Losing the label of elitism

“The palliative care, or hospice, movement provides demonstrably excellent care for those patients and families with whom it has direct contact. However, it has been criticised over the years for focusing on a significant yet small population of terminally ill cancer patients. It has also been accused of collecting patients together in what some have seen as ‘collective dying’. The answer to these charges is, of course, the integration of palliative care philosophy into core clinical practice.[1]

As early as 1974 in the USA, the St Luke’s Hospital Center in New York initiated the hospice team. This acted as a consultative peripatetic team available for multiprofessional advice to any medical service that requested it. This was replicated the following year in Canada at the Royal Victoria Hospital, Montreal, as the palliative care service, although a small dedicated bedded unit soon developed as well. These initiatives were followed in the UK by the St Thomas’ Hospital palliative care team in London in 1977 and in Norway by the Haukeland University hospital support team in Bergen in 1982. Since then, it has become increasingly common for general hospitals to develop palliative care consultative services not only in the UK and America but throughout Europe.[2]

At the same time as these developments were taking place, community support services and day hospices were being set up. These were either linked to specialist inpatient units or stood alone. The combined effect of these developments was the spread of palliative ideas far beyond the immediate hospice environment. Nursing and medical students were demanding, and receiving, palliative care courses in their curricula. Questions relating to the end of life were also being included in clinical examinations.

A recent meeting of the European Federation of Internal Medicine specialists in Lisbon included a session devoted to end-of-life care and examined questions of early discharge from hospital as well as general principles of palliation.[3] Similarly, the author recently found himself discussing with medical educators from the USA how palliative philosophy and communication skills should be integrated into the undergraduate curriculum.

However, there is still much to be achieved. On both sides of the Atlantic, there is a reluctance to acknowledge death as a normal part of life and an acceptable outcome in appropriate circumstances to an episode of medical care. There is also difficulty in recognising that the terminal phase of life has been reached. In the UK, the End of Life Care initiative by the Department of Health has commended various tools to help clinicians approach the end of life of their patients more appropriately. These include the Liverpool Care Pathway (LCP) for dying patients.[4] The LCP has been written about in this journal on several occasions. It is a flexible, auditable mechanism for promoting discussion between the multiprofessional team, the patient and family to achieve the best end-of-life care. In my own hospital there has been interest in joining other units who are adapting it for use in the intensive care unit. This follows acknowledgement that, despite the best endeavours of the intensivists, there will always remain a finite mortality rate in intensive care units. We hope to carry a substantive article in the future concerning such adaptation of an end-of-life tool for use in intensive care units.

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In conclusion, the only way that the charge of elitist care for the privileged few can be rebutted is by thorough continuing integration of palliative care philosophy into mainstream medical practice. This is not to advocate the abandonment of centres of palliative excellence such as the hospices, but the adaptation of what has worked well for advanced cancer to all other patients who are approaching the end of life.”

Andrew Hoy, *Editor*

References
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