

CHAPTER 3

PROPOSAL: 'COPING WITH DEATH AND DYING', AN ADDITION TO THE EXISTING CURRICULUM FOR MEDICAL STUDENTS IN THAILAND

3.1 Introduction

The need for palliative care will increase in the near future: the population is aging, and deaths due to cancer and AIDS are raising. The health care system of Thailand will have to cope with this problem. Have preparations been started?

The people who will have to play the role of agents of change and who will have to respond to the impending crisis are the physicians, because they have the power due to the tendency in paternalistic approach of medicine in Thailand. Palliative care is total care: are the physicians adequately prepared and trained for it?

This proposal concerns an addition to the existing curriculum of medical students regarding palliative care. At the same time it has as a result a recommendation to the concerned authorities about the realization of the implementation of palliative care throughout the health care system of Thailand. This recommendation can serve as a document containing basic information for further discussions among involved parties.

3.2 The Problem and its Context

At present, patients with cancer and AIDS have to suffer physically and emotionally and in the end they will die of their disease. The AIDS problem is on the increase: for the year 2000, the projected global cumulative total of adult AIDS cases is close to 10 million, of which almost 90 per cent will be in the developing countries. It is estimated that tumors will develop in 10 to 40 per cent of HIV patients (Stjernsward, 1993).

According to a projection of AIDS deaths in Thailand (low scenario) the number in 1996 would be 40,451 and in the year 2000 it would be 129,353 (Viravaidya, Obremsky and Myers, 1993). These numbers strongly suggest that deaths due to AIDS are going to increase sharply during the coming years. In the field of AIDS, until a vaccine or a simple curative agent becomes universally available, access to excellent palliative care must be the mainstay of AIDS therapy.

The incidence of cancer continues to increase throughout the world, specially lung cancers. While most cancers occur in older people, there is a tendency to assign a lower value (especially economic value) to a loss of life in older age groups compared with that in young populations. This is reasonable considering the years of life, enjoyment and productivity losses. However, a death at 35 or a death at 70 will still be associated with similar degrees of suffering (Doyle, Hanks & MacDonald, 1993).

In Thailand, in a period of 6 years, there was an increase of 13.5 per 100,000 population in the cause of deaths due to cancer (see Table 1).

Table 3.1

Malignant Neoplasm Deaths in Thailand.

Year:	Number:	Rate/100,000
1987	16,905	31.5
1988	18,284	33.5
1989	20,385	36.8
1990	22,154	39.3
1991	23,332	41.2
1992	24,961	43.5
1993	26,132	45.0

Note. Source: MOPH, 1995.

Not only cancer and AIDS will be the concern for the future, but there is also an enormous increase in the numbers and proportion of the elderly, in contrast to the decreasing proportion of caregivers. The need for palliative medicine is definitely growing. Priorities will therefore have to be addressed for future strategies in health care.

According to Stjernsward (1993), close to 60 per cent of the world's new cancer patients are occurring in developing countries; at least 80 per cent of these patients are incurable at the time of diagnosis, and only 5 per cent of the world's total resources for cancer control is available in the developing countries. He also states that with the knowledge that relatively inexpensive, effective and scientifically valid methods exist for palliative care, it is tragic to see how almost all efforts and resources in the developing countries go to therapeutic approaches, with a very limited effect. The

medical profession should come to realize that palliative care will be the only pragmatic, humane and affordable solution, both for cancer and for AIDS patients, at least for the time being and for the years to come. The provision of palliative care for AIDS and cancer patients requires attention at the top decision-making and political levels in a country: the World Health Organization has made palliative care a priority in its Global Cancer Control Program, especially regarding the relief of cancer pain. Several countries have established guidelines on cancer and pain relief.

3.3 Palliative Care

What is palliative medicine? Doyle, Hanks and MacDonald (1993) explain it as follows in the introduction of their textbook:

Palliative medicine is total care - of body, mind and spirit. This is undeniable and unavoidable. So often in medical practice this is acknowledged and a claim made that it is always practiced, but this is transparently not so. ... Many doctors find themselves focusing almost exclusively on physical problems. When so-called 'social problems' are encountered, they are passed to the social worker who may never meet the others involved in that patient's care. If 'spiritual problems' are uncovered, they are more likely to be met by embarrassed silence... Emotional problems ... are dealt with in a perfunctory manner as if a few minutes explanation and reassurance will cure all this... In palliative medicine, where the doctor is but one important member of ... a team, each patient is recognized as having physical, emotional, social and spiritual needs as well as problems, and each need is given full and equal attention. No man can be rendered pain free whilst he still wrestles with his faith. No man can come to terms with his God when every waking moment is taken up with pain or vomiting. (p. 6)

Medicine today is aimed at cure. Every patient is a challenge to prove the physician's skills and to go on with the treatment. Sometimes the

patient or the family has to intervene to stop unnecessary treatments. At this point many doctors tend to disappear. The loss of their power over life poses a significant threat for them and they turn away from the patient who personifies their weakness. Every time a patient dies, his doctor is reminded that his own and mankind's control over natural forces is limited and will always remain so (Nuland, 1993). It is very hard for a doctor to admit that 'no more can be done'.

Doctors have difficulties to cope with 'failure' and with the unbearable feeling that there is nothing they can say or do for the patient, because they have not been trained for it. Elisabeth Kubler-Ross (1975) expressed it in the following way: "What do you expect from medical students who are prepared exclusively in the *science* of medicine, medical schools give them little help in its *art*." The question then arises: Do the medical schools in Thailand train the medical students in the 'art' of medicine?

In the UK, informal questioning in medical schools at the end of the 80s, had already elicited the view of many teachers that everything which needed to be taught was already taken care of. The recollections of newly qualified doctors belied that statement: some recalled not having been taught anything about the special problems of the dying patient, and almost without exception they, and many more senior and experienced colleagues, expressed the need for more formal training, so incompetent and lacking in confidence did they feel when confronted by death (Rapin and Weber, 1991; Field, 1993). More studies were carried out and teaching modules for undergraduates and postgraduates were developed. Certain subjects were central in the curricula: pain and symptom control, emotional and social needs, and spiritual care (Doyle, Hanks & MacDonald, 1993).

3.4 Aim of the Proposal

The need for palliative care is here and it will increase during the years to come because of the rapid aging of the world population, the increase of deaths related to tobacco use, and the increase of AIDS (Stjernsward, 1993).

It is necessary to include palliative medicine in curricula of health professionals and in the planning of health care programs. However, if coverage has to be achieved, it is important to remember that compassion not combined with wisdom is inefficient in relieving suffering. A rational approach, stressing a public health approach rather than an institutionalized one, should be a priority for those involved in implementing existing knowledge in palliative care (Stjernsward, 1993).

It is worthwhile to explore how the problem is being perceived in Thailand. More specifically: How do Thai physicians experience the confrontation with death and dying? What do they need to learn about palliative medicine? What is feasible in terms of hospital services or community-based services? What are the possible alternatives?

Because of the tendency to a paternalistic approach in medicine, physicians are the ones who have to support these possible programs of setting up the implementation of palliative care. They will have to be a source of strength for these programs. Otherwise medicine will continue to treat the terminal patients 'as if' cure would be possible, and people would suffer needlessly.

This proposal aims at :

1. Creating an addition to the existing curriculum for medical students concerning knowledge, attitudes and skills in palliative care. This addition will allow the student to develop:
 - a. An understanding of the principles of palliative care.
 - b. An understanding of the strengths of teamwork.
 - c. Confidence to cope with difficult questions.
 - d. The need for application of clinical skills to ensure the best possible quality of life for patient and family (Smith, Finlay, Lennard and Twycross, 1992).
2. Formulating a recommendation about the realization of the implementation of palliative care throughout the health care system of Thailand.

The proposed study will be executed by an inquiry team, which will visit the UK to obtain the necessary information, followed by a survey of all the final year students of the medical schools of Thailand.

3.5 Rationale

The implementation of palliative care is not a simple issue: it requires education of medical professionals as well as an awareness of the policy-makers, it will even call upon a change in management of the health care system. At this point it becomes a political issue which needs time to develop. The problem is that there is very little time left. The increasing number of deaths in Thailand due to AIDS speak for themselves: in 1996 it

was estimated to be 40,451 and in the year 2000 it will be 129, 353 (Viravaidya, Obremsky and Myers, 1993).

Action is needed and a start can be made by looking at the educational aspects regarding palliative care for the physicians. Relief of physical symptoms must be the foundation on which all other aspects of palliative medicine rest. It follows then that the physician plays a central role in the team. Physicians, however, need to draw on the knowledge of other disciplines to ensure co-ordination of care for any individual patient. Co-ordination requires effective communication and leadership: both of these issues can lead to difficulties (Ajemian, 1993). The physician may easily be considered as the leader of the team because of the paternalistic approach in medical science in Thailand. However, an important issue has to be considered: although the physician can be 'seen' as the leader, he/she has to realize that other members of the team are equally important because they are team members with special expertise and training. For physicians this means that they will have to consult nurses, social workers, patients and family members. It is of the utmost importance that physicians are informed properly; they will have to function as the agents of change during the implementation of the palliative care process. The principles of palliative care should therefore be included in their curriculum.

In the West, several studies have been conducted to define training needs. These studies can be used as references and can serve as a guide for new programs. A palliative medicine curriculum has been developed and published in 1992 by the Association for Palliative Medicine of Great Britain and Ireland. This contains a syllabus which sets standards for training doctors in palliative medicine. The working party which produced the



syllabus used the following definition of palliative medicine (Smith, Finlay, Lennard, & Twycross, 1992):

Palliative medicine is the appropriate medical care of patients with advanced and progressive disease for whom the focus of care is quality of life and in whom the prognosis is limited (although sometimes it may be several years). Palliative medicine includes consideration of the families' needs before and after the patient's death. (p. 1)

The syllabus covers following aspects which are relevant to the training of the medical student: physical aspects, psychological aspects, religious and cultural aspects, ethical aspects, teamwork, and organizational aspects.

The Education Department of Marie Curie Cancer Care published in 1992 a curriculum about teaching ethics. Formal education in ethics is often lacking in training and this curriculum fulfills this need: it is not a planned course, but it is intended to be flexible enough to enable teachers to use it within a variety of teaching settings and groups (Teaching Ethics, 1992). This curriculum is valuable material to be used in this study.

In Canada, a curriculum for palliative care has been published: it addresses the specific attitudes, skills and knowledge which undergraduate medical students should possess at the time of graduation relevant to 22 problem areas including: major symptoms, psycho-social distress, collaborative work with other health professionals, and home care planning (MacDonald, 1994).

There is a lot of literature available on this topic: excellent journals have been created over the past few years and the 'Oxford Textbook of Palliative Medicine' (see bibliography) is a must for the background reading. It is the most comprehensive and scientific text on the rapidly developing

specialty of care for the dying; it is an indispensable guide for all those involved in palliative care.

It is important that attention is being paid to the existing results of the conducted research, but conclusions can not be drawn relying on these results only: every country has its specific cultural, religious and social aspects which influence the general approach of dealing with suffering, death and dying. Moreover, there are the available resources which will play a role in feasibility of possible programs.

While gathering information about the topic and its background, while looking at realized applications in other places, it is possible to explore the possibility for a way of implementing palliative care in the Thai community. The health care system of Thailand has to prepare itself regarding the increasing pressure of AIDS and cancer patients.

In Thailand there are signs of a growing awareness. During my information gathering, I came across several small-scale studies which have been carried out. Associate Professor Sivalee Sirilai of Mahidol University conducted research in 1988 with the aim to study the conceptual and practical criteria of clinical physicians towards death and the prolongation of life for the terminally ill. This included how they made decisions when facing ethical problems related to the prolongation of life by artificial means or allowing the patient to die (Sirilai, 1988).

In 1994, two teachers of The Thai Red Cross Nursing College conducted a study with the objective to explore how patients and nurses reacted to terminal care. They collected information from 86 terminal patients and 254 nurses (Ajarn Chatchanaj and Ajarn Champonuch, personal communication, September 1995). Also in 1994, a thesis was

written by a Master of Nursing student on “The study of nurses’ self awareness and caring behavior for terminally ill patients” (Daodee, 1994). Another Master of Science student did her thesis on: “A developmental model of hospice care in St. Louis Hospital” (Sriworakul, 1994). In Ramathibodi Hospital, on the obstetric cancer ward, a project is being conducted. Monthly meetings are organized in which physicians, head-nurse, nurses and a professor discuss the situation and the treatment of terminally ill patients. Their aim is to improve the quality of life of these patients.

These are only a few studies I came across, there must be more. It suggests that medical professionals are aware of the need but more research is needed, so that clear conclusions can be drawn for necessary additions in curricula of health professionals.

3.6 Objectives

3.6.1 Objectives of the study

The study will concentrate on developing an addition to the existing curriculum regarding palliative care for medical students in Thailand. Special attention will be paid to cultural, religious and social aspects.

Moreover, this study aims at providing a basis for further negotiations with the Ministry of Public Health, concerned professional associations, and other authorities regarding the implementation of an integrated palliative care program in the health care system of Thailand.

To reach these objectives, the proposal aims at facilitating an inquiry team for a visit to the UK, followed by a survey in Thailand. This survey comprises a self-administered questionnaire for all the final year medical students, and discussions in focus groups in the different medical schools in Thailand.

3.6.2 Objectives of the team

The study objectives of the team during the visit to the UK:

1. Determine what knowledge, skills and attitudes are needed by the physicians regarding palliative care.
2. Describe the constraints to implementing such changes in the curriculum for medical students.
3. Start the preparation of the recommendation of an addition to the existing curriculum for medical students concerning palliative care by preparing the questionnaire.
4. Prepare a recommendation to be presented later on to the concerned authorities for future studies to realize the implementation of palliative care throughout the health care system in Thailand.

The study objectives of the team after their return to Thailand:

5. Explore how death and dying are perceived by Thai physicians, by means of the questionnaire.
6. Describe the social and cultural factors which have to be taken into account regarding palliative care.
7. Define what training needs are necessary regarding palliative care for medical students.

8. Formulate these needs in an addition to the existing curriculum for medical students.
9. Make recommendations for an addition to the existing curriculum for medical students concerning palliative care.
10. Make recommendations for future studies to realize the implementation of palliative care throughout the health care system in Thailand.

3.7 Research Questions for the Team

Looking at the study objectives the research questions will consequentially be:

1. What behaviour (attitude?) characterizes the Thai physicians in their attitude towards death and dying.
2. What are the problem areas for physicians when coping with death and dying?
3. What are the knowledge, skills and attitudes needed by physicians, to be able to apply the palliative care principles?
4. What changes should be made in the existing curriculum so that medical students will be prepared better to cope with death and dying?
5. What should be recommended for a future implementation of palliative care throughout the health care system in Thailand?

3.8 Plan of Work

3.8.1 The inquiry visit

The study contains two main parts, the first is an inquiry visit of a team to the UK, the second part is a survey of the final year medical students of Thailand by means of self-administered questionnaire, followed by discussions in focus groups in the different medical schools in Thailand.

The visit intends observation of existing services in collaboration with a renowned training center. This visit is imperative because palliative care is not practiced yet in Thailand as it is in the UK. The training center which is attached to the St. Christopher's Hospice has a good reputation and is equipped with an excellent library for literature research, as well as a whole range of training aids and materials. The hospice provides possibilities for practical training and the staff employed is used to dealing with trainees.

It would be very difficult for Thai physicians, nurses or social workers to understand fully the concepts of palliative care if they have not been part of its application in real life. They will experience what it means to work in an interdisciplinary team. Professionals who have had this opportunity may develop different working practices from those who develop more in isolation. The teamwork climate encourages more confidence and perhaps a greater insight into the special skills of other practitioners (Thomas & Mimmack, 1994). This exposure can not be taught by a literature research; it needs participation.

Palliative care applies the interdisciplinary team approach and therefore it is necessary to include persons from different disciplines. In the interdisciplinary team, the identity of the team supersedes individual

professional identities. Members share information and work together to develop goals. Leadership is shared among team members depending on the task at hand and the interactional process is vital to success (Ajemian, 1993). Therefore, it is necessary that people of different disciplines visit the site together: their personal experiences will be needed to discuss the team approach regarding teaching and also the future integration of palliative care into the health care system in Thailand.

The committee of inquiry, or the research team will consist of 5 members. First, there should be a researcher, who is expert in qualitative analysis and who is employed by the College of Public Health of the Chulalongkorn University, Bangkok, Thailand. He/she will be the responsible person of the team taking care of the organizational aspects of the visit, guided by her/his professional knowledge. Next, there should be two physicians, preferably an experienced physician with profound knowledge of the structure of the health facilities in Thailand with regard to the future implementation of palliative care into the health care system. The second physician should be a young one who finished his studies within the past one or two years so that he can recount the teachings during his/her study period. Next, there should be an experienced nurse who has had considerable contacts with terminal patients. Finally, there should be an experienced social worker who has worked with terminally ill patients and their relatives.

The visit to the UK will be organized for a duration of 8 weeks, so that the team members will have the opportunity to:

1. Participate in a short course on palliative care (3 weeks).
2. Be involved in the practical experience of application of the principles of palliative care, both in the hospice and in the home care service.
3. Visit some other hospices and interview the staff regarding experiences.
4. Interview general practitioners and community nurses, who participated in the workshops for palliative care and who have practical experience.
5. Interview the social workers and chaplains involved in palliative care.

The team members will use the lodging facilities of the training center, connected to the St. Christopher's Hospice in London. This training center has a well-equipped library, which can be used freely by the team during their stay and which provides an excellent source for a literature review as well as wide scope on teaching materials related to palliative care. The training center also has small conference rooms available which will facilitate the team to organize the necessary meetings during their stay. Computer facilities are also available, including E-mail.

The detailed program will be worked out by the responsible person of the team in cooperation with the training officer of St. Christopher's. The programme will be based on certain objectives regarding the study; the team will have to obtain information about how to determine what knowledge, skills and attitudes of the medical students should be improved towards the

care of terminally ill patients. They will also work on gathering information so that they can prepare recommendations for future studies to realize the implementation of palliative care throughout the health care system in Thailand. During the visit the team members will have meetings regularly where the different topics will be handled and prepared and where progress will be recorded.

3.8.2 The survey

The study will be considered as a cross-sectional descriptive study which will be performed among all the medical students of the final year by means of a self-administered questionnaire. The sample covers all the medical students of the final year at different universities of Thailand. This sample size (100 %) is needed to improve validity and generalizability for all the universities in Thailand. The total sample size will be approximately 1200, being the total number of final year medical students throughout the country. Data from different universities can be compared. The resulting data will be analyzed by the researcher using the EPI program which is designed for quantitative research.

The questionnaire will contain questions related to measurable variables such as knowledge about the physical aspects: the disease process and symptom control. Questions about pharmacology and the statutory regulations will also be included. These concern the quantitative aspect of the research.

For the qualitative aspect discussions in focus groups will be organized in the different universities. A random sample of 5 % of the final year students in each university will be done to form the focus group: this

will result in a group of approximately 15 persons. The topics will concern the psychological aspects of palliative care, such as family and social background of the patient, communication skills, psychological responses, sexuality, grief and awareness of personal and professional feelings. Further the discussions will cover religious and cultural issues, ethical aspects and teamwork (Smith, Finlay, Lennard and Twycross, 1992).

For processing of the quantitative data the Ethnograph program can be used. Text to be analyzed is typed into the computer. Codes are assigned to segments of interest, the computer can recover codes together with the associated text (Fielding and Lee, 1992).

The main objective of the study is to recommend an addition to the existing curriculum for medical students regarding palliative care. To collect data, which will be needed to help to define the training needs, a self-administered questionnaire will be distributed to all the medical students of the final years, and discussions in focus groups will be organized in all the medical schools in Bangkok (Chulalongkorn Medical School, Ramathibodi and Siriraj Medical Schools under Mahidol University, Thammasat Medical School, Srinakarindha Medical School and the Pramongkutkloa Medical School) and outside Bangkok (Khon Kaen and Chiang Mai).

Preparations for the questionnaire will be initialized during the visit in London: the available literature will be a help to the team in defining the variables to be measured. Several studies have been carried out, of which the contents will be very useful, curricula have been designed as mentioned before. Special attention will have to be paid to the cultural and religious aspects of Thailand, which have a great influence on the perception of death and dying.

The findings of the study visit in the UK, together with the results of the analysis of the data from the questionnaire will constitute the final report. This will include a proposed addition to the curriculum for medical students and also a recommendation for future implementation of palliative care in the health care system.

The report on the study will be presented by the researcher and the other members of the team during a workshop. This workshop with panel discussion will be organized at the College of Public Health, Chulalongkorn University, in presence of the Dean of the College of Public Health, the representatives of the funding agency, the representatives of the Ministry of Public Health, the Ministry of University Affairs, the Presidents of the different Universities and the concerned professional associations.

3.8.3 Time table

The study will be carried out over a period of 6 to 7 months, according to the following schedule:

Table 3.2

Time Table for Activities of the Proposal.

Month:	Activities:	Staff required:
Month 1:	Recruitment of the team. Preparation of the visit to the UK.	Researcher. Secretary.

(table continued)

Time Table for Activities of the Proposal. Continuation.

Month:	Activities:	Staff required:
Month 2:	<p>Inquiry visit to the UK.</p> <p>Course in palliative care.</p> <p>Literature research.</p> <p>Visit other hospices.</p> <p>Interviews with staff.</p>	<p>Researcher.</p> <p>Physician 1.</p> <p>Physician 2.</p> <p>Nurse.</p> <p>Social worker.</p>
Month 3:	<p>Inquiry visit to the UK.</p> <p>Interviews with staff.</p> <p>Development of the questionnaire.</p> <p>Preparation of discussion of focus groups.</p> <p>Outlining of recommendations.</p>	<p>Researcher.</p> <p>Physician 1.</p> <p>Physician 2.</p> <p>Nurse.</p> <p>Social worker.</p>
Month 4:	<p>Report writing on findings in the UK.</p> <p>Completion of the questionnaire.</p> <p>Obtaining of necessary permissions.</p> <p>Distribution of the questionnaire.</p> <p>Organization and conducting focus groups.</p>	<p>Researcher.</p> <p>Physician 1.</p> <p>Physician 2.</p> <p>Nurse.</p> <p>Social worker.</p>
Month 5:	Data analysis.	<p>Researcher.</p> <p>Secretary.</p> <p>Two assistants for logging in data.</p>

(table continued)

Time Table for Activities of the Proposal. Continuation.

Month:	Activities:	Staff required:
Month 6:	<p>Final report.</p> <p>Submitting of reports to authorities.</p> <p>Organization and conducting of a workshop with the management of the different universities and the authorities of the MOPH .</p> <p>During the workshop the reports will be presented and panel discussion will take place.</p>	<p>Researcher.</p> <p>Physician 1.</p> <p>Physician 2.</p> <p>Nurse.</p> <p>Social worker.</p> <p>Secretary.</p>

3.8.4 Budget

Table 3.3

Required Budget for the Proposal.

Item:	Description:	Quantity:	Costs:	
Equipment & communication costs:	Portable computer with Thai alphabet.	1	US \$ 1,500	
	Telephone & fax.	lump sum	US \$ 600	
	Photocopies.	2500	US \$ 100	
	Printing questionnaire.	1200	US \$ 480	
	Postage.	lump sum	US \$ 320	
	Subtotal: US \$ 3,300	Travel costs in Thailand.	lump sum	US \$ 300
	Inquiry visit to the UK:	Visa for UK.	5	US \$ 300
Air tickets UK, return.		5	US \$ 5,750	
Insurance.		5	US \$ 200	
Lodging & food.		5: 35\$/d	US \$ 9,800	
Training costs (travel included).		5	US \$ 4,000	
Subtotal: US \$ 21,250		Per diem.	5	US \$ 1,200
Salaries:	Researcher.	7 months	US \$ 8,400	
	Senior physician.	3 months	US \$ 4,320	
	Junior physician.	3 months	US \$ 2,880	
	Nurse.	3 months	US \$ 2,400	
	Social worker.	3 months	US \$ 2,400	
	Secretary.	4 months	US \$ 2,240	
	Assistant 1.	2 weeks	US \$ 240	
	Subtotal: US \$ 23,120	Assistant 2.	2 weeks	US \$ 240
Total costs:			US \$47,670	

3.9 Feasibility of the Study

The study is aimed at producing an addition for the curriculum for medical students in Thailand, and also a recommendation for an integration of palliative care in the health care system. The workability of the study depends on the availability of funding. The total costs are estimated at US \$ 47,670. In case funding can be provided the study can be carried out according to the time table. The researcher will be the responsible person to conduct the study; final responsibility will be in hands of the College of Public Health, Chulalongkorn University of Bangkok, Thailand.

The feasibility of this study will also depend on the cooperation of the management of the different universities, specially regarding the focus group discussions. Since personal relations play an important role, it is of the utmost importance that the management of the different universities is approached by professors who are known to them and who are in favor of the proposal.

3.10 Ethical Implications

The study will include all the final year medical students of all the medical schools in Thailand, in order to improve the validity to the outcome. The questionnaires will be anonymous so that participation will be enhanced. Permission has to be obtained for the questionnaires as well as for the focus group discussions from the management of the different universities in Thailand.

Palliative medicine itself covers a number of special ethical features that need to be noted concerning the patient and his family. These ethical issues can be summarized as: issues of care and comfort, issues of consent and communication, issues of life and death, issues of needs and resources and issues of HIV infection (Wilkinson, 1993). Physicians will be faced with these issues, which may contribute to a feeling of uneasiness and professional stress. During the discussion with the focus groups this aspect will have to be considered because medical students may be reluctant to talk freely about personal feelings and experiences related to death and dying. The atmosphere during the discussion is very important and this can be taken care of by the professors of the different medical schools, on condition that good cooperation with the researchers has been established.

3.11 Summary

The most important factor underlying this demand for palliative medicine training is the increasing number of patients who need palliative care and who are dying with unrelieved suffering, while measures exist and are within reach, if appropriate decisions are being made.

The aim of this study is to develop an addition to the existing curriculum regarding palliative care for medical students in Thailand. Moreover, this study aims at providing a basis for further negotiations with the Ministry of Public Health, concerned professional associations, and other authorities regarding the implementation of an integrated palliative care program in the health care system of Thailand.

The study contains two main parts, the first is an inquiry visit of a team to the UK, the second part is a survey of the final year medical students of Thailand by means of self-administered questionnaire, followed by discussions in focus groups in the different medical schools in Thailand.

Many patients could benefit from this programme expansion.

Palliative care is a philosophy that has a direct impact on costs: the last year of life in cancer patients may represent as much as 75 per cent of total health care costs of a life time. A shift in patterns of care could reduce the costs enormously (Scott and MacDonald, 1993).

3.12 References

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