

# Specialty training in Palliative Medicine – Need of the hour

S Adinarayanan

The World Health Organisation (WHO) Global Atlas of Palliative Care at End of Life states that for every 100000 adult population there are 377 requiring palliative care at the end of life.<sup>1</sup> It is estimated that worldwide 20 million people require palliative care every year at their end of life and 69% are adults (over 60 years) and 6% children. Amongst adults 78% who require palliative care live in low and middle-income countries; 90% of this burden is constituted by those dying from non-communicable diseases like cardiovascular, cancer and chronic obstructive pulmonary disorders in that order. Of the children who require palliative care, 98% again belong to low and middle-income countries. This WHO report also estimates that about 37.4% of all deaths from all causes need palliative care. Temel and colleagues showed that there is a survival benefit when palliative care is applied early in the disease process at the time of diagnosis itself.<sup>2</sup> This also shows that suffering, when it is well addressed can prolong useful life and benefit patients. In India an estimated 6 million may need palliative care and 60% of those dying annually will die of long suffering from advanced illnesses.<sup>3</sup> Even today only 1% of people requiring palliative care are receiving it in India.<sup>4</sup> This scenario is only going to worsen as more people are living longer with incurable diseases and the majority are non-communicable ones like cancer.

In order to implement the WHO revised definition of palliative care<sup>5</sup> for adults and children it is imperative to look at the formidable barriers that are existing and the means to tackle them. The major barriers exist at the level of policy, education, medication availability and implementation. The World Health Assembly has asked all member states to integrate palliative care into routine health care, which is seen as a major boost.<sup>6</sup>

Despite all these measures there remain barriers that are difficult to overcome. Apart from government policies and medication availability, a major hurdle is from within the medical fraternity itself. With medical care always focusing on cure, the health professionals both doctors and nurses refrain from talking anything connected with death. They also refuse to allow effective palliative care to be provided to their patients under the pretext that they are knowledgeable and are already providing it. Therefore the greatest challenge to implement effective palliative care as envisaged by WHO is, to incorporate palliative

care at the undergraduate level itself and also create separate specialist training for it. Unless this is done it will be difficult to enlist the cooperation of the medical community and patients will continue to be deprived of the much-needed care. Palliative medicine must be developed as a separate specialty in its own right and introduced into the undergraduate medical and nursing curricula. Fellowships for other related specialists must be established to enable them to incorporate palliative care as part of comprehensive care of their patients.

In the developed world, palliative care is far more realistic because they have developed it as a specialty, especially in the USA, UK and some European countries.<sup>7</sup> In the USA, Hospice and Palliative medicine was created as a specialty in 2006 and in the UK it was a specialty as early as 1987 itself.<sup>8,9</sup> Over the last four decades a vast body of knowledge has been accumulated on the science of palliative medicine and more than ten journals exist today to espouse the cause and publish scientific research in palliative medicine apart from various internet sites, fora and associations at the national and international levels.

In India the IAPC (Indian Association of Palliative Care) has been in existence from 1994 and has been growing from strength to strength. With its active involvement the first specialty in Palliative medicine was started at Tata memorial hospital in 2012 and in AIIMS from 2016. The state of Kerala has an impressive palliative care network known as the NNPC (Neighbourhood Network in Palliative Care) along with two institutions as WHO collaborating centres (Institute of Palliative Medicine, Calicut and Pallium India, Trivandrum). In spite of these, their penetration is rather static for the last few years. The pioneers of the palliative movement in Kerala also feel that their main barrier in the beginning, was the unwillingness of the medical community to accept the concept of palliative medicine and care. Similar problems have been faced in delivery of care palliative care by the author since 2007. Policy may not get implemented unless the medical fraternity accepts it. As the primary care physicians and specialists do not fully understand the tenets of palliative care and its benefits, the concept does not trickle down to the patient and carer level and therefore, they do not ask or seek for it out of ignorance. This leads to unnecessary suffering for the patient and carers. Whenever the question of palliative care comes up

S Adinarayanan

Assoc Professor  
Dept of anaesthesiology  
JIPMER  
Pondicherry

## Correspondence

Email: adinarayanans@gmail.com

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for discussion, the usual refrain is that “We are already doing it” or “How is my specialty concerned with it”. Those familiar with the contents of the Oxford textbook of palliative medicine which is into its fifth edition will agree with me that the principles and practice of palliative medicine is based on high quality research and as much evidence based as other medical specialties.

A body of specialists trained in palliative medicine will also empower us to make inroads into national level policy making, involve the policy makers and ensure political will and backing to implement palliative care as per WHO vision and mission statement. Till 2014 there are at least 26 countries that have palliative medicine as a specialty or subspecialty.<sup>7</sup> This recognition as a separate specialty has also been seen as a turning point for palliative medicine. Another advantage is that it helps to develop advocacy and evidence base for the practices that alone can ensure its viability in the long term. The development of palliative medicine as a specialty ensures that departments of palliative medicine will be setup and will get the due recognition and support that it deserves. This will also make research and evidence possible for integrating palliative care at the primary care physician level itself. It will then follow that there will be three levels of care: one at the primary level, the other at the level of related specialties and the third at the level of palliative medicine as a specialty for advanced care and for managing patients with complex symptoms and problems. This will also ensure that care models are created and delivered at various areas like hospital wards, outpatient and home and community.

As more and more people get to live longer coupled with advances in medical science, future medical professionals will be grappling with issues of suffering and death as never before. Only a background of palliative medicine can come to their help with stress on communication and effective symptom management. The patients and carers will also be in a position to demand consultations with palliative specialists when

faced with serious illness and at the end of life. Unless we “let go” of the urge to cure at all costs and accept that alleviation of suffering is more important at end of life and faced with serious illness, we will be denying people their basic human right to dignity and peace till death. This paradigm shift is possible only when palliative medicine is developed as a separate specialty in its own right to complement and strengthen existing models of care and at the same time offer high quality evidence based care as part of routine management of serious illnesses.

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