Curing Diseases and Healing Suffering: Inspiration from Developments in Palliative Medicine

Douglas T. Bridge*

Palliative Care Service, Royal Perth Hospital, University of Western Australia, Perth, Australia.

SUMMARY

Geriatrics and palliative medicine are medical specialties that share much in common: they are relatively recent disciplines, they deal with the elderly, and end-of-life issues are prominent. They both aim to provide an improved quality of life for patients whose health is generally deteriorating. However, the two disciplines have significant differences. Geriatrics arose out of the Western scientific medical tradition, which has a disease-oriented, curative focus. Palliative medicine sprang from the hospice tradition, which began as a protest against perceived deficiencies in the existing biomedical model of care. This report explores the philosophy underlying palliative medicine, and what it might have to offer to the discipline of geriatric medicine in end-of-life care. [International Journal of Gerontology 2008; 2(2): 29–32]

Key Words: geriatrics, hospice care, spirituality, thanatology

What is Geriatrics?

The Royal Australasian College of Physicians is the body responsible for training medical specialists in Australia and New Zealand. It states, "Geriatric medicine is concerned with the medical care and social, preventative and rehabilitative aspects of health and illness in older people."

The curriculum for trainees in the specialty of geriatrics lists nine areas in which trainees must achieve proficiency. As one might expect, these include: knowledge of the normal aging processes; an ability to assess impairment, disability and handicap; and knowledge of rehabilitation, preventative approaches and health promotion. The ninth requirement is interesting: "an understanding of principles of palliative care".

Correspondence to: Dr Douglas Bridge, Palliative Care Service, Royal Perth Hospital, GPO Box X2213, Perth, Western Australia 6847, Australia.
E-mail: douglas.bridge@health.wa.gov.au
Accepted: April 1, 2008

What is Palliative Care and How Did It Begin?

In 1990, the World Health Organization defined palliative care as having the following characteristics:

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and during their own bereavement.

The evolution of modern palliative care can be linked to the pioneering efforts of a number of visionary individuals, whose contributions deserve recognition. The first and most famous was Dame Cicely Saunders, widely acknowledged as the founder of the hospice movement. Dame Cicely was a tall, strong-willed, dominant figure.

Her remarkable life has been chronicled by her official biographer Shirley du Boulay[1].

Dame Cicely's professional life began as a nurse. A back injury forced her to discontinue nursing, so she took up social work. She developed a burning passion to improve the lives of patients dying from cancer. She discovered that pharmacologic advances in the use of opioid analgesia were not being used in clinical practice. She realized, as have many others, that political power is often needed to bring about a fundamental change in ways of thinking. A colleague advised her that she would never have enough power to effect the changes she sought, because she was only a social worker. Power, she was informed, lay in the hands of the medical profession. So in 1957, at the age of 38, she qualified in medicine. She proceeded to transform the care of the dying. Initially, she felt obliged to establish her own independent institution, St Christopher's Hospice, in Sydenham, a suburb of London. Being independent enabled her to develop treatment protocols and staff attitudes that may not have been possible in a traditional hospital.

The concepts and protocols developed by Dame Cicely were soon transported to North America. This can be substantially attributed to the energy and vision of another prophetic figure, Dr Balfour Mount. Dr Mount was trained as a urologist, but he soon transferred his energy to caring for the terminally ill. In 1973, he paid his first visit to St Christopher's Hospice, where he developed a lifelong friendship with Dame Cicely[2].

In the 1980s, a third charismatic figure began to dominate the hospice movement in the United Kingdom. After a decade of medical missionary work in Africa, Scotsman Dr Derek Doyle threw all his energy into the development of palliative care as a part of mainstream health care. He also promoted palliative medicine as a distinct specialty with a rigorous training program and high academic standards, on a par with other specialties like cardiology and neurology. This included the production in 1993 of the prestigious *Oxford Textbook of Palliative Medicine*, of which Dr Doyle was the founding chief editor.

Curing Diseases and Relieving Suffering

These developments in the field of palliative care were mirrored by a parallel movement within mainstream medical care. In 1982, Dr Eric Cassel published his landmark article in the eminent *New England Journal of Medicine*[3]. He announced that Western scientific medicine, for all its brilliance in eliciting pathology and treating disease, was failing to address the fundamental issue of suffering. He argued persuasively that relief of suffering must be one of the goals of medicine.

The subsequent two decades have witnessed a rapid evolution of research, policies and education in the area of "spirituality in medicine", which is closely linked to suffering.

Not all palliative medicine specialists agree with this holistic model of medical care. Some are more comfortable confining their efforts to the relief of symptoms. Ten years ago, Dr Sam Ahmedzai, a professor of palliative medicine, wrote, "The view now, within palliative medicine, is that it is okay to be a symptomatologist—and proud of it!"[4]

Although not all medical practitioners feel comfortable exploring spiritual issues, their importance is beyond dispute. Research into spiritual distress is in its infancy. A fundamental problem is that we do not yet have an agreed definition of spirituality, and the terminology is imprecise.

Rediscovering the Spiritual Element in Health

In the 19th century, a sick patient was a member of a community. He was cared for at home and attended by members of the clergy as well as the medical profession. In the 20th century, dying became a medical event, which happened in a hospital, directed by health professionals. The focus was on fighting the disease and combating the final enemy, i.e., death.

In the 21st century, we are witnessing a restoration of the spiritual dimension as a part of health care. Birth and death are two points in human life where the biological and the spiritual intersect in a powerful way. Birth is universally celebrated with great joy, but death remains an uncomfortable topic for many people, including doctors. Palliative medicine practitioners are forced to confront death if they are to survive both professionally and personally. Dr Christina Puchalski is a palliative medicine specialist and also founder of the Washington Institute for Spirituality and Health. She has written, "Traditionally, society at large and the Western medical system have viewed death as something to be avoided, and the emphasis placed on a

cure. When someone is dying, the health system is ill-equipped to deal with that person, because there is no cure or fix. This may be due, in part, to the fact that caring for the dying challenges caregivers to examine issues about their own mortality."[5]

Beyond the Christian Religion and Western Culture

In the past 20 years, palliative care has spread throughout the world. It transferred easily to English-speaking countries with a Christian heritage, such as Australia, New Zealand and North America. Could it also adapt to other cultures and religious orientations? English theologian the Reverend Dr Michael Wright has written, "Non-religious patients demonstrate similar needs to their religious counterparts: for love, for meaning, for forgiveness and for transcendence." He continued, "… palliative care is faced with the question of how to acknowledge the Christian tradition of hospice while at the same time demonstrating equity towards spiritualities expressed through other religions or none"[6].

Taiwanese neurologist and palliative care physician Professor Ming-Liang Lai, speaking from a Buddhist perspective, noted that the concept of spiritual care has been a part of both Eastern and Western medicine from ancient times. He argued that physicians should play a role in spiritual care. To enable this to occur, he said that doctors must first address their own spirituality: "… doctors … should pursue spiritual growth to provide better spiritual care for patients and their families"[7].

Palliative Care in Asia

In the past 10 years, hospice/palliative care has spread rapidly throughout Asia, encouraged by the Asia Pacific Hospice Network, which is vigorously championed by Australia's equivalent of Dame Cicely Saunders, teacher/nurse/doctor Rosalie Shaw. From a small administrative base in Singapore, Executive Director Dr Shaw encourages sectors of the network in Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Myanmar, New Zealand, Philippines, Singapore, Taiwan, Thailand and Vietnam, with vigorous support from Australia.

Palliative care services have been evolving in Taiwan since 1990. Because of political disagreements, the United Nations did not include Taiwan in its review of palliative care worldwide. Hospice specialist and obstetrician-gynecologist, Dr Sheau-Feng Hwang, argued convincingly that hospice palliative care in Taiwan has achieved a level of maturity equal to the best in the world. He said that Taiwan should be ranked alongside 35 other countries worldwide that have achieved the highest level of program development[8].

Open discussion about a diagnosis of cancer and dying was initially considered contrary to oriental culture. However, recent research from Taiwan drew a different conclusion. Of 37 patients with terminal cancer admitted to hospices, the degree of "spiritual transcendence" was found to be proportional to the degree of awareness of their condition. Put simply, those who knew about and accepted their death were more peaceful than those who were ignorant of their impending death. The authors concluded that "telling the complete truth is necessary even when dealing with terminal conditions"[9].

The Hospice Foundation of Taiwan has been very active in the promotion of palliative care, with numerous educational activities to train health professionals and volunteers. The promotion has not been limited to symptom control. Over the past 5 years, the foundation has developed a spiritual care program, in recognition of the special importance of spiritual issues when patients are facing death.

Integrating Geriatrics and Palliative Medicine

Our elderly patients will be best served by combining the skills of geriatricians and palliative medicine specialists. The first issue of this journal included an inspiring opening statement about the mission of the Taiwan Society of Geriatric Emergency and Critical Care Medicine. The passionate effort to improve the quality of life of elderly citizens is commendable. Palliative medicine adds another dimension. Despite the best efforts of geriatricians, there will come a time in the life of every patient when it is right to change direction and to acknowledge that death is near. At that time, it is important for everyone (patient, family and health professionals) to be clear about the goals of treatment. This "changing of lanes" can be emotionally traumatic[10].

So, what can palliative medicine offer to geriatrics? The discipline of palliative medicine affirms the

commitment of geriatricians "to fight against aging"[11], but also encourages them to:

- recognize when death is the appropriate outcome;
- assist the patient, family and other health care professionals to negotiate the difficult "changing lanes" from curative to palliative intent;
- see that dying can be a profound spiritual experience for the patient and family, resulting in a healing process despite physical deterioration[12];
- overcome death by embracing rather than avoiding it;
- experience the inner strength and liberation that come from facing one's own death.

By integrating the wisdom of both specialties, we may achieve the hope expressed by the editors of this journal: "… in the final journey to the end of life, a time that is often filled with moans and sorrow may be replaced by the sound of laughter and gaiety!"[11]

References

1. Du Boulay S. Cicely Saunders: Founder of the Modern Hospice Movement. London: Hodder & Stoughton, 1984.
2. Mount BM. Snapshots of Cicely: reflections at the end of an era. J Palliat Care 2005; 21: 133–5.
3. Cassel EJ. The nature of suffering and the goals of medicine. N Engl J Med 1982; 306: 639–45.
4. Ahmedzai SH. Five years, five threads. Prog Palliat Care 1997; 5: 235–7.
5. Puchalski C, Dorff E, Hendi Y. Spirituality, religion and healing in palliative care. Clin Geriatr Med 2004; 20: 689–714.
6. Wright M. Spirituality: a developing concept within palliative care? Prog Palliat Care 2001; 9: 143–8.
7. Lai ML. Physicians play a role in spiritual care. Taiwan Hospice Headline 2006; 8: 2.
8. Hwang SF. Hospice palliative care in Taiwan, 2007: adding to the complete global mapping. Taiwan Hospice Headline 2007; 9: 1–2.
9. Leung KK, Chiu TY, Chen CY. The influence of awareness of terminal condition on spiritual well-being in terminal cancer patients. J Pain Symptom Manage 2006; 31: 449–56.
10. Thompson GN, McClement SE, Daeninck PJ. "Changing lanes": facilitating the transition from curative to palliative care. J Palliat Care 2006; 22: 91–8.
11. Tsai CH, Shih SC. Opening statement. Int J Gerontol 2007; 1: 1.
12. Mount BM, Kearney M. Healing and palliative care: charting our way forward. Palliat Med 2003; 17: 657–8.