



Thais Raquel P. Pinheiro, MD  
thaisraquel@sobramfa.com.br

## **36 – The Role of Family Medicine in Palliative Care - Now and in the Future**

Thais Raquel P. Pinheiro, MD  
Family Doctor with SOBRAMFA

### ***A Brief Introduction of Palliative Care***

Palliative Medicine is an ancient practice. Some centuries ago the only thing that doctors could do was palliative care (Melo, 2003). Palliative comes from *palliare*, a Latin term that means to cover, to decrease difficulties, exactly what medicine was. Cecily Saunders in 1960 developed the principles of modern hospice and palliative care. She heard patients and learned with them about their real necessities, making the decision to dedicate her life to care of terminally ill patients. She emphasized excellence in pain and symptom management; care of the whole person including their physical, emotional, social and spiritual needs; and the need for research in this newly developing field of medicine.

Nowadays, this philosophy is present in an extensive number of countries and in many palliative care services.

In 1968, Dr Elizabeth Kubler-Ross, a psychiatrist working closely with terminally ill people in the United States, published her seminal work, *On Death and Dying*. This book, for the first time, described the psychological crisis of the terminally ill person in terms of defined stages – denial, anger, bargaining, depression, and acceptance. This book has since become essential reading for clinicians who care for the terminally ill. She was the first to show the needs of dying, stressing the need for personal autonomy, death with dignity, and the benefit of death at home versus in a health care facility (Melvin, 2001; South-Paul et al, 2004).

According to World Health Organization, palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial 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 or postpone death; 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 patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if 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 and manage distressing clinical complications .

### ***Palliative medicine and death: a reality in daily practice***

Palliative Medicine is the study and management of patients with illnesses in which cure is no longer possible and an end point of death is expected within a finite period of time. The focus is on the control of symptoms and maximizing patient's self-defined quality of life (Melvin, 2001; Rakel, 1995). The complex goal of suffering relief can't be one-dimensional but must include the four human dimensions of human experience: physical (pain, dyspnoea, cough, constipation, delirium), emotional (anxiety, depression, grief), social (financial concerns, unfinished business) and spiritual (guilt, sadness, worthlessness). To provide this complete assistance the palliative care is usually delivered by an interdisciplinary team (Melvin, 2001; South-Paul et al, 2004).

Human suffering and death are real facts in daily doctors' activity. In spite of that, we still observe a big lack of professionals that are properly trained and prepared to deal with this subject (Blasco, 1997).

Death is a phenomenon that disrupts medical practice. It is not uncommon that doctors don't consider death as a real possibility. Death is not some unhappy fact that comes and makes the doctor's brilliant acting more difficult. Nowadays we can find doctors that use high-level technology but, in some way, give up their incurable patients, with whom their technical knowledge doesn't work. They are doctors for "new cars", "runners for short running". They are unable to remain comfortable in situations where purely biomedical technical skills are not enough (Blasco, 1997).

Experts agree that experimentally based and developmentally appropriate ethics education is needed during medical training to prepare medical students to provide excellent end-of- life care (Ahmedzai, 1982; Billings & Block , 1997;Caralis &Hammond , 1992; Lloyd- Williams & MacLeod, 2004 ).

In the U.S. a survey has demonstrated that the majority of medical schools do not provide palliative care knowledge during graduation. The researchers suggested the implementation of palliative guideline in medical curriculum (Aalst-Cohen et al, 2008).

### ***Family Medicine and Palliative Care: a Win-Win Relationship***

The reason why family doctors integration to palliative care services is of the utmost importance becomes clear if we understand the principles of Family Medicine.

Family Medicine's focus and action fields are: primary care, medical education and leadership. Trained in a specialty that is focused on person, the family physician is a person's specialist (Blasco et al, 2003).

Irygoyen says that the Family Medicine participation on palliative care occurs because both specialties focus on continuity care, prevention and family dynamics study.

Family Medicine's philosophy promotes doctors that have as a professional goal to improve health and quality of life of their patients in a broader sense. The doctor-patient relationship doesn't end with some incurable and deathly disease, even with the patient's death, as the relationship with the family goes on after that (Irigoyen, 2002).

In Brazil the elderly population is growing and doctors will need to deal in an increasingly frequency with terminal ill patients and their families. That reality will demand doctors with not only general clinic knowledge, but also, and not less important, communication and leadership skills. These doctors will need to lead multidisciplinary teams to be effective to their patients and respective families.

## **Take Home Message**

- Palliative Medicine is the study and management of patients with illnesses in which cure is no longer possible and an end point of death is expected within a finite period of time;
- Family Medicine integration with palliative care occurs because both specialties focus on continuity care, prevention and family dynamics study;
- Family doctors as person's specialists can provide a multidimensional patient care;
- Communication skills, leadership and the ability to provide comfort and empathy to the patients and their families are very important skills to complete this doctor's profile.

## **Original Abstract**

<http://www.woncaeurope.org/content/role-general-practitionerfamily-physician-palliative-care-now-and-future-state-art-session>

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