

Should palliative medicine be a compulsory part of undergraduate medical training?

The General Medical Council necessitate that newly qualified doctors should be able to provide “compassionate interventions” for patients nearing the end of life⁽¹⁴⁾. Nonetheless, there is significant variability in the provision of palliative care education amongst UK medical schools. The lack of adequate and consistent teaching engenders a culture whereby junior doctors feel ill-equipped to deliver care to patients approaching death. Given the UK’s ageing population and the growing demand for end of life care, we have a dichotomy between the needs of patients and the competence of future doctors.

Palliative medicine is a relatively new field, being first recognised as a medical speciality in 1987. The comparative ‘youth’ of palliative care (PC) in the medical sphere is reflected in the fact that some UK medical schools do not prioritise PC teaching. According to a recent study, only 67% of UK medical schools provided an official PC component in their teaching curriculum⁽¹¹⁾. There is also ambiguity in the design of the PC course in some medical schools: the PC curriculum is established formally through ‘active planning’ in only 43% of institutions and 1 in 10 schools had no designated teaching lead⁽¹¹⁾. Equally, the time dedicated to PC teaching varies greatly. The consensus from the European Association for Palliative Care is that medical schools should provide at least forty hours of PC training to undergraduate students⁽¹⁵⁾ but some schools allocate only six hours in total of teaching time whereas others allocate over 100⁽¹⁰⁾. These inconsistencies reveal a huge imbalance between the standards of palliative medicine teaching across the UK, with a proportion of students missing out on well-devised and well-delivered PC content.

Some medical schools state that the lack of palliative care teaching is as a result of timetabling issues⁽⁵⁾ or funding⁽¹¹⁾. I would argue that these reasons are superficial and mask a much deeper barrier: the ethos of modern medicine itself. To quote Atul Gawande: “the purpose of medical schooling [is] to teach how to save lives, not how to tend to their demise”⁽¹⁶⁾. The early years at medical school concentrate on the pathology of dying – understanding what ‘death’ looks like from a post-mortem specimen or on a histology slide. Death becomes detached from a human narrative; as medical students, we view it simply as a malfunction of human physiology. As students’ clinical exposure increases, we are taught how to treat patients, learning by rote first line, second line, third line therapies. Everything is orientated towards maximising cure and minimising decline. Death is therefore seen as a sign of failure rather than the natural course in a patient’s journey. Consequently, palliative care - which goes against the impetus to preserve life at all costs - is somewhat alien.

Inevitably, our culture of cure over care encourages the medicalisation of death. In 2017, 46% of deaths occurred in a hospital⁽¹⁷⁾, and almost a quarter of occupied hospital beds are taken up by patients who are in the last year of life. The care of the dying therefore occurs predominantly in institutions where efficiency and protocol are paramount. As a result, end of life care (EOLC) management can tend to the formulaic. Indeed, the now-defunct Liverpool Care Pathway was deemed as purely a ‘tick-box’ protocol⁽¹⁸⁾, drawing criticisms of doctors not personalising care to the individual needs of the patient. Unfortunately, this sense of adhering to regimental practise is apparent in PC training, whereby undergraduate teaching focusses heavily on managing the physical symptoms of dying. Evidence has demonstrated that the main topics covered by PC curricula are the assessment and management of pain, principles of symptom management and death certification⁽¹⁰⁾. At the other end of the spectrum, attitudes towards death, managing bereavement and the cultural aspects of EOLC are rarely covered. Concentrating on purely the physical symptoms disregards the

concept of the complex interplay of 'total pain', a model pioneered by Cicely Saunders which states that pain is physical, psychological, spiritual and social. Although knowledge and understanding of how to tend to the physical symptoms of a dying patient is fundamentally important for medical students to learn, it should not be at the detriment of dedicated teaching on these wider aspects of death and dying. Medical students need to be taught how to adequately manage the psychological and spiritual pain of patients in their care – pain that cannot be treated via a protocolled approach.

Teaching on spirituality is often sparse in the medical school curriculum. In one UK hospital, 94% of staff and students had not received any formal training in providing spiritual care to patients⁽⁶⁾. The absence of satisfactory education of the non-physical aspects of death and dying is attributed to a reduced involvement of sociologists and psychologists in delivering teaching to medical students⁽⁴⁾. Teaching provided solely by clinicians propagates the medicalisation of EOLC and impacts on the ability of future generations of doctors to care holistically for patients.

Currently, our death-averse medical system and over-focus on managing the physical symptoms of the dying are not preparing medical students for life as a junior doctor. We know that prior to medical school students will have had little contact with death and dying⁽¹³⁾. As students gain clinical experience, exposure to end of life scenarios can aversely impact students' attitudes and increase death anxiety⁽⁹⁾. This anxiety is still present after graduating. In a recent survey, 65% of FY1 doctors questioned said they had felt 'personally distressed when caring for patients with palliative care needs'⁽¹⁾. Particular difficulties experienced by FY1s included communicating with patients and their families about death⁽⁷⁾. Predictably, some of the more 'practical' tasks such as certifying deaths or viewing bodies were perceived as easier. Lack of consultant support and the frequency of senior-led decisions to 'overtreat' patients added to the difficulty faced by young doctors. Given that after the

first year of qualification a FY1 doctor will care for around 40 patients who die and a further 120 patients in their final months of life, it is vital that young doctors feel comfortable in challenging EOLC situations.

It is evident that the area in which PC education needs to improve is communication skills. Communication is by far the most important tool a doctor has when caring for a patient who is about to die. Sensitive and honest conversations provide a space for the physician to allay anxieties, provide reassurance and explore patient fears. Including palliative care discussions earlier in the disease course is helpful for patients⁽⁸⁾. Unsurprisingly, 90% of patients with a life-threatening illness report never having discussed EOLC issues with their clinician⁽²⁾. Although patients themselves are uncomfortable at broaching a conversation about death, doctors too are guilty of evading these difficult encounters. Death anxiety can impair doctors from speaking frankly and honestly with patients, and a personal fear of death may discourage healthcare professionals from breaking bad news to patients⁽³⁾. Poor communication on behalf of the medical professional can also cause more harm to the patient. “Iatrogenic suffering” can occur after inadequate communication leaves patients with more hurt and anger⁽¹²⁾. Baroness Neuberger called for a ‘National Conversation’ about dying⁽¹⁸⁾, and medical students and doctors alike are pivotal players in this dialogue.

Caring for the dying can be one of most rewarding aspects of a doctor’s professional life. Unfortunately, PC training is falling short in preparing young doctors for caring for dying patients. All medical schools include at least some aspect of PC training in the curriculum, so making PC teaching ‘compulsory’ will make little difference to the current failings in undergraduate education. Equally, simply increasing PC teaching on the timetable will not tackle the root of the problem. Instead, there needs to be a change in culture. Modern medicine must embrace death as something that need not

be resisted. All clinicians – from medical student to senior consultant – should be encouraged to adopt a narrative that a timely death is not a failure. All of us should be encouraged to talk frankly about our own fears of death, to ensure that when we are caring for a dying patient we do not shy away. Doctors are not superheroes and they can't cure everyone - but they do have the power to ensure patients have a good death.

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