Education in terminal care

DEREK DOYLE, MB, FRCGP, K. M. PARRY, FRCPE, FFCM, R. G. MACFARLANE, MD, FRCP

SUMMARY. A survey of the education in terminal care received by a wide range of doctors in Scotland showed that clinical instruction in the physical and emotional aspects of the care of the dying had been generally inadequate, and that the educational influence of a special unit or hospice could be significant. Doctors who had undertaken traineeships in general practice tended to have had more comprehensive training in terminal care—and to be more enthusiastic about further education—than others. We conclude that planned vocational training schemes in all disciplines need to be re-examined for the provision they make for education in terminal care, and that continuing education in the subject may need to be improved for all doctors.

Introduction

IN recent years public concern about the quality of care being given to the dying has been accompanied by a growth in professional demand for more training and experience in terminal care. As the extent of training needs depends on previous education and experience in terminal care, we decided to enquire into these needs through a postal survey of doctors which asked about their previous training and experience; we also sought their opinions on how current educational arrangements could be improved.

Method

Questionnaires asking about education and training experiences in various aspects of terminal care were sent to 292 doctors practising in Scotland. Of these, 96 were pre-registration house officers, 100 were principals in general practice and 96 were consultants in various specialties. House officers were asked about their undergraduate experience, principals and consultants about postgraduate experience. Of the principals and consultants, half had been appointed recently.

Results

General practitioners

Of the 80 general practitioners who responded to the questionnaire, 36 (45 per cent) were Members or Fellows of the College, 44 (55 per cent) had been trainees and 25 (31 per cent) had had experience in geriatrics. The response of general practitioners to questions on postgraduate education and training in terminal care is shown in the Table. Those who had been trainees in general practice had had more comprehensive training in terminal care than those who had not, and more of the former were willing to consider working for four weeks in a special unit than the latter. More than 80 per cent of the respondents were willing to attend training sessions dealing with the physical and emotional aspects of the care of the dying. Like their hospital colleagues, however, only one third or less had attended conferences, symposia or study days on terminal care. Although good terminal care demands an awareness of social and spiritual needs, only 18 per cent of general practitioners had had discussions with social workers and 36 per cent with the clergy.

Comments by general practitioners

Individual comments by general practitioners were mainly that there was a need for additional and special learning facilities for all doctors, including supervised personal experience and special courses or attachments, particularly to hospice-type units. A four-week attachment was thought by many to be too long, but the difficulty of providing clinical teaching in terminal care was acknowledged. The value of personal guidance from experienced doctors was stressed.

Consultants

Eighty-four replies were received from the 96 consultants approached (see Table). More consultants than general practitioners had studied the nursing aspects of terminal care (though still less than 50 per cent), and more had discussed terminal care with social workers.

Derek Doyle, Medical Director, St Columba's Hospice, Edinburgh; K. M. Parry and R. G. MacFarlane, Scottish Council for Postgraduate Medical Education.

© *Journal of the Royal College of General Practitioners*, 1982, 32, 335-338.

Postgraduate education and training: general practitioners and consultants.

	General practitioners						Consultants	
	Trainee experience (44)	(per cent)	Non-trainee (36)	(per cent)	Total (80)	(per cent)	(84)	(per cent)
Since you graduated have you had any lectures, discussions, tutorials or instruction on:								
Pain control?	39	(89)	22	(61)	61	(76)	58	(69)
Symptom relief (other than pain control)?	28	(64)	16	(44)	44	(55)	44	(52)
Communicating with dying patients?	28	(64)	12	(33)	40	(50)	36	(43)
Nerve block techniques?	7	(16)	6	(17)	13	(16)	30	(36)
Palliative radiotherapy?	13	(30)	6	(17)	19	(24)	46	(55)
Palliative chemotherapy?	13	(30)	8	(22)	21	(26)	48	(57)
Nursing problems of the terminally ill?	19	(43)	14	(39)	33	(41)	38	(45)
Bereavement counselling?	28	(64)	12	(33)	40	(50)	29	(35)
Have you had any clinical instruction in terminal care?	9	(20)	6	(17)	15	(19)	23	(27)
Have you worked in a radiotherapy unit?	1	(2)	1	(3)	2	(2.5)	7	(8)
Have you had discussions with or talks from social workers about the terminally ill?	6	(14)	8	(22)	14	(18)	33	(39)
Have you attended lectures or talks about bereavement counselling?	21	(48)	9	(25)	30	(38)	16	(19)
Have you visited a hospice, palliative control unit or continuing care unit?	14	(32)	8	(22)	22	(28)	28	(33)
Have you attended any conferences/study days/symposia on terminal care?	13	(30)	12	(33)	25	(31)	19	(23)
Have you had discussions with or talks from the clergy on the spiritual aspects of terminal care?	13	(30)	16	(44)	29	(36)	24	(29)
Have you read any books on the physical aspects of terminal care?	16	(36)	13	(36)	29	(36)	44	(52)
Have you read any books on bereavement?	19	(43)	10	(28)	29	(36)	27	(32)
Would you consider it worthwhile to work for four weeks in a special unit caring for the terminally ill?	27	(61)	18	(50)	45	(56)	31	(37)
Would you find it helpful to attend sessions dealing with:								
The physical aspects of the care of the dying?	42	(95)	27	(75)	69	(86)	59	(70)
The emotional aspects of the care of the dying?	40	(91)	26	(72)	66	(83)	58	(69)
Bereavement counselling?	37	(84)	13	(36)	50	(63)	52	(62)

While about one third had had instruction in bereavement counselling or had read books on it, about two thirds felt the need for further training in both the physical and emotional aspects of terminal care—figures only slightly lower than those for general practitioners.

Comments by consultants

There was strong support from several consultants for special courses or attachments, for additional and special learning facilities for all doctors and for continuity of care to be provided by the doctor who had looked after the patient in the early stages of the illness rather than by a specialist in terminal care. A number thought that experience in the care of the dying was best acquired by having responsibility for the day-to-day care of patients and were sceptical about formal instruction. Others were doubtful if counselling could be taught, even with the help of social workers or the clergy. Generally the importance of good terminal care was stressed, but opinion varied on how best it could be acquired; clinical experience was the single most important factor.

Pre-registration house officers

The 96 pre-registration house officers were asked about undergraduate education and training. Graduates of the University of Edinburgh appeared to have had more specific training in terminal care than those of other universities. This may reflect a greater use made in Edinburgh of hospice-based training and, possibly, the interest in terminal care generated by the activities of the Edinburgh Medical Group. The influence of teachers' attitudes was considered significant. Several house officers had had personal difficulty in dealing with terminally ill patients or their relatives. Other comments again stressed the need for and the value of personal experience under supervision rather than formal instruction, although counselling training was thought by some to be helpful.

Discussion

The survey was not designed for statistical analysis but to gain insight into the training received, sought and needed; its imperfections are recognized. The responses

suggest that education in many aspects of terminal care is at present inadequate and that doctors are dissatisfied with their skills. This conclusion supports the findings of Parkes (1978), who reported poorly controlled pain in nearly 30 per cent of patients dying at home and in 20 per cent dying in hospital. Levy and Sclare (1976), Soukop and Calman (1977), Carne (1979) and Doyle (1980) have demonstrated that good terminal care can, and often should, be provided at home, where 90 per cent of patients spend most of their last year; yet only 55 per cent of the general practitioners in our survey had received training in symptom control, 50 per cent in bereavement counselling and only 19 per cent had had clinical instruction. It is sometimes said that skills such as communication and counselling cannot be taught, but there is good evidence to disprove this (Maguire *et al.*, 1980) and recent proof that good communication helps the dying patient.

A Central Health Services Council working group on terminal care (Wilkes, 1980) has recommended that "a terminal care component should be included in the medical training of students" and that "medical students would, like nurses, benefit from instruction in counselling techniques"; it also proposed that "all general practitioners and community nurses should have an opportunity to attend a course on terminal care". Looking at the need for specialists in terminal care the working group went on:

> "This problem [the lack of postgraduate training in this field] should be considered very seriously by the Joint Committee on Higher Medical Training and the relevant advisory committees on specialist training. Those bodies responsible for radiotherapy, general medicine, anaesthetics, geriatrics and general practice should consider whether trainees in their specialties might usefully undertake a six-month option in terminal care."

Our survey shows the preponderance of didactic over clinical instruction and the educational benefits of hospice-based training. Attachment to a hospice for any length of time was thought by half of the respondents to be impracticable, but ways must be found of providing appropriate experience in the care of the dying for medical students and qualified doctors which does not intrude into the privacy and dignity of patients. Teaching methods need to be examined and the benefits of one-to-one and small group learning should be explored.

References

Carne, S. (1979). Managing the dying patient in general practice. *Modern Medicine,* **24,** 25-29.

Doyle, D. (1980). Domiciliary terminal care. *Practitioner,* **224,** 575-582.

Levy, B. & Sclare, A. B. (1976). Fatal illness in general practice. *Journal of the Royal College of General Practitioners,* **26,** 303-307.

Maguire, P., Tait A., Brooke, M., *et al.* (1980). Effect of counselling on the psychiatric morbidity associated with mastectomy. *British Medical Journal,* **281,** 1454-1456.

Parkes, C. M. (1978). Home or hospital? Terminal care as seen by surviving spouses. *Journal of the Royal College of General Practitioners,* **28,** 19-30.

Soukop, M. & Calman, K. C. (1977). Cancer patients: where do they die? An analysis. *Practitioner,* **219,** 883-888.

Wilkes, E. (1980). *Terminal Care: A Report of a Working Group.* London: HMSO.

Address for reprints

Dr K. M. Parry, Secretary, Scottish Council for Postgraduate Medical Education, 8 Queen Street, Edinburgh EH2 1JE.

Words our patients use

'Peely wally'—not looking well (Greenock).
'He really gets his hair off'—A baby having a tantrum (Shropshire).
'Cranky'—an irritable person (County Cork).
'Niggly'—petty (County Cork).
'Jag'—injection (Scotland).
'Glut'—phlegm or mucus (Scotland).
'To play steam with someone'—to get angry with them (South Yorkshire).
'To be bad with the bile'—to feel sick (South Yorkshire).
'Wingey'—not very ill, slightly fretful and feverish (as of a child) (North-east England).
'Hangy'—worse (North-east England).
'Crook'—ill (Australia and New Zealand).
'Crazy as a chook'—agitated (New Zealand).

Patients with psychosocial problems

A study has tested the hypothesis that family practice patients with intrapersonal psychosocial problems are likely to be identified as having more health problems in general than patients not afflicted in this way. Thirty-one per cent of all patients in the study practice were defined as having intrapersonal problems (on the criteria given), and 94 were randomly selected for study. Study group patients were found to have a significantly greater number of family problems, hospital admissions, major surgical procedures, number of visits to the practice, gastrointestinal disorders and illness due to inflammatory causes than normal controls. They also had more psychiatric care, more attention from allied health professionals and more frequent psychotropic drugs.

Source: Brennan, M. & Noce, A. (1981). A study of patients with psychosocial problems in a family practice. *Journal of Family Practice,* **13,** 837-843.