Reviews

Terminal Care: Report of a Working Group. Standing Medical Advisory Committee, DHSS. 1980. HMSO.

In March 1979, a working group chaired by Professor Eric Wilkes was set up on behalf of the Standing Medical Advisory Committee of the DHSS 'to consider the organization of primary, continuing and terminal care services for cancer.' That group has now reported its findings.

Wilkes' report draws attention to the considerable advances that have been made in both the physical and the psycho-social aspects of terminal cancer care in the last decade. This extends to the family as well as the patient and should, where appropriate, continue after bereavement.

Although many of these advances stem from the Hospices, their implications are not limited to Units of this kind and the working party does not envisage a large increase in the number of Hospices. They seek to ensure that every dying patient has access to professional staff who can provide the appropriate care wherever the death may occur. To achieve this they recommend the development of 'special units' in every region, some within Hospices, but others in General Hospitals, where they can provide specialist consultant services to other hospital staff as well as to primary care teams, without necessarily removing dying patients from their care. Hospices should become centres of expertise where staff can be trained in the techniques of terminal care and where research can be carried out but they should not attempt to serve more than a small proportion of those who die from cancer.

Although the report recommends that all nurses and medical students receive training in the psychological aspects of dying and bereavement, it makes no mention of our profession either as teachers or members of the 'special units' which it seeks to set up. This amazing lapse reflects the situation in the field. I recently wrote to 64 units providing terminal care in Britain and found that only 8 out of 38 who replied had a consultant psychiatrist. Yet half the items in the working party's list of 'Further Reading' were written by psychiatrists and there is a large body of knowledge on which we can draw if we choose to play a part in initiating and supporting 'special units' in our own regions. I would be glad to hear from psychiatrists who have an interest in this field and would like to be informed of meetings or other events.

C. M. PARKES

St Christopher's Hospice,
Lawrie Park Road,
London, SE26.

[See also Correspondence, pp. 187-88 and report of conference below.]

Under Discussion

Dying and Bereavement—A Conference for Psychiatrists

Recently, Dr Colin Murray Parkes wrote to all the hospices and continuing care units in the United Kingdom, asking for information about psychiatrists associated with them. The names of about thirty people were returned. Nine of those met recently at St Christopher's Hospice, together with Dr Parkes, Dr John Fryer (an American psychiatrist who has been Director of Studies at St Christopher's for the past year), Dr Loma Feigenberg, an oncologist and psychiatrist from Stockholm, and Dr Sam Klagsbrun from New York. Some conference members had been involved in the care of the dying and bereaved for years; others came because of their interest in and wish to help a hospice already established or still in the planning stage, in their own neighbourhood.

We considered our various ways of working as consultants: in clinical roles, as team members, offering staff support, and also being available to advise in administrative matters. Most of us functioned as therapists too, and as teachers. Each participant distributed his or her time differently in these three areas, and it was most valuable for us to exchange ideas. The extent of our involvement was determined by our own clinical bent, the time available, and also the expectations each local organization had about psychiatrists. In this context the replies to the original questionnaires were interesting. Some commented that they had no psychiatrist, but now wondered if they should. Others had been disappointed in the contact they had with psychiatrists, finding them too intrusive on the one hand, or 'only prepared to prescribe drugs' on the other. It became clear that a lot of groundwork is necessary to define the needs of dying and bereaved persons and of the staff who care for them, and to prepare and train psychiatrists who would like to do this work.

Although most of us would not want to encourage a specialty of thanatology, we agreed that our basic psychiatric training had not equipped us adequately to care for the dying and bereaved. We were at different stages in acquiring, through experience, the special skills we needed.