Letters
Correspondance

Subspecialties in family medicine: a question of values

Dr Shadd's argument in favour of palliative care as a subspecialty[1] hinges on a tautology: that any area of medicine is either a specialty or subspecialty or not. His argument can be reduced to the following statements:

- Family medicine is a specialty (as declared by the College of Family Physicians of Canada in 2007).
- All specialties contain subspecialties.
- Family medicine, therefore, has subspecialties.
- *Subspecialty* has a clear definition (according the Royal College of Physicians and Surgeons of Canada.
- Palliative care fits the definition of a subspecialty.
- Palliative care, therefore, is a subspecialty.

However, this is not really a debate about whether or not palliative care fits into a Royal College definition, especially because this definition has not been adopted by family physicians or integrated into family medicine training or organizational structures.

Should palliative care be a specialty? This is a normative question. It is a question of values, a question of how things ought to be. It is not a positive question, a falsifiable question, or an issue of definitions and categorization. Dr Shadd's positivist answer to a normative question assigns palliative care to the set of subspecialties, but offers no cogent argument for or against the question at debate. Just because the College of Family Physicians of Canada has asserted that family medicine is a specialty—just because family doctors can now hold contradictory titles like "generalist specialist"—does not de facto lead to the conclusion that family medicine must have subspecialties. If we are to properly address the pressures to introduce family medicine subspecialties, family physicians will have to identify and articulate the meaning and value of generalist practice. We will have to engage with other normative questions: Should family medicine have subspecialties? What would we call these doctors—subspecialist-generalist-specialists? What would family medicine subspecialties mean for the spirit and affirmative practice of generalism? What motivates our discipline to engage in the fracturing of medicine and the denaturing of health care into ever smaller pieces?

Is any of this a good thing?

—Aaron M. Orkin MD
Thunder Bay, Ont
by Rapid Responses

Reference

1. Shadd J. Should palliative care be a specialty? Yes. *Can Fam Physician* 2008;54:840,842 (Eng); 844,846 (Fr).

Response

Dr Orkin's critique of my argument is quite right—I provided a positivist answer to a normative question. My only defense is that the original question that I was asked to address was "Is palliative care a specialty?" Only after my submission was the question changed to "Should...?"

The editors were right to change the wording. "Should" is the question with which we need to grapple. My answer is still yes, although my argument is different. Our ultimate goal must be to improve the care of people with palliative needs. In the long run, this involves not only knowledge translation (ie, helping all providers to employ best practices) but knowledge generation (so that best practices 50 years from now are better than best practices today). In every field of medicine, knowledge generation comes primarily from those engaged in the field full-time. Therefore, part of a broad strategy to improve palliative care would be to encourage physicians to engage in palliative medicine full-time and to enhance the knowledge and skills of this cadre of physicians. It isn't about the title. It is about raising the bar.

What happens if we don't? One of 2 things: either the bar will not be raised (which will be a disappointment for every Canadian at risk of dying) or it will be raised by someone else within the Royal College alone (which will be a disappointment to those who see family medicine as the beating heart of palliative care). Should palliative medicine be a specialty? Yes, because the bar needs to be raised. And we need to take a leading role in raising it.

—Joshua D. Shadd MD CCFP
Kingston, Ont
by Rapid Responses

Regarding palliative care

As a third-year medical student and future family physician with a focused area of practice in sports medicine, I have to say that extra training in family-related fields is clearly a must these days. There are 3 facets of focused areas of practice that particularly interest students:

1) Many medical students who plan to do family medicine would like to do extra training.
2) A focused area of practice in family medicine equals better quality in that specific area of family medicine.
3) The family practitioner group model of practice is growing all across Canada. New medical students are learning the importance of having an area of focused practice and what it can do to increase the general knowledge of a multidisciplinary group of physicians and other health care workers.

Having members with focused areas of practice allows the health care group to have a consulting service by the most knowledgeable physician in that area, who then furthers opportunities for group learning by discussing the cases at team meetings.

Having read both sides of the debate, I think that Dr Vinay doesn't offer much of a strong argument against palliative care as a specialty.[1] Specifically, to say that we will rally exclusively to those physicians with a focused area of practice is not a strong enough argument. If this debate occurred 10 to 20 years ago, then yes, the issue would be totally different. But now, medicine is increasingly multidisciplinary. More than ever, we need to work together as a team in managing the whole spectrum of our patients' needs.

Bottom line: we need to work as a team of health professionals and understand our limits. Family medicine physicians are known as the expert generalists of all fields equally. Realistically, this means we individually have some areas of practice that we are less comfortable with, and others in which we are more proficient.

Family medicine–focused areas of training are necessary to enhance our knowledge in particular fields, whether they be palliative care, sports medicine, geriatrics, obstetrics, or any other areas of care. In the end, this will work toward increasing the quality of care delivered to our patients.

—Jean-Claude Quintal
Ottawa, Ont
by Rapid Responses

Reference

1. Vinay P. Should palliative care be a specialty? No. *Can Fam Physician* 2008;54:841,843 (Eng); 845,847 (Fr).

Hypercalcemia

In the June 2008 issue of *Canadian Family Physician*, Dr O'Brien provides a concise and practical review of the treatment of nausea and vomiting in palliative care patients.[1] Still, I would like to take an opportunity to clarify and expand on 2 statements that were made on the topic of hypercalcemia.

First, "Hypercalcemia should be anticipated in patients with bone metastases." Hypercalcemia of malignancy (HCM) occurs in patients with or without osteolytic bone metastases.[2] In particular, many tumours that frequently develop bone metastases (prostate, small cell lung, and colorectal cancer) are rarely associated with HCM.[3]

Anticipating HCM involves taking into account not only the presence of bone metastases, but also the primary tumour location and histology. Breast, lung, and head or neck cancers are common primary tumour locations and squamous cell and adenocarcinoma are common histologic subtypes.[4] Of the hematologic malignancies, multiple myeloma is frequently associated with HCM.[5]

Hypercalcemia of malignancy is broadly divided into 2 categories: humoral hypercalcemia of malignancy and local osteolytic hypercalcemia. The former refers to the paraneoplastic release of humoral factors, mainly parathyroid hormone-related peptide, whereas local osteolytic hypercalcemia refers to the local destruction of bone by tumour with calcium release. There might be considerable overlap between these 2 mechanisms in the pathogenesis of HCM.[6]

Second, "Hypercalcemia can be corrected with saline, diuretics, and bisphosphonates." Since their introduction, parenteral bisphosphonates have become the mainstay of treatment for HCM. As before, copious hydration for volume reexpansion is crucial. With respect to loop diuretics, despite their ability to promote calciuresis, they should be used with caution because of the risk of recurrent hypovolemia and metabolic abnormality.[6] If diuretics are utilized, ensure the patient is fully hydrated and avoid thiazide diuretics, which could worsen hypercalcemia.[7]

—Gary R. Wolch MD
Edmonton, Alta
by e-mail

References

1. O'Brien C. Nausea and vomiting. *Can Fam Physician* 2008;54:861-3.
2. Francini G, Petrioli R, Maioli E, Gonnelli S, Marsili S, Aquino A, et al. Hypercalcemia in breast cancer. *Clin Exp Metastasis* 1993;11(5):359-67.
3. Major P. The use of zoledronic acid, a novel, highly potent bisphosphonate, for the treatment of hypercalcemia of malignancy. *Oncologist* 2002;7(6):481-91.
4. Penel N, Dewas S, Doutrelant P, Clisant S, Yazdanpanah Y, Adenis A. Cancer-associated hypercalcemia treated with intravenous diphosphonates: a survival and prognostic factor analysis. *Support Care Cancer* 2008;16(4):387-92. Epub 2007 Aug 21.