
PALLIATIVE CARE

A MULTIDISCIPLINARY APPROACH

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Abstract

In the last two decades we have observed, even in Romania, an almost radical change of the pathology spectrum. The efficiency of Medicine has increased, new drugs are being produced, there are new techniques and advanced medical devices (which has greatly increased life expectancy), but, in parallel, while there is a decrease in the prevalence of infectious diseases, we can observe a continual increase in the frequency of chronic and degenerative diseases. This type of pathology is accompanied by severe physical, psychological, and spiritual suffering. In those situations when an adequate curative therapy is not available, we should at least reduce the physical and psychological discomfort by providing symptomatic treatment, which includes palliative care, whose objective is to reduce the symptomatology of the illness. This study tries to identify, on the one hand, the place and role of palliative therapy (medical, psychological and spiritual) and, on the other hand, to stress the importance of the harmonious interaction of the different types of interventions used during the care of the terminal patients. This article intends to be an argument for a congruent intervention, based on mutual understanding and cooperation between the professionals involved in the treatment of the patient, in order to reduce and overcome his suffering, and not based on competition, which can lead to disastrous consequences for the patient.

Keywords: terminal patients, palliative care, multidisciplinary approach, integration

1. Introduction

The contemporary society has witnessed some important improvements that have an applicative impact in various scientific fields, including that of Medicine. This progress has allowed some new and more precise methods to be used for diagnostic and therapeutic purposes. The above-mentioned progress also has led to major changes in the approach to patients and to diseases, changes that, unfortunately, did not always benefit the patient or his family. The increased accuracy of diagnosis techniques and of early medical intervention, the

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extended breadth of medical specialisations and the possibility of understanding the level of specialisation, the progress of the medical and pharmaceutical research, have led to an increased efficiency of medical interventions. However, medical science remains helpless in many cases. The narrow specialisations and an excessive technical approach can lead to a narrow, fragmented patient approach and to the neglect of the situation, of the complexity and uniqueness of the patient. Man, whether healthy or ill, is a complex and unique being, with his biological features, with his personal history, with his socio-cultural context, with his beliefs and lifestyle. Highly-specialised medical approaches focus strictly on the body, but often neglect the psycho-social and spiritual side. A fragmentary approach of the human being, of the patient, or his consideration only in terms of physical/medical needs does not answer human needs and the purpose of medical therapies.

J.-C. Larchet refers to ‘the process of dehumanisation’ of present-day medicine [1]. H.T. Engelhardt also underlines the risk of dehumanisation of the medical act in the context of excessive technologisation and inappropriate use of medicine [2]. Both authors emphasise the urgent need to address human beings as a whole, as a single body, as a result of the interactions between the bodily, psychological, and spiritual dimensions. Healing, wellness, and the quality of our lives depend on the physical, psychological, and spiritual health alike. Neglecting one part affects the quality of human life. In these conditions, the need for a multidisciplinary approach becomes obvious. The holistic approach – involving multidisciplinary, and for which we advocate – has deep and strong roots both in the secular culture and in the Church experience. The Fathers of the Church also had a holistic, multidisciplinary view, considering “man in its entirety, with all his three dimensions – bodily, mental and spiritual” [1, p. 9]. Nowadays, many doctors are in favour of the importance of spiritual care also [2-4].

2. Arguments in favour of a multidisciplinary approach

Palliative care was developed as a response to the needs of severe or incurable patients who live in an over-technologised and precipitant society, where there is less and less time for the spiritual dimension. The fundamental problems (sufferance, fear of facing pain and death) remain essentially the same. Illness causes physical, psychological, and spiritual suffering. There is a search for ways to improve the situation, to overcome suffering by understanding its meaning, to discover its sense and to integrate/accept it at a personal level. The purpose of providing palliative care is primarily the reduction of the suffering at the somatic, psychological, and spiritual level as well.

The organisation of palliative care is based on (1) the identification and understanding of key issues, irrespective of time, geographical area, and cultures and on (2) the way we define the concept of palliative care, principles formulated in response to the following questions: why, for what purpose, who, when, and how palliative care is offered.

The way in which the inherent confrontation with suffering and death is recognised and accepted, integrated and lived at a personal level, has a dual impact: on the one hand, (1) it has an impact on how different health professionals: (a) address the disease, the therapy, the intervention, (b) communicate and collaborate with the intervention team for the benefit of the patient, (c) establish a personal relationship with the patient and his family and, on the other hand, (2) determine the acceptance and integration, as least traumatic as possible, of this reality by the patient and his family. Metropolitan Hierotheos Vlachos refers to ‘overcoming death’ (or suffering) when it is clear that “death is the one that dominates human existence and the salvation of man is to overcome death” [5]. He stresses the failure of the theoretical debates (very numerous on this topic) in rendering the complexity, the intensity of human feelings, and the inner confusion within the actual context of the confrontation with death, emphasizing the central role of the faith in this process.

The World Health Organisation’s (WHO) definition of palliative care as “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” [6] gives a synthetic answer to the questions of why, for what purpose, and when, and stresses the need for a palliative-care multidisciplinary approach. Beyond the general issues related to basic human needs, the concept of ‘quality of life’ is burdened with a great deal of subjectivity [7]. The way in which people perceive and represent a ‘quality of life’ is different, but it always involves an inner balance, an acceptance based on the understanding and integration of life’s events.

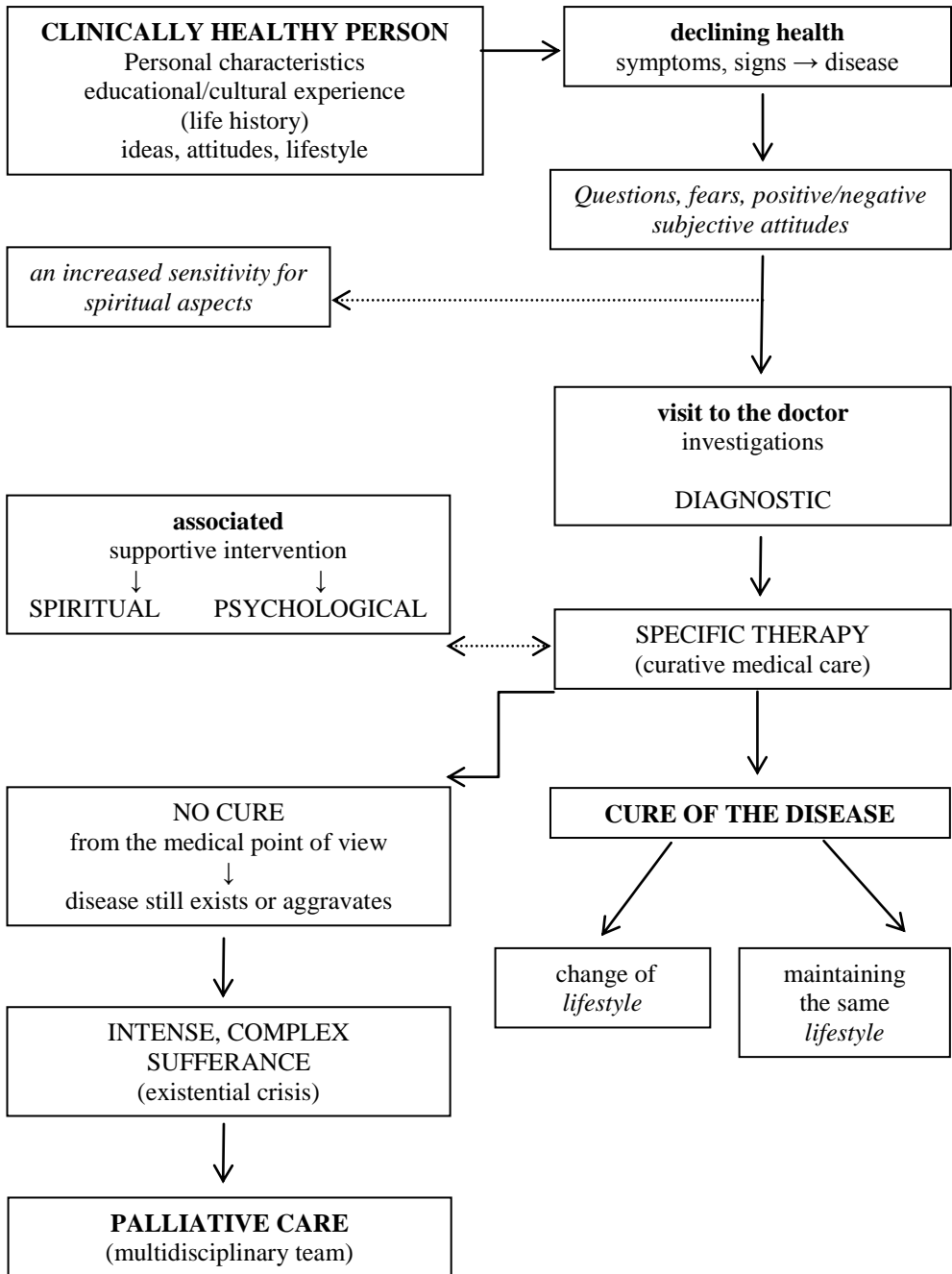
To whom, when, and why is palliative care offered? Palliative care is focused on the patient (care for body, mind, and soul) and his family members who, on the one hand, suffer, but on the other hand are an important external resource for the patient. A fundamental requirement is adapting care to the uniqueness of the individual and to the context. Age, diagnosis, evolution, the person’s life experience, his spiritual beliefs, and his faith are some of the variables that palliative care should take into account. Palliative care is administered at any age and at any stage of the disease. It emphasises the importance of early proactive, but not reactive, interventions in palliative care [8]. Often, an early palliative intervention, with a multidisciplinary team, prevents excessive suffering [9].

The intervention of the palliative care team must meet the objective formulated in the WHO definition (improving/diminishing physical, psychological, and spiritual suffering) and the complexity of the patient’s needs in all areas, but without trying to generalise or undermine some dimensions. Physical pain, various somatic symptoms, and the physical inability to continue one’s activity in the same way, are just one aspect of the disease. Palliative care takes place in the area where medicine recognises its limits, where it recognises and accepts that it is unable to heal, but can only alleviate suffering; physical

pain relief allows the patient to focus on the spiritual aspects inherent in this moment of his life [2]. Living the experience of a disease – primarily of a serious, incurable illness – brings dramatic changes in the life of the patient and of his loved ones [10]. The disease produces a powerful inner ‘storm’, queries concerning the past, the present, and the future, a search for answers, for the meaning of life and suffering. The patient is in crisis, he is struggling to integrate his experiences, which may generate a strong inner conflict. Often, crises will generate important changes at the personal level, especially in the spiritual area, in the hierarchy of values, in the way he understands and experiences life. The patient needs to understand and attribute a meaning to his suffering. Often, the core of suffering is represented not so much by the physical pain, but by the psychological and spiritual suffering, desperation, and hopelessness. The results of an epidemiological study conducted in a Parisian hospital indicate significant spiritual and psychological suffering associated with a serious, terminal illness: 80% of the subjects mentioned the spiritual suffering, 77% mentioned the multiple psychological symptoms (emotional lability, despair, depression, anxiety, anger), 66% reported pain and physical symptoms. Only 33% of the subjects mentioned physical pain as the main problem, most of them mentioning psychological suffering as being primary [11].

Who provides palliative care and how? Is there an optimal model for such an intervention? Which is it? The answer depends on how one conceptualises the patient and the objectives of palliative care. Several models focusing on different aspects have been elaborated in the attempt to find the optimum model. The model of dignity [12], the integrative model [13], the TLC model of palliative care [8], and the bio-psychosocial-spiritual model [14] are only some of them. An analysis of these models identifies some common features. Palliative care cannot ignore the psychosocial and spiritual distress, which is a fundamental component of suffering. Integration, early intervention, continuity of the intervention, and constant adaptation to the patient’s needs are basic requirements of efficient intervention. Palliative care is a dynamic process, involving various specialists focused on patients’ needs in their context, specifically a result of the socio-cultural characteristics of the environment and of the life history of the patient. A healthy person, from a somatic point of view (as well as a sick one, regardless of the severity of his illness), belongs to a cultural and spiritual community. His own personal history, his beliefs, attitudes, lifestyle, and understandings affect the way in which the patient understands and approaches disease and faith. The challenge lies in the elaboration and validation of a universal, flexible model that can correspond to general objectives and principles, to international standards, being, at the same time, adaptable to the patient’s context (see Scheme 1).

An efficient intervention involves an accurate assessment of the situation, of the patient’s internal and external resources, the elaboration of the intervention plan, and monitoring its application.



Scheme 1. Palliative care integration – a general model.

The multidisciplinary approach is the only possible answer to the question of who provides palliative care and how. Engelhardt believes that the palliative care multidisciplinary team represents the place where the human encounters the spiritual and the faith [2, p. 366]. An integrated approach is essential to the medical and Christian views and also “re-examining how health professionals should relate to their patients” [2, p. 354]. Health care is important, but medicine, Engelhardt says, “only postpones death. It can only ameliorate, not banish human suffering” [2, p. 353].

There are many arguments in favour of this approach: the complexity and uniqueness of the human beings, the complexity of the human suffering and of the patients’ needs, the double quality of the intervenients who provide care – their capacity as professionals, experts and their quality of human beings who also experience suffering. Beyond the suffering of the patient and of his family, the palliative care team faces their professional and human limits, their questions and queries. Being aware of the limits of science, both in the case of patients and in the case of experts as human beings, can often lead to a dramatic impact at a personal, existential level. Each team member will make his contribution without going into the ‘field’ of the others. Efficient care can be provided only by an efficient team, a compact team, in which they assume their specific responsibilities and cooperate for the good of the patient. Multidisciplinary answers the complexity of the problem and responds to the existing needs. Illness and suffering involve biological, psychosocial, and spiritual factors. For the actions to achieve their purpose, medical interventions should be associated with psychological and spiritual interventions, because the spiritual factors “may play a role, either as sources of disease or as means of healing” [1, p. 80]. The importance of the spiritual care becomes increasingly stressed by experts in the field [3, 15-17].

What is the contribution of the doctors in the spiritual area? It is a question that needs to be answered by both doctors and theologians [1, 2, 18]. All above-mentioned authors admit the role of the doctor and of the priest in approaching and improving the condition of the patient, in reducing his suffering, trying to identify a common area of intervention, and, at the same time, establishing the limits and the peculiarity of each profession. Suffering affects the whole person and brings to the surface important spiritual matters: therefore, spiritual care is a mission of the multidisciplinary team members, including even surgeons, as Hinshaw asserts [3]. Larchet stresses the Christian spiritual component of the doctor as a human being, talking about the necessity of the Christian physicians who have “adopted the medicine of their time” [1, p. 80]. The practice of medicine ‘in a Christian way’ means professional competence, assimilation, integration of the medical scientific progress without resorting solely to its mechanical aspect, but acting in a manner that exceeds the purely technical aspects and the fragmentation of the intervention, addressing the patient as a whole, as a bodily and spiritual unity. Approaching the same issue, Engelhardt underscores that the treatment of pain (the essential target of medical intervention in this case) must be in connection with the spiritual aspect [2, p.

322]. The patient's freedom to accept religious and spiritual intervention is also emphasised [1, 18, 19]. The request for the intervention of the priest should come from the patient, believes Larchet [1]. Paul Meyendorff, in his volume *The Anointing of the Sick*, emphasises that the Church and the health care professionals have a different understanding of disease. While the medical profession is currently anchored in tangible reality, offering or at least willing to give an immediate, but temporary, cure, the healing given by the Church does not depend on the context, on time or space. Modern medicine is necessary and useful, but it “does not address to the total reality of human existence, and therefore does not offer the healing that is ultimate in nature” [19, p. 85]. The complexity and importance of the multidisciplinary care is obvious, says Meyendorff: “healing is too important to be left solely to the medical profession” [19, p. 9].

The efficient activity of the team is based on competence, value and mutual respect, and respect for patients and their general awareness and acceptance of the team's goal: to alleviate the suffering and to maintain the quality of life [7]. Palliative and curative care areas are not excluded, but their proportion varies, depending on the disease and on the needs and choice of the patient.

The way in which the team members perceive, accept, and exercise their role within the team has an important impact on the efficiency of the intervention. Each team member, according to his specialisation, has a range of skills and accesses specific information concerning the patient. At the same time, they establish a personal relationship with the patient, which complements and refines the already known information. In the absence of real cooperation between team members, cooperation based on the recognition of their value as persons and professionals, and on mutual respect, team efficiency is low – even harmful – and the goal of palliative care is not achieved. Team members are not in competition, they should not undermine each other, they should mutually support each other. The roles of the health care specialists of a multidisciplinary team are clearly defined and relatively easy to quantify, but in the case of the priest, of the spiritual father, his tasks are less explicitly formulated and for some they are less obvious or valorised, and can sometimes be minimised or denied by some members of the team, affecting the efficiency of palliative care. It is an aspect that should be analysed. The problem is complex and is related to cultural characteristics, to the place and role of medicine in contemporary society. Engelhardt refers many times to the need to re-examine how health care professionals relate to their patients [2].

An important role is played by the leader belonging to the medical profession; his skills, but also his human, personal values guide his approach, his attitude, and his actions. In order to intervene efficiently, the team must fulfill some specific requirements concerning its composition and functionality regarding: the skills, the expertise of its members, their personal characteristics (degree of motivation, personal beliefs concerning health and disease, flexibility, openness for cooperation, acceptance of their limitations, empathic ability,

optimism, sense of self-efficacy), their relationship, and knowing and respecting the competence and attributions of oneself and of the other team members. Competence, respect, complementarity and integration are key elements for efficiently functioning to the benefit of the patient.

Integration is crucial for the team: the same thing can be said about cooperation in the service of the patient, not domination or arrogance. Suffering – Engelhardt says – “pulls us back from our hubris” [2, p. 309]. Integration is a key concept. It refers to integrating suffering in life, integrating different specialists in the palliative care team, assuming one’s own place and role in the team, respecting the patients and their teammates; the integration of these dimensions – medical and spiritual, Christian – for those who provide palliative care and for the patient; the integration concerns the individual level, the specific skills of the medical experts, and the Christian moral dimension [2]. It refers to the integration of some diverse and complex emotions: guilt, fear, trust, hope, and faith.

3. Conclusions

The complexity and intensity of the suffering caused by severe and/or terminal illness require a complex and flexible multidisciplinary team. Specific curative medical care and palliative medical care are complementary; their proportion varies in different areas of intervention.

Psychological and spiritual support is not conditioned by the existence of a serious, incurable disease, but it is useful at any time, and is especially necessary when we deal with suffering at the end of life.

The efficient activity of the team is conditioned by: (a) the competence of team members, (b) their human quality (motivation, beliefs, and personal values), (c) the clarity of their roles, responsibilities, and limits as team members, (d) clearly stated objectives accepted by them, and (e) the development of an action plan created and customised in response to the real needs of the patient. Competence, mutual respect, knowledge, and acceptance of the limits of their own profession and respecting the needs and liberty of the patient are basic conditions in palliative care.

The common approach of the issues – but from different perspectives – should not lead to competition, but should be based on integration, cooperation, efficiency, communication, and, why not, on prayer.

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References

- [1] J.-C. Larchet, *Creștinul în fața bolii, suferinței și morții*, Sophia, București, 2004, 78.
- [2] H.T. Engelhardt, *The Foundations of Christian Bioethics*, Scrivener Publishing, Salem (Mass.), 2000, 322.
- [3] D.B. Hinshaw, *Surg. Clin. North Am.*, **85** (2005) 257-272.
- [4] E. Bruera and D. Hui, *J. Clin. Oncol.*, **28** (2010) 4013-4017.
- [5] H. Vlachos, *Psihoterapia ortodoxă: continuare și dezbateri*, Romanian translation, Sophia, București, 2001, 122.
- [6] ***, *Cancer pain relief and palliative care*, World Health Organisation Technical Report Series, **804** (1990) 11, online at <http://www.who.int/cancer/palliative/definition/en/>, (05.04.2012).
- [7] M. Aluaș, *Studia Universitatis Babeș-Bolyai. Bioethica*, **56** (2011) 83-94.
- [8] A.F. Jerant, R.S. Azari, T.S. Nesbitt and F.J. Meyers, *Annals of Family medicine*, **2** (2004) 56-60.
- [9] J. Temel, J. Greer, A. Muzikansky, E.R. Gallagher, S. Admane V.A. Jackson, C.M. Dahlin, C.D. Blinderman, J. Jacobsen, W.F. Pirl, J.A. Billings and T.J. Lynch., *New Engl. J. Med.*, **363** (2010) 733-742.
- [10] ***, *Molitifelnic*, IBMBOR, București, 1998, 144.
- [11] V. Morize, D.T. Nguyen, C. Lorente and G. Desfosses, *Palliative Med.*, **13** (1999) 105-117.
- [12] H.M. Cochinov, T. Hack, T. Hassard, L.J. Kristjanson, S. McClement and M. Harlos, *J. Clin. Oncol.* **23** (2005) 5520-5525.
- [13] J.M. Milstein, *J. Perinatol.*, **25** (2005) 563-568.
- [14] D.P. Sulmasy, *Gerontologist*, **42** (2002) 24-33.
- [15] A. Kellehear, *Palliative Med.*, **14** (2000) 149-155.
- [16] J.M. Milstein, *The Journal of the Medical American Association*, **299** (2008) 2440-2441.
- [17] E.L. Moss and K.S. Dobson, *Canadian Psychology*, **47** (2006) 284-299.
- [18] D.P. Sulmasy, *Chest*, **135** (2009) 1634-1642.
- [19] P. Meyendorff, *The Anointing of the Sick*, St. Vladimir's Seminary Press, New York, 2009.