctors should be impersonal about death.
- (5) Describe how, why, and when to intervene therapeutically to tell patients the truth about their impending death.
- (6) Manage a situation when a consultant, practitioner, or relative has determined that the patient should not be told the diagnosis yet the patient requests further information about his condition.
- (7) Describe how, why, and when to discuss with the family or relatives, or both, the imminent death of a loved one.
- (8) Describe the ill effects spiritually and psychologically on the patient and family of poor communication.
- (9) Describe how to distinguish worry and anxiety from morbid anxiety or unhappiness and sadness from clinical depression in the terminally ill patient, spouse, or close relatives.
- (10) Prepare relatives for bereavement, grief, and loss.
- (11) Distinguish normal from abnormal patterns of bereavement.

PART 3

- (1) Describe the features of pain to be relieved in terminal illness (particularly malignant pain), the commonly used drugs and other means of pain relief (nerve blocks, radiotherapy, etc), and the appropriate routes of administration.
- (2) Describe the principles which should be applied to relief of pain in terminal illness.
- (3) Describe the range of symptoms commonly encountered in terminal care and the drugs commonly used to relieve the symptoms.

PART 4

- (1) Describe the usual reasons for admitting terminally ill patients to hospital.
- (2) Describe the role of the general hospital or hospice in the care of the dying.
- (3) Describe what can be achieved in domiciliary care of terminal illness and the community resources available to help general practitioners provide the best care.
- (4) Describe the obstacles to the provision of good care.
- (5) Describe the roles of the general practitioner, health visitor, clinical nurse, and social worker in home care.

Psychological management of terminal illness

Students are provided with reading material that outlines concisely the stages of dying discussed by Kubler-Ross,⁶ reactions to bereavement, and the principles underlying psychological management of the dying. The box (below) contains a summary of these principles.

Principles of psychological management of the dying

- Make time to listen; be sensitive to the patient's feelings and inner needs.
- Facilitate discussion of the anxieties, fears, and suspicions of the patient and his or her family.
- Present the truth gently, subject to the patient's desire to receive it.
- Discuss death before it happens with both patient and family.
- Relieve the patient as far as possible of guilt and irrational fears.
- Be accessible to the patient and relatives.
- Anticipate and explain the process of bereavement.
- Communicate effectively with other health and social workers and with specialist hospital colleagues.
- Be as optimistic as the situation permits to avoid hopelessness until it is inevitable.

The handbook summarises reactions to bereavement. Students are expected to be familiar with these before coming to the discussion on terminal care and the following session on bereavement.

The whole emphasis of teaching in these sessions is to make students sensitive to the needs of the dying and aware of their own attitudes to death. A spiritually unhappy and psychologically disturbed patient usually indicates an unsatisfactory and perhaps distrustful doctor-patient relationship. Students are instructed to tell the truth gently and with compassion, whenever possible, provided the patient has indicated a desire to know it. The most challenging and rewarding situation arises for both parties when the patient no longer denies reality and wishes to discuss death. Students are helped to overcome their fears of having to care for the terminally ill and bereaved. They are made aware of the value of accessibility and support in these social crises for patient and family. A patient with religious faith should derive great spiritual comfort if doctor and cleric work hand in hand.

Next year the students will also receive instruction in counselling relevant to these topics in a three hour session on the day immediately after that spent talking about terminal care and bereavement. The departments of general practice and mental health are sharing the planning of the counselling session.

Physical management of terminal illness

Students are taught the principles underlying the relief of pain in terminal cancer and the drug control of common symptoms.¹⁰ They learn that chronic pain is a major problem in patients with terminal cancer and is often inadequately controlled in practice. They are instructed in regular prophylactic routines of administering oral analgesics every four hours, which need not impair the patient's alertness. Addiction and tolerance are not problems, and a careful history will usually show the source and type of pain. They are taught to start with simple analgesics to relieve mild to moderate pain before proceeding to narcotic analgesics for more severe pain. Most patients with moderate pain can be relieved for long periods with 5-10 mg morphine given by mouth every four hours. Injections are rarely needed, certainly not before drowsiness, weakness, or dry mouth make impossible any form of oral treatment.

Studies at St Christopher's Hospice reported by Twycross¹³ showed that there was no clinically observable difference in oral analgesic properties between diamorphine and morphine. In fact, morphine is now widely regarded as the most useful strong analgesic available. Students learn that it is usually prescribed in a mixture with chloroform water, is well absorbed, and gives a peak blood concentration after one and a half to two hours. Treatment usually starts with 5 mg every four hours increased if necessary to 100 mg every four hours. Another very useful and recently available preparation is MST-Continus 10 mg (sustained release tablets of morphine sulphate). It can be used every 12 hours and will be effective in most cases of moderate pain. If it proves ineffective morphine in solution regularly by mouth every four hours can be substituted.

The students are taught to avoid the use of pentazocine (Fortral), pethidine, dextromoramide (Palfium), and methadone hydrochloride (Physeptone) for pain relief in terminal illness. These are short acting drugs, some of which have unacceptable side effects. They are taught that useful additions to sedate and relieve nausea and vomiting are chlorpromazine (Largactil) and prochlorperazine (Stemetil). Cyclizine (Valoid) and metoclopramide (Maxolon) are also often used to relieve vomiting.

Finally, students are alerted to the need to pay careful attention to oral hygiene and the relief of the many common bodily symptoms associated with terminal cancer. These have been well defined by Dr Mary Baines.¹⁰ The box (next page) contains a summary of the general principles that apply to the use of analgesics in patients with terminal cancer. Students should learn these.

Environment of care

Students should discuss fully where terminal care can be provided and by whom because, owing to the success of the hospice

Relief of pain in terminal cancer

- Ascertain the nature and source of pain.
- Plan a prophylactic four hourly oral drug routine and prevent pain developing.
- Maintain treatment by mouth for as long as possible.
- Use morphine as the drug of choice in oral treatment; diamorphine may be preferred for parenteral administration.
- Disregard fears of tolerance and addiction.
- If oral analgesics fail to relieve pain explore other resources, nerve blocks, radiotherapy.

movement and student conditioning in a hospital environment, they may initially tend to see the solution to terminal care in the provision of more specialised units and a detachment of terminal care from the work of generalists, in hospital and general practice. Recent data⁴ show that 59% of all deaths take place in hospital and 30% at home. Many patients, however, are admitted to hospital only a few days before death. Most people would prefer to die in their own homes assuming adequate support is available. In this respect the inadequacy of night nursing support is often a big factor. Other factors are intractable physical, mental, and social problems—for example, severe incontinence and bed sores, mental confusion, intractable pain, and failure on the family's part. The role of the family doctor should be to alleviate distress and misapprehensions surrounding death, supported ably by the nursing team and social services. We teach integrated community care, the general practitioner assuming overall responsibility for home care. He can obtain advice and support at any time from his local hospital or hospice.

The hospice—Students are encouraged to see the hospice as a centre with specialised staff and facilities structured to meet the emotional, spiritual, and physical needs of terminally ill patients. The Marie Curie Homes are discussed in the same context. In many areas the hospice provides day nursing and other support to help the

primary health care team to provide the best possible care in the community. The hospice is also depicted as a research centre in which staff work to develop new techniques to solve complex clinical and social problems associated with terminal illness. Our teaching does not presuppose that most patients who are terminally ill need to be in a hospice or other special unit. The ideal in each health authority area would be to have an integrated terminal care service which would embrace general practice, hospital, and special unit.

Conclusion

These therefore are the objectives and subjects covered by the interdisciplinary teaching session on terminal care. In a further article, next week, I shall describe the format of the teaching session and the methods by which students are assessed.

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(Accepted 26 September 1984)

For Debate . . .

Certifying death in infancy

MAUREEN J SCOTT

For almost 150 years death certificates have formed a basic record of the most serious effect of disease on a population. Observations of changes in patterns of mortality have provided a measure of the effect of changes in the biosocial conditions of populations or in the medical management of diseases.

Perinatal mortality

Perinatal mortality, defined as the incidence of stillbirths and deaths to the end of the first week of life, has been extensively studied¹ and used as a measure of outcome of pregnancy in women

of varying biosocial characteristics delivered under differing patterns of health care. The interpretation of data on perinatal mortality is often confused by doubts about the definition of the populations to which published data refer and by the use of different forms of registration and certification to record information about causes of stillbirth and death.²

CURRENT CERTIFICATION

At present in the United Kingdom two different forms of certificate are used to record cause of death in stillborn and liveborn infants, and the obvious shortcomings of these documents have led the authors of the *Second report* from the Social Services Committee on Perinatal and Neonatal Mortality to record, "we were unhappy about the forms used for the medical certification of perinatal deaths," and to recommend that, "certificates for stillbirths and deaths of infants occurring within the first month are amended

Department of Community Medicine, Queen's University of Belfast, Institute of Clinical Science, Belfast BT12 6BJ

MAUREEN J SCOTT, MD, lecturer in community medicine