Dying to know; education about the end of life

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“Nothing in life is to be feared
It is only to be understood”

In writing this, Marie Curie could have been referring specifically to the care of people at the end of life. Since Victorian times death has become more hidden, often moved out of the view of most of the public and some of the professions. With the development of the South Link Health Chair in Palliative Care there is a possibility that death and dying will gain a higher profile in the education of medical students and others who need to learn how to care for people near the end of life. Cicely Saunders, the founder of the modern hospice movement, was aware of this aspect of modern life and medicine when she created a professional discipline the hallmark of which has been the combination of scientific understanding with personal concern. Readers of her work will know well that she identifies one of the key moments of her journey as her meeting and subsequent relationship with David Tasma, a 40-year-old Jewish man who had survived World War II and the Warsaw ghetto. He spoke with her often about his life, his sufferings and what he wanted from his care-givers. “I only want what is in your mind and in your heart” he told her, an oft quoted comment that addresses both the cognitive and interpersonal aspects of palliative care. Accordingly, as my colleague David Barnard points out, palliative care and palliative care education have embraced three broad areas:

1. The science and techniques of pain and symptom management.
2. Knowledge of psychological, social and spiritual aspects of dying and grieving.
3. Self knowledge on the part of care givers, especially regarding personal attitudes towards death and loss.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems, physical, psycho-social and spiritual.

**Palliative care:**

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten nor postpone death
- Integrates psychological and spiritual aspects of patient care
- Offers a support system to help patients to live as actively as possible until death
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families including bereavement counselling as indicated
- Will enhance quality of life and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy and includes those investigations needed to better understand distressing clinical complications.
Landmark dates in the modern history of palliative care include the opening in 1967 of St Christopher’s Hospice in London; the opening in 1974 of the first hospice programme in the United States in New Haven, Connecticut; the establishment in 1975 of the first palliative care programme in a major academic medical centre at the Royal Victoria Hospital in Montreal; the establishment of the first hospices in New Zealand in 1979 at the Mary Potter Hospice in Wellington, Te Omanga Hospice in Lower Hutt and St Joseph’s Mercy Hospice in Auckland; the recognition in 1987 by the Royal College of Physicians, of Palliative Medicine as a medical sub-specialty in Great Britain; the publication in 1993 of the first edition of the Oxford Textbook of Palliative Medicine, the definitive scientific textbook in the field; the recognition of Palliative Medicine as a vocational sub group by the Medical Council of New Zealand in 2002 and the development of the first Chair in Palliative Care in New Zealand in 2003 through a partnership between South Link Health, the Otago Community Hospice and the University of Otago Dunedin School of Medicine.

Four aspects of medicine and society in Britain, Canada, the United States, Australia and New Zealand have contributed to the growth of palliative care in those countries.

1. Advances in medical technology mean that the notion of medical futility has become more difficult to define. Consequently some people experience invasive interventions and endure pain and a sense of helplessness throughout their last weeks and days of life that could be eased with a more realistic approach.
2. Doctors concentrate more on the patho-physiology and cure of disease rather than the patient’s experience of illness with a consequent lack of attention to assessment and management of symptoms in medical education and practice. This can result in a greater burden of preventable, but at times unnoticed, suffering.

3. The changing face of our society, with the loss of the nuclear family and the development of a community that no longer seems to care, has caused the burdens of caring for a person who is dying to fall more heavily on the members of isolated families and particularly on women.

4. The difficulty that professional and lay people sometimes have around people who are dying or bereaved frequently increases those people’s sense of loneliness and suffering, making a philosophy of care that emphasises human contact especially attractive.

David Barnard and his colleagues, in their book *Crossing Over; Narratives of Palliative Care*, identified seven overarching themes that emerged from their research into patient narratives at the end of life.

i) There is no hard distinction between active treatment and palliative care, and forcing patients to choose between them is hostile to good outcomes.

ii) High quality palliative care requires a convergence of personal and institutional effectiveness.

iii) Variations in socio-economic status are more likely to affect the quality of palliative care than the patient’s diagnosis.
iv) The definition of a “good death” is highly variable.

v) Patient or family-centred care can appear more successful to the palliative care team than to the patient or family.

vi) Relationships with patients, families and caregivers pass through many stages over time.

vii) Professional caregivers, as well as patients and families, bring their histories of death and loss into the caring relationship.

Eleven years ago my friend Chris James and I published a paper entitled *The Problematic Nature of Education in Palliative Care*. In that paper, whilst acknowledging that palliative care was emerging as a field of medical care in its own right, we identified that there were many aspects of palliative care that are problematic, particularly in the field of education. There are a number of those elements that remain problematic today. The aspects reviewed in that paper included the lack of a long tradition and adequate conceptualisation of palliative care; the significance of psychological, emotional and spiritual aspects of care; the importance of, but inadequate understanding of, symptom control; the fact that palliative care is not curative in the accepted sense; the multi-professional nature of palliative care; the range of different settings of palliative care and the fact that palliative care givers have to perform their duties in situations where the emotional and psychological demands on them may be immense.

For some, the field of palliative medicine may be relatively easily defined, for example in the curriculum published jointly in the UK by the Association
for Palliative Medicine and the Royal College of General Practitioners. In this part of the world, the ANZSPM Medical Undergraduate Curriculum for Palliative Care had endorsement by all the deans of medical schools in Australia and New Zealand shortly after it was published in 1997, but sadly almost nothing happened. More recently, the Chapter of Palliative Medicine of the Royal Australasian College of Physicians has defined a curriculum for the training of specialists in palliative care medicine which *will* make a difference, at least to the education of specialists.

The relatively short life of palliative care to date means that there is not a long history of academic exploration and scrutiny. The essence of hospice care is the provision of “good quality care” however this good quality care is often ill-defined and difficult to measure. There is a danger that the physical dimensions of care may inevitably take priority over the other aspects that make up the totality of care because they lend themselves more readily to scrutiny and measurement. Because of this difficulty in measurement there is, for some, a difficulty in conceptualisation. Academic measurement is so often assessed in quantitative terms that qualitative evaluation is sometimes difficult to grasp. The Greco-Roman origins of western medicine suggest a medical model for illness; diseases are problems that have solutions. Michael Kearney has argued, as have others, that in developing its competence, western medicine has lost its caring. The emergence of palliative care is seen as a compassionate response to needs not being met by developed western medicine. As an emerging field however, it is restricted by the poorly developed conceptualisation that often accompanies new areas of care.
Our understanding of spiritual issues, for instance, is often sadly limited to religious beliefs or opinions without adequate reference to, or exploration of, the true significance and meaning of our spirituality. A further implication of the emerging nature of palliative care is that the elements that make up a “good” palliative care physician have not yet been defined.

Much is made by the profession and the media about the ability to control pain as death approaches. The development of expertise in the field of pain control has given a certain credibility to the discipline of palliative care, although it is still inadequately understood by many. Severity and persistence are often the hallmarks of difficult symptoms at the end of life. These can cause considerable distress, not only to the patient, but also to the practitioner and have the potential to distort the framework within which he or she makes professional judgements. Over the last 30 years, as the modern hospice movement has gained momentum, great strides have been made in our understanding and management of pain. Initiatives such as the JCAHO Pain Management Standards in the United States establish pain as the “fifth vital sign” and there are requirements for the promotion of acute pain management in that country. Michael Cousins, speaking at the meeting of the Australian and New Zealand Pain Societies in Christchurch, last year identified the enormous individual and social costs of pain. Previous estimates of the financial costs of chronic pain (in Australia, in excess of $A10 billion per annum) are thought to be a gross underestimate. Yet why does it seem that so many people have to endure poorly managed pain?
The explosion of understanding of how pain is mediated, the identification of new pain receptors, novel pharmaco-therapeutic approaches and a furthering of basic science should lead us to believe that we are on the verge of conquering this major health problem. And yet daily we hear of or see people in clinical practice whose pain is inadequately controlled. It’s not as if the pharmacological management of pain is often unduly complex. As my colleague Professor Geoff Hanks pointed out at the same meeting, most cancer pain responds to simple principles that have been promoted by the World Health Organization over the last 20 years. Our knowledge of the sites and mechanisms of action of opioid analgesics has dramatically increased over that time and most industrialised countries at least have access to a range of simple analgesics, non-steroidal anti-inflammatory drugs and opioid or opioid-like drugs. Perhaps one of the most significant ways in which pain is poorly understood is the inability of practitioners to see and manage pain as it really is; a multi-factorial problem.

The assessment and management of pain are seen by many as the cornerstones of effective palliative care. Attention to detail is essential at every stage of that assessment and management.

For the palliative care educator there are many challenges here. Teaching must acknowledge the true complexity of symptom control of the terminally ill. It must recognise the importance of reflecting on and learning from experience and allowing opportunities for collaboration between practitioners.
Although it can be argued that the majority of care is essentially palliative, in many medical interventions an outcome considered to be only palliative is neither desirable nor satisfactory. The non-curative nature of palliative care may not be an issue for those involved, some of whom have made a deliberate choice to care for terminally ill people, however it remains an important issue to be addressed in palliative care education together with such aspects as the uncertainty of palliative care and the anxiety developed in the caregiver during his or her work.

Responding to the particular needs of individual people is fundamental to all medical care. The needs of people who are dying are likely to be more wide ranging than the needs of those who are not, and in the delivery of palliative care those needs will be met by individuals and teams of different kinds. Listening to the patient’s story and paying attention to the language used helps in the formulation of a diagnosis. Medical students should learn a methodical approach to assessment at an early stage that can be carried through their career. Because most clinical medicine is based on the biomedical model it may be hard for some to recognise all the dimensions of pain. Dame Cicely Saunders, over 30 years ago, identified the importance of seeing pain in its totality – that is, a symptom having physical, psychological, social and spiritual components.

It is relatively easy to identify the physical causes of pain and for some it is possible to identify early, the psychological elements of pain (the potential or real losses associated with a terminal illness). But how good are we at
identifying the other elements of pain? But how good are we at recognising the social or spiritual dimensions of pain?

Frances Sheldon, a British colleague who sadly died this year, recognises that the “losses experienced by people with advanced cancer in relation to their social world are concerned with their engagement with the world outside home and with the roles and relationships within the family”. Financial hardship often accompanies serious illness and puts additional strain on an already challenging situation for a family. The inability of individuals and families to maintain their previous levels of social engagement can create additional burdens that can be manifest as pain. It is not hard to recognise that persisting pain, especially if associated with approaching death, can be a wearying prospect.

Neither is it hard to recognise that some people will experience the pain of therapeutic failure. Imagine the pain of loss – loss of role, loss of independence, loss of a future. Imagine too the pain associated with sadness and worry – worry about family and friends and about the future. The pain of fear is very real – the fear of pain or of suffering, the fear of dying or of death itself. Suffering is a uniquely individual experience that is quite different to the presence of pain. Suffering is intensely personal and often multi-dimensional. Relief of pain on its own will not always relieve suffering and, particularly in the management of people near the end of life, attention to the relief of suffering by all members of the team may ease this considerable burden.
In addressing the totality of pain it is essential that a team approach is adopted – rarely, if ever, can one individual identify all the elements of one person’s pain.

The range of individuals in those teams allows palliative care to be multi-disciplinary and multi-professional in a way that other specialties in medical care are not. Within hospice/palliative care teams difficulties occasionally arise in the grey area between medical and nursing functions as roles become blurred. There is a difficulty of sharing knowledge in the care setting. The complexity of palliative care knowledge and its use as a basis for action present a particular challenge for those faced with the task of explaining aspects of palliation to others. This task may be yet more challenging because others in the team may not have adhered to the same “framework for understanding” which is essential for sharing if understanding is to take place. The implications here for palliative care education are significant. The task is not solely one of teaching palliative care, but also of encouraging those involved to understand fully and to be able to articulate to others their theories and bases for action and to develop in other caregivers a framework for the understanding of practice.

Michael Eraut has warned against professional education focusing on and artificially isolating the “academic” components of knowledge while ignoring the knowledge embedded in application and practice. He preferred the inclusive term “professional knowledge: the knowledge possessed by professionals that enables them to perform professional work with quality”.

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The development of competent practitioners requires a systematic way of ensuring that the students we teach have an adequate understanding of the need for continuing professional development. One of the central tenets of professional development is enhanced performance. Professionals develop a specific knowledge base to formulate and generate their professional work. Experience allows that knowledge base to expand in ways that cannot be readily linked to traditional teaching methods. Reflective practice proposes that problems are often not clear or well defined and it is the intermediate steps within reflection that help in clarification of problems and the development of solutions or new strategies for action. In Donald Schön’s model, learning is directed by performance problems and teaching is seen as guiding or coaching performance rather than the more traditional telling of facts and theory (pot-filling). Students work on specific professional problems standing alongside a professional as teacher in that area. Schön also talks of the “right kind of telling” that takes place when students work closely with their teacher to learn how to frame the questions and to respond in an appropriate manner.

This is exemplified at the Dunedin School of Medicine by the development of the student mentoring programme.
LEARNING TO CARE

Frederick Hafferty, in his book, *Into the Valley* identified specific problems in medical training related to feelings inculcated during that training. He noted the variability with respect to affect that can be traced to the tension between medicine’s dominant values of detachment and distance, and the lay values of concern and affectivity. His study characterised individuals wrestling with these concepts; they were unable to resolve the emotional difficulty of practising clinical medicine without enjoying any formal institutional support for their continued efforts to maintain a sense of self as sensitive, caring and reflective social beings. Over time he suggested it was easy to tire of the struggle. The emotional and psychological demands of palliative care are immense. The distance and detachment that are possible, and perhaps even desirable, in other forms of medicine are not so in palliative care. Indeed, there is a case for arguing the opposite; that is that engaging with people who are sick is an essential feature of palliative care. Further, to tire of the struggle to be caring and sensitive as a consequence of the overwhelming demands, would be a negation of the principle theme of palliative care practice.

Some of my own work has involved investigating how doctors perceived they had learned to care. During the interviews in one study doctors retrospectively identified “turning points” at which they first perceived some notion of what it means to care for someone who is dying. The doctors often used poignant language and a number wept when recollecting the strong
feelings associated with these critical incidents. They felt that their training had been inadequate in preparing them for such care. This situation should no longer be accepted in our universities.
One of the simplest reasons that medical students go to school is to be changed. They submit themselves to what is known to be a long ordeal in order that they might come out differently to how they went in. This process of change is a multi-faceted one that can be considered to be most heavily influenced by the process of socialisation.

Medical socialisation is a long and complex process that is highly structured, uniform and contains collective experiences that draw medical people together. Essentially all medical students pass through a similar basic core curriculum - they share experiences and learn similar topics. The knowledge and skills they are expected to acquire are the same and therefore some of the attitudinal changes expected of them will also be the same.

Sociologists have been impressed by the powerful effect of the medical world in changing or altering attitudes, beliefs and values. “Dissecting a cadaver, attending an autopsy, delivering a baby, witnessing a death - are all part of a unique set of tests, ordeals and rituals designed to transform an ordinary person into a doctor”.

The process of socialisation brings with it an understanding of what Oliver Sacks calls the “quintessential human condition of sickness”.
That process has also been described as “the process by which people selectively acquire the values and attitude, the interests, skills and knowledge - in short, the culture - current in the groups to which they are, or seek to become, a member”. We have opportunities here in Dunedin to change the way that our medical students are socialised, but it will take a change in the culture for this to occur.

Becker et al. write of a transformation of identity that takes medical students away from their future patients and themselves. Frederic Hafferty talks of the students’ belief that their training is a rite of passage, interwoven with emotional and physical trials. Students talk of rites of separation. They move into a different culture and structure of feeling rules which are particularly pertinent when considering the care of dying people. How do physicians learn to deal with something that is at odds with what medicine is trying to do? Which lay values do they learn to keep and which do they let go? Hafferty views a tension between the indeterminacy of the clinical mentality (believing that every patient is unique) and the orderly basis of rational scientific knowledge. He suggests that the students’ preoccupation with the academic rigors of medical training direct their attention away from the inculcation of values, attitudes, motives and the rationales concerning what it means to be a physician. He feels that they are engulfed by their role as basic science students initially and thus distanced from their role as physicians-in-training and they believe their survival depends on focusing on the present and the accumulation of scientific facts. There is however another tension, which comes early on in the students’ career. Early exposures (in
their second year) to death and dying act as rites of passage or separation, distancing themselves from their previous lay identities and allowing them to move towards a more “medical” persona.

This conflict was identified in a slightly different form, decades earlier, in 1927, by Francis Peabody. The practice of medicine in its broadest sense includes the whole relationship of the patient with his physician. Even at that time, students were taught a great deal about the mechanism of disease, but very little about the practice of medicine. “The training is too scientific and the students do not know how to take care of patients”. Has there been sufficient change? Treatment of disease may be entirely impersonal, but the care of a patient must be completely personal. Sadly though, there have even been suggestions being empathetic “takes too long” in a busy day! The pressure of work leads to doctors primarily treating disease; the conditions are not conducive or favourable to establishing a personal relationship. Peabody writes of a “great group of patients in which it is not the disease but the man or woman who needs to be treated…The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding are needed. The reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine…The secret of the care of the patient is in caring for the patient.”

By the time they start practicing medicine most doctors have had two decades of learning. As medical students these doctors started with a dead body and quickly were taught everything that was similar in each human
being and that process continues. As they progress there is evidence that their compassion and understanding of what makes people different declines. Shifts in interpersonal values begin before the first day of medical school - socialisation begins prior to the start of formal training. Students encounter a vast field of knowledge and soon discover that they cannot master it all. They are socialised into uncertainty. “Uncertainty and death (are) the only certainties.”

So how do we help them to become caring clinicians? How do they learn that it is important to practice in a humane way? We need to identify what it means to care and how to listen to those that we are caring for.

Caring can be thought of as a behaviour or as a motivation. As a behaviour it is often thought to mean “looking after people and seeing to their needs”. As motivation it can refer to being fond of someone, feeling sympathy or empathy for them, being concerned for their well-being or having a professional commitment to seeing to their needs. It could be argued that the best caring professionals show both of these aspects of care. These are the values that many of us would hope are being inculcated in the medical graduates from the University of Otago.

In his book *The Illness Narratives* Arthur Kleinman outlines his understanding of how the interpretation of illness meanings or narratives can contribute to more effective care. He sets out a practical clinical method that practitioners can (and should) apply to provide more effective and
humane care [of chronically sick people]. He writes that his “alternative therapeutic approach originates in the reconceptualisation of medical care as (1) empathic witnessing of the existential experience of suffering and (2) practical coping with the major psycho-social crises that constitute the menacing chronicity of that experience”.

Empathy is an elusive concept in medicine. Empathy can be what we see or feel when we look at a picture, read a book, listen to music or experience a play. Empathy is much more than just knowing what we see or feel though, it is the image and the emotion generated by the picture or the music, the book or the play. Empathy helps us to know who we are and what we feel. William Blake wrote:

“Can I see another’s woe,  
and not be in sorrow too?  
Can I see another’s grief,  
and not seek for kind relief?”

True empathy focuses on the impact that disease and its treatment have on a patient’s ability to lead a meaningful life. Specifically it involves caring for the fate of another human being.

“The surprise of intimacy  
makes the journey richer  
as we walk together  
along unknown paths.”
The concept of empathy is relevant to the care of people who are dying because more than anything they are people in need.

Daniel K Sokol, writing in the *Times* in March this year quoted the American author Lewis Thomas:

“One of the hardest things to learn in medicine is what it feels like to be a patient”

He points to T S Eliot’s poem *East Coker* to illustrate the inner turmoil of surgeons. He mentions Rieux, the doctor in Albert Camus’ *The Plague* experiencing fear, doubt and even revolt at the injustices of death and then goes on to identify Tolstoy and Solzhenitsyn as wonderful examples of writing to illustrate the plight of patients.

The use of literature and the arts can stimulate imaginative identification with the characters, writers, artists or composers that will allow us all at least vicarious experience of the issues or events that are being described before having to deal with them as clinicians. The success of the use of literature rather than case studies depends on the skill of the writer who stimulates our imaginations in a way that may not happen with a case history. The skilled writer gets us involved with the voice in the writing so that we experience something of their trials with them. Literature and drama can also teach about communication between individuals – verbal and non-verbal – in a way that might not otherwise be seen. When reading literature we don’t really
have a chance to interrupt – the writer continues in what he or she is saying despite our presence.

Two years ago I edited an anthology *Snapshots on the Journey* that started as an attempt to help those learning to care at the end of life to understand what it might be like for those actually experiencing that journey. It was created to provide a chance to explore what it might be like to approach death. Poems were used that could comfort, enlighten, challenge or inspire; to articulate feelings that are often otherwise hard to express. I included one of my own poems that is about being with a man as he died one night in Wellington.

**Companionship**

*As physician I listen and feel and touch and sense that death is not too far.*

*As companion I sit and feel your hand in mine as you struggle to speak and let me know how fearful this is, this path you tread.*

*Time moves on and sitting up you stare into the distance.*

*Sweat on your brow and in your eyes waiting, watching, hoping it will not be so.*
As the light comes up your handgrip tightens
you sit forward to ease your breath.
Then, as if you know, you say quite clearly
“Oh no, not now”.

Life’s last breath comes gently now
and you sink just slowly onto my arm.
Your slender grip now leaves my hand
and death takes you quietly through the gate.

One of the challenges for the Dunedin School of Medicine, and indeed all the schools within the Faculty of Medicine, is to ensure that we help develop doctors who care. We have an opportunity through a unique partnership between different agencies to help in the development of a medical workforce which can respond to the needs of all New Zealanders. This is not a challenge that can be met by one person alone. It requires commitment to change within the whole school. The University has, in creating this position, suggested it is willing to meet that challenge, a challenge also taken up by South Link Health and the Otago Community Hospice. We will all endeavor to ensure that we work together to make that change a reality.

I began this talk by identifying Cicely Saunders as the inspiration behind the development of the modern hospice movement and it is fitting that I end with something she said that could well be reinforced in every medical student’s mind as they go about their clinical work, learning about caring for
people who are sick. It isn’t just the management of disease that is important; it is the way that we relate with people at any stage in their lives. It is essential that if we are to encourage the development of humane doctors in the future that we help them to remember that with each person they meet:

“You matter because you are you, and you matter until the end of your life.”
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A number of people have helped in many ways as this talk developed. I want to acknowledge especially the support, each in their own way, of Chris James, Murray Tilyard, John Adams, Bridget McHardy, Kathy Young and the Dunedin School medical educators. Jenny Clifton has been there as much of my thinking developed and I thank her.

There are others who have been there at other times – too numerous to mention. I thank them all. Claire Beynon let me use some of her inspirational artwork in the presentation and I thank her for that.

Finally, I want to acknowledge the central place in my life of my daughters who have experienced much change as I have travelled this journey – their love sustains me and helps me realise that first and foremost I am a fortunate man; a “guy with daughters”.

Rod MacLeod was trained in medicine at the University of Dundee. He chose to specialise in General Practice and trained for that in Norfolk in the east of England where he eventually practiced as a rural GP for almost 10 years. He developed an interest in end-of-life care and took a period of prolonged study leave to work in six hospices in the south of England – all with a community focus. He then changed career and started work full-time with a community based hospice in Bath. At the same time his interest in medical education developed. He went on to complete a diploma and then a master’s degree in medical education, again from the University of Dundee.

The move to New Zealand in 1994 represented a further change in lifestyle, and the chance to teach in a different culture and to influence the way that doctors learn to care for people who are dying. In fact, that learning was the topic of his PhD thesis completed in 2002. Prior to taking up his current post he was Director of Palliative Care at Mary Potter Hospice in Wellington. He was also a clinical senior lecturer in the Department of General Practice at the Wellington School of Medicine.
As well as a clinician he is interested in education and research in palliative care having published over 60 articles in this area in national and international journals. His book *Snapshots on the journey – an anthology of poems through death and remembrance* was published by Steele Roberts, Wellington, in 2002.

He has worked with the National Health Committee on a working party looking at the care of people who are dying and was a member of the advisory group for the Ministry of Health/HFA/NHC who developed the National Strategy for Palliative Care for New Zealand.

He sees the opportunity to work as the South Link Health Professor in Palliative Care at the Dunedin School of Medicine and at the Otago Community Hospice as a truly exciting prospect and demonstrates the true commitment of the University of Otago to improve the way that doctors learn to care for people at the end of life.
LEADING THINKERS
ADVANCEMENT PROGRAMME

The Leading Thinkers Advancement Programme invests in people. There are two elements to the programme, “Knowledge Leaders” and Advancement Scholarships.

The Knowledge Leaders component, including the South Link Health Chair in Palliative Care, supports academic leadership in areas which are especially relevant to the economic, environmental and social development of New Zealand. Many projects have a multi-disciplinary character.

The Government has announced that it will match, dollar for dollar up to $25 million, money raised for Knowledge Leader projects.

Other projects funded or partially-funded so far include

• McKenzie Medical & Surgical Repatriation Fellowship
• Caroline Plummer Fellowship in Community Dance
• Dunedin City Council Chair in Entrepreneurship
• Centre for Sustainability
• Edgar National Centre for Diabetes Research
• Community Trust of Otago Centre for Trace Element Analysis
• Ron Lister Chair in Geography
• Van der Veer Chair in Parkinson’s Diseases
• Carl Smith Medal for Emerging Researchers

Advancement Scholarships so far established include

• Transpower University of Otago Bachelor of Applied Science Scholarships
• Alexander McMillan First-in-Family Scholarships
• J&L Callis First-in-Family Scholarships
• Otago University Development Society Trailblazer Scholarships
• University of Otago Alumni Scholarship
• New Zealand Federation of Graduate Women (Otago Branch) Scholarship

Other Advancement Initiatives include the addition of the Joseph Banks’ Florilegium to the Hocken Library.