The need for specialized training programs in palliative medicine

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Abstract

CANADA FACES A SIGNIFICANT AND GROWING BURDEN of terminal illness. There are major unresolved economic, ethical and social issues related to care at the end of life. Despite the international reputation for Canadian efforts in palliative care, the medical profession in Canada has largely failed to recognize the importance of the field, as evidenced by the lack of commitment on the part of most medical faculties at Canadian universities to developing academic strength in palliative medicine, the lack of content in the undergraduate curriculum and of postgraduate programs in palliative medicine, and the lack of support for research into end-of-life care. The authors propose a conjoint initiative by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada to develop specialized training programs in palliative medicine as a critical step in addressing this crisis.

Résumé

LES MALADIES EN PHASE TERMINALE représentent un fardeau important et de plus en plus lourd pour le Canada. D'importantes questions économiques, éthiques et sociales sont encore à régler en ce qui a trait aux soins à la fin de la vie. Malgré la réputation internationale des efforts que le Canada déploie dans le domaine des soins palliatifs, la profession médicale du Canada n'a guère reconnu l'importance de ce domaine, comme le démontrent le fait que la plupart des facultés de médecine des universités du Canada n'ont pas créé de bassin d'enseignants en médecine palliative, l'absence de contenu en médecine palliative dans le programme d'études de premier cycle et l'absence de programmes de niveau postdoctoral, ainsi que le manque d'appui à la recherche sur les soins à la fin de la vie. Les auteurs proposent une initiative conjointe du Collège royal des médecins et chirurgiens du Canada et du Collège des médecins de famille du Canada afin d'élaborer des programmes de formation spécialisée en médecine palliative, moyen crucial de faire face à cette crise.

Palliative care is at an important crossroads in Canada. The field has grown in importance and public support since the introduction of palliative care programs at St. Boniface Hospital, Winnipeg, and the Royal Victoria Hospital, Montreal, in 1974–75. Its status is exemplified by the importance accorded the field by 2 recent national reports, that of the Expert Panel on Palliative Care,[1] issued as part of the report of the Cancer 2000 Task Force, and that of the Special Senate Committee on Euthanasia and Assisted Suicide.[2] Palliative care measures were accorded a high priority by citizens in the state of Oregon when they were asked to rank health services in anticipation of decreases in health care funding in the early 1990s.[3] The report of the Special Senate Committee suggested that palliative care would likely be given a similar priority by Canadians.[2]

Despite this apparent high degree of public support, there has been a disappointing response from the medical profession in terms of developing palliative care services and the discipline of palliative medicine.[4] Very little palliative medicine is taught to undergraduates in Canadian medical schools. The situation in postgraduate training is little better. Although many postgraduate programs in family medicine include some exposure to palliative care, it is neither mandatory nor extensive, and exposure to such training is rare in any of the postgraduate programs of the Royal College of Physicians and Surgeons of Canada. Accreditation standards for undergraduate and postgraduate training generally fail to consider palliative medi-

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cine. There are few full-time palliative care physicians on university faculties in this country.

At the same time, the burden of illness is growing because of both the increasing proportion of elderly patients in society and the rise in the prevalence of cancer. Various studies suggest that the care of patients in advanced stages of illness is far from optimal.[5–8] To address these needs there must be increased professional acceptance, priority, funding, recruitment, and development of research and education in palliative medicine in Canada.

We recognize that most palliative care will and should be delivered by family physicians and, to a lesser extent, by oncologists and other specialists. However, the enormity of the task of providing educational programs and performing research on which to base clinical practice demands that there be a small number of training centres and physicians with specialized training in the discipline of palliative medicine.

Can palliative medicine be legitimately defined as a "specialized" body of knowledge, skills and attitudes? The question of whether palliative medicine should be treated as a specialized discipline in Canada is not new; it was debated in 1988[9–13] and again in 1994.[14–16] By a variety of criteria (e.g., a defined need, a separate and specific body of knowledge, skills and attitudes, a shared set of principles, public acceptance, defined standards of practice, a literature devoted to the field and a research base), palliative medicine is clearly a distinct discipline. Moreover, the field has already been recognized as a specialty in the United Kingdom (since 1987) and in Australia and New Zealand (since 1988).

A more direct answer to the question of whether palliative medicine constitutes a specialized body of knowledge, skills and attitudes is evident from the nature of the work itself. The physician providing palliative care is confronted by patients with multiple diseases, complex symptoms and syndromes, and multiorgan failure, so meticulous attention to treatment is required. The frequent use of many drugs necessitates a good understanding of their pharmacology and interactions, as well as the influence of age, disease and organ failure on drug metabolism. Interdisciplinary team relationships are essential to success. The physician must be exceptionally skilled in communication with the patient and the family, so that he or she can respond to social, psychological, and spiritual or existential concerns, and must be willing to explore the nature of his or her own perceptual and cognitive obstacles to communication. The family is both an essential part of the team and a focus of care for the physician. Given the broad base of knowledge, the wide range of skills needed and the distinct set of attitudes that characterize palliative medicine, the practice of the discipline is fully as challenging, demanding and complex as that of any other field in medicine.

How can we develop the research base and educational programs needed to better prepare physicians for the practice of palliative medicine? Given that such training will be needed by family physicians and specialists alike, we believe that there is a need for specialized training programs that would be open to certificants of either college — the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. Training could be expected to range from as much as 2 years or more of fellowship training for candidates wishing to make a career in the field as consultants or full-time palliative care physicians to shorter periods of 6 months to a year for those entering family medicine or specialist practice who envision a significant component of palliative care in their work. To be credible, such programs must be rigorous, have clear objectives, be well supervised by experienced physicians in an interdisciplinary setting and have regular evaluation processes congruent with the objectives for both the trainees and the program.

Admission to such fellowship training could be open to qualified certificants from either college. Consideration could also be given to crediting a year of fellowship training in palliative medicine for candidates who require an additional year of training in one of the generalist specialties of the Royal College. In provinces with funded third-year residency positions in family medicine, some of these might well be used for an additional year of training in palliative medicine.

The impact of establishing such training programs would likely extend beyond the immediate purpose of providing additional training for physicians. Some of the consequences would be to help recruit new trainees to the field, to strengthen the critical mass of individuals committed to palliative medicine, to provide training for students from other health care disciplines in aspects of palliative care, to provide leadership for educational and research programs and to help develop new models of care delivery. Moreover, the establishment of such training programs would make an important statement about the value and priority attached to competency in the care of the dying.

Creating such specialized training programs would be associated with a far greater likelihood of influencing other medical education programs to adopt the values and principles of palliative medicine than continuing palliative care training on its current ad hoc basis. Palliative medicine has much to offer the field of medical education through its emphasis on such issues as meticulous attention to complex symptom control, whole-patient care, an interdisciplinary team approach, enhanced communication skills, support programs for the bereaved and the many ethical concerns relevant to end-of-life care.

The failure of the profession to formalize such training programs will continue to send the message to both the medical profession and the public that the knowledge, skills and attitudes of palliative medicine can be taught in an ad

hoc fashion, that palliative medicine is not really a specialty and that it does not deserve the same priority that we accord other disciplines in medicine for which specialized training programs exist. Furthermore, failure to do so may slow the development of the field, jeopardize the investment in palliative medicine that already exists in a number of academic centres in Canada, discourage new recruits from entering a field where they see little potential for a professional career and thereby even further delay the acquisition by all physicians of generic skills in the care of the dying.

Joint accreditation by the 2 national colleges would add both value and credibility to the accreditation process and recognition to the field. There is already precedent for joint site visits of existing programs such as geriatrics and care of the elderly. Such a venture would provide a powerful example of professional collaboration. The time is opportune to address the problem, and the need is significant. The colleges have a unique opportunity to take a bold and innovative action that will greatly benefit the profession, the discipline and the public.

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