Should palliative care be a specialty?

NO

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There is currently discussion in the field about changing palliative medicine into a formal medical speciality. This would have both advantages and disadvantages. But is it a good idea?

Like birth, death is a normal not a pathologic event. The role of medicine is to help patients without overmedicalizing them. Medicine can provide patients with relief while still allowing them to be fully themselves. Palliative medicine focuses on all aspects of pain—physical, psychological, relational, social, spiritual, and religious. It centres on patients and patients' comfort as well as that of their families. Palliative medicine is holistic, global, multidimensional, and interdisciplinary, and works in intimate proximity to families. Training attentive family physicians who are able to coordinate treatment, share decision making with other professionals, and treat patients as individuals is, therefore, crucial. Is there an approach for which family medicine is better suited? Family medicine is all the more suited to palliative care because often a patient is emerging from a long medical relationship with a specialty that focused on a diseased organ. During this relationship, the patient as a person is often in the background. End-of-life is the time to reverse this situation and treat the patient, not the disease.

Patients often spend their dying days in hospital. The home, however, is becoming, and in the near future will be, the normal setting for dying. A well-structured care team, even when supported by high-quality nurses and volunteers, cannot perform the task of caring for a dying patient without help. The patient's family and friends must also become intimately involved. The complexity of the human, social, psychological, and medical aspects of dying at home requires the on-site presence of a doctor with all the qualities of a skilled family physician.

Obviously, everyone dies. And everyone should have ready access to palliative care, regardless of where they live in Canada. The development of palliative medicine has resulted in an urgent need for skilled professionals in this field. It seems to me that the emergence of universal access to palliative care will require above all the involvement of family physicians. Family physicians are already working in every part of the country. I see them developing or maintaining careers in family medicine with palliative care components.

Even in a university hospital that delivers leading-edge care, palliative medicine is crucial. With all our health strategies and sophisticated technologic approaches, we sometimes forget that we are caring for sick people—people who might choose to discontinue treatment. Family physicians involved in palliative care on these hospital care teams are valuable resources for patients and important role models for younger professionals. These professionals will learn how each approach has its place in a teaching hospital, when to change strategies, how to get families involved, and how to remain actively compassionate at the hospital and in other places.

Palliative medicine does not lend itself to becoming a speciality in the same way that medical care focusing on a specific organ does (eg, cardiology or respirology) or that medical care focusing on a phase of life does (eg, pediatrics or geriatrics). Palliative care is, by its very nature, multidisciplinary and holistic.

Research into and assessment of care activities and care technologies are carried out in similar ways in palliative medicine and in family medicine departments. Palliative care and family medicine are similar in their approaches, data collection, analyses, and written reports. Training in family medicine already includes exposure to research and offers basic preparation for doing research. After being trained in family medicine, family physicians who are interested can take an additional 1-year palliative care rotation. This training turns out competent palliative care consultants, but not researchers. Appropriate education in palliative care research would require specific training for a longer period of time (at least 2 or 3 years in my opinion) in clinical research, epidemiology, or another relevant discipline, as is currently being done in family medicine.

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The parties in this debate will refute each other's arguments in rebuttals to be published in an upcoming issue.

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Creating a speciality out of palliative care does not offer a real solution to the emerging need for research in the field and could even have a negative effect on efforts to recruit professionals into this aspect of care.

In 1940, C.S. Lewis[1] wrote that pain and suffering are "God's megaphone to rouse a deaf world." By this, he meant that certain situations in life can suddenly bring us face to face with the mystery of humanity, which is both beautiful and fragile. It describes our response to the birth of a child or our reaction to a dangerous rescue operation that has ended successfully, but also to the suffering of someone who is dying and being taken from the family. These experiences call out for a response that transcends borders, ideologies, and cultures. Techniques, while necessary, are dwarfed by this call. Palliative medicine works in the shadow of these experiences and grows by becoming increasingly involved and expanding its efforts to respond to the needs of patients and their families. This type of care takes time, vision, an understanding of families and societies, personal availability, and science that is regularly updated. Surely this is the very description of the family physician we are trying so hard to train.

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Competing interests

None declared

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Reference

1. Lewis CS. *The problem of pain*. Oxford, Engl: The Centenary Press; 1941.

CLOSING ARGUMENTS

- Palliative medicine is, by its very nature, multidisciplinary.
- The practice of palliative medicine complements the specialties.
- Palliative medicine takes a holistic, family-centred approach.