Palliative care is no longer the Cinderella specialty

“For as long as I can remember, palliative care has been the Cinderella specialty. This is not a surprise, as death is taboo in Western cultures. Recently, however, things have begun to change – at local, national and international levels. This is a hugely exciting time to be involved in palliative care, as it gains widespread recognition and acceptance.

At a local level, the realm of palliative care has extended from terminal care to embrace symptom control and psychosocial support. Palliative care teams are carrying out Trojan work, not only in the hospices but in acute hospitals, in facilities for care of the elderly, and out in the community in the patient’s home. There has been a shift in provision to include both cancer patients and those with non-malignant diagnoses, including cardiac, respiratory, neurological and renal pathologies. New processes and care pathway approaches – such as the Liverpool Care Pathway for the Dying Patient and the Gold Standards Framework – have been developed.

At a national level, governments are recognising the importance of palliative care. An end-of-life care strategy, which is elegantly summarised in this edition (see pages 16–18), has been published for the first time in England. This is now being followed up with a ‘Quality Markers Consultation’ paper. Palliative care is now no longer seen as a luxury specialty, but as an essential aspect of healthcare provision.

At an international level, palliative care is being practised in more and more countries. In many of them, it has been included in the undergraduate medical school curriculum. Palliative care is a recognised medical specialty with an increasing number of schemes available for higher specialist training. Developments are taking place across Europe, as the European Association for Palliative Care (EAPC) strives to standardise symptom-control assessment tools. By definition, this will enable audits and research to be performed meaningfully across different countries.

The importance of providing the best standard of palliative care is now recognised. Evidenced-based guidelines have been published. Palliative care research is entering a new era and is now attracting international funding and recognition. There are growing numbers of palliative care research units worldwide, and more young clinicians and scientists are becoming involved in this important aspect of palliative care.

In 2008, the EAPC Research Network launched a Junior International Forum (JIF). The aim is to build a strong foundation for the provision of high-quality, effective and collaborative palliative care research that will produce better palliative care at a clinical, scientific and social level. The position is clear: end-of-life has become a priority.

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Palliative care is unique in that it is a patient-centred, multiprofessional specialty that embraces a wide range of settings and disciplines. Advances in technology should aid us in better communication between providers.

In an environment of political goodwill, and with the heightened profile of the specialty, we need to communicate and share good ideas and good evidence-based practice, and we should support one another in our attempts to achieve ‘good deaths’ for patients, ensuring that their symptoms are controlled and they are treated with respect and dignity.

This paradigm shift in the palliative care environment gives rise to opportunities and challenges that must be anticipated if we are to adapt to the changes that come with this new environment.

It is at this exciting time that I have the privilege of taking on the role of Editor of the *European Journal of Palliative Care*. Dr Andrew Hoy will be a difficult act to follow. He has been my mentor and role model, and I would like to thank him for developing the journal while Editor. I hope that I can do it justice in the future.”

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