DR. BALFOUR MOUNT AND THE CRUEL IRONY OF OUR CARE FOR THE DYING

Janice Hamilton

In Brief • En bref

Dr. Balfour Mount of Montreal thinks that the health care system, because of its fixation on disease processes, may have forgotten that it also has a mandate to alleviate suffering. "We need to recapture that vision," says Mount, who describes palliative medicine as a "rich combination" of clinical pharmacology, rehabilitation medicine and internal medicine. Mount says there is a cruel irony in our care of the dying. "Although these are the sickest people in our health care system, when medical technology doesn't know what to do, the quality and quantity of care falls away. How can we justify that?"

Le D^r Balfour Mount, de Montréal, est d'avis que parce qu'il est fixé sur les processus morbides, le système de soins de santé a oublié qu'il a aussi le mandat d'alléger la souffrance. «Il faut reprendre conscience de cette vision», affirme le D^r Mount, qui décrit la médecine palliative comme une «combinaison riche» de pharmacologie clinique, de médecine de réadaptation et de médecine interne. Le D^r Mount affirme que notre façon de soigner les mourants est d'une ironie cruelle. «Même s'il s'agit des gens les plus malades dans notre système de soins de santé, lorsque la technologie médicale ne sait plus quoi faire, les soins diminuent en qualité et en quantité. Comment justifier cela?».

Dr. Balfour Mount stared out his office window overlooking the steep slope of Mount Royal while he answered an urgent phone call from a former colleague's family. That physician, in his 80s, had just died at home. A home-care nurse from the Royal Victoria Hospital's Palliative Care Service, which Mount directed, was on her way to the house at the time.

"He was able to be at home to the end because he had a caring family who made that a priority," Mount said. Also, nursing and physician resources were available to the family, thanks to the palliative-care program Mount started 20 years ago.

Until recently, Mount held a new Chair in Palliative Medicine at McGill University. He was also director of Palliative Care McGill, a division of the Department of Oncology that oversees palliative care at nine McGill-affiliated hospitals. These institutions range from a francophone chronic-care facility not otherwise linked to McGill to community hospitals and a children's hospital. The largest programs involve home-care services and bereavement follow-up. In many cases, the patient's family physician or community-health clinic is involved, while palliative-care staff provide support upon request.

In June, Mount tendered his resignation from his posts in response to what he called "serious roadblocks to the continuation of the development of academic palliative-care programs at McGill." At press time, he was continuing discussions about these problems with the Ministry of Social Affairs of Quebec, and with representatives of the university and the hospitals involved.

In Canada, palliative-care programs are the exception rather than the rule. One recent estimate suggested that only 5% of Canadians have access to palliative care, a situation Mount finds intolerable: "To not have competent palliative-care resources available in the 1990s is unethical and cannot be excused."

He argues that widely available palliative care is essential for both ethical and economic reasons. Ethically, he finds it unacceptable that people are allowed to suffer. As for cost, "we can't afford not to do it."

When doctors and administrators ask how they can set up a palliative-care program when so few beds are now available, he tells them to count the patients who are currently in those beds. A quick census usually reveals that a substantial portion are terminally ill.

Mount recently visited a 100-bed hospital, where staff were startled to find that about a fifth of their patients could be considered recipients

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Janice Hamilton is a freelance writer living in Montreal.

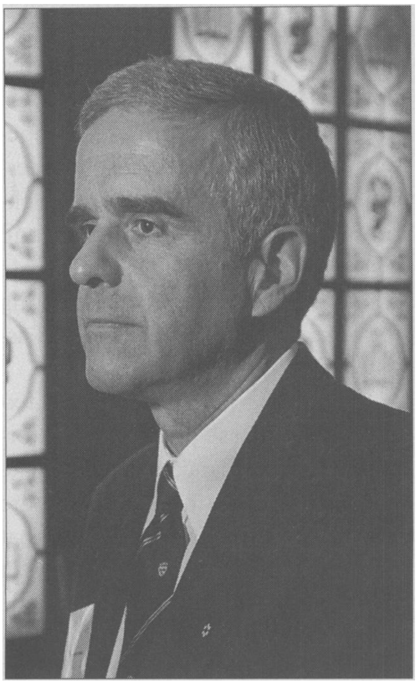
of palliative care. He suggested that if they grouped the palliative-care patients together with competent staff and a home-care program, they could free active medical and surgical beds.

Mount admits it is very difficult to care for a dying person at home, but for many people dying at home remains the ideal. However, families need to have resources they can call on, and backup beds for respite care. "We can't just shift the dying into another kind of ghetto of inadequate care," he says.

He argues that palliative care is more than just symptom control — it means caring for the whole person. "We're body, mind and spirit," Mount emphasizes. "These are interdependent, and problems in each domain profoundly influence well-being in every other domain." In the end, palliative care involves physicians, nurses, social workers, dietitians, occupational therapists, physiotherapists, music therapists, volunteers, even hairdressers.

As for palliative medicine, Mount describes it as "a rich combination of clinical pharmacology, rehabilitation medicine and internal medicine." Although some people think it is similar to chronic care, he suggests that it is more like emergency medicine. "The needs of the patient often change rapidly and radically. There needs to be continual reassessment of those needs if you're going to have effective and cost-effective care, an alert, comfortable patient and a functional family."

Phil Carpenter, *McGill Reporter*



Dr. Balfour Mount: "To not have competent palliative-care resources available in the 1990s is unethical and cannot be excused."

For Mount, caring for the dying can be very rewarding. He recalls the time his wife picked him up after a particularly turbulent and trying day. "I was very tired, but as I slumped into the seat I said: 'I really enjoy what I do.'

"These are the patients for whom 'nothing more can be done,' " he says. "Yet you can so easily make such an immense difference to suffering. You make a difference with someone who has pain when, with a simple adjustment of medication, you get their pain under control.

"You make a difference when you remember that one of the pains cancer patients suffer is due to constipation, and you write a prescription for bowel medications at the same time as you prescribe a narcotic.

"You make a difference when you recognize the complex cascade of feelings, reactions and fears that come to the surface when we contemplate our own finite nature.

"You make a difference when you take the time to sit down and listen, when you stay there in the face of unanswerable questions.

"You make a difference when you ask the person who is ill, and the family members, what the pain means to them.

"And you make a difference when you assess the family system, find its pressure points, find out who is at risk for pathological grief reaction, and start planning for grief support before the loss occurs."

Mount's decision to pursue a career in medicine was influenced by his father Harry Mount, a neurosurgery pioneer in Ottawa, and his older brother, Jim, an ophthalmologist. He trained at Queen's University and McGill and at the Memorial Sloan-Kettering Hospital in New York, specializing in surgical oncology and urology.

One of the greatest influences in those student years was Dr. Ford Connell, a professor of internal medicine and cardiology at Queen's. Connell used to make rounds on Sunday mornings; Mount, realizing that "internal medicine was bigger than I was," asked if he could go along. "Connell was a blustery General Bullmoose of a figure. He replied: 'Don't expect any teaching.' But the one thing he couldn't resist was teaching." Mount continued to take those semiprivate tutorials for 2 years.

"I have a variety of clear memories of Connell as a physician, but they boil down around his amazing ability to balance medical competence and meet people where they were," recalls Mount, who says Connell could talk stock markets with a stressed businessman in one bed, then put his feet up on the bed of a fisherman in the next room and chat about the man's family. "When we said goodbye at the end of the last rounds, Connell growled, 'Well, Mount, you may not have learned much internal medicine, but I hope you learned something about how to talk to people.' "

The turning point in Mount's career came in 1973. He was a busy surgical oncologist at the Royal Victoria Hospital, and in the laboratory he was studying a murine model of testicular cancer. Then he was asked to conduct a study on attitudes toward dying at the hospital, and to find out just how patients died. The results shocked him.

Mount says the study authors expected to find that dying patients had unmet psychosocial needs, but they also found that patients had unmet physical needs, including inadequate control of pain and other symptoms, and poor nursing care. Other studies showed that, in cases of terminal illness, communications were often blocked, patients experienced isolation and distrust, doctors visited less frequently when they knew the patient was dying, and nurses felt uncomfortable.

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>
> **— Dr. Balfour Mount**

"What was fascinating to me was that disastrously inadequate health care was happening in a first-rate McGill University teaching hospital, and we were not aware of it," says Mount. Moreover, he knew his colleagues to be committed, caring people. It seemed the problem was rooted in the system.

Two years later, in 1975, Mount headed up the hospital's new Palliative Care Service, and the first patient was admitted. A similar program was set up the same year at Winnipeg's St. Boniface General Hospital. Eventually these Canadian programs became models followed by the World Health Organization and hospitals in more than 30 countries, which were used to integrate hospice concepts into health care systems.

In the last 20 years, Mount says, there have been improvements on many fronts. Most of Canada's medical schools provide some undergraduate teaching in this area, and there is active interest in family-medicine training programs in palliative care. Peer-reviewed journals have studied the topic, and there have been national and international scientific meetings on the care of the terminally ill. Today, the Canadian Palliative Care Association has divisions in every province.

The Canadian Society of Palliative Care Physicians (CSPCA), which Mount heads, was recently formed with a main goal of establishing palliative medicine as a new specialty. Members of the CSPCA have met with the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada to discuss the issues involved.

"The primary goal is not to medicalize dying," explains Mount. "We see the need for a specialty only because the needs of the dying require equal consideration with other health care needs at the shrinking budgetary table."

He cites as examples the United Kingdom, where palliative care became a specialty in 1987; it was followed by Australia and New Zealand.

"There is an ethical imperative that communities examine how people die in the community," he adds. "When the studies are done, they'll find that, unless there are specialized programs and unless there are individuals who have made it their business to develop competence in this area, there is still unnecessary suffering."

Mount also sees the need for more research in the field of pain control. The use of opioids varies by up to 50 times in university-based hospital programs in Canada. "There are low-dose centres and there are high-dose centres treating the same patient populations," he notes. "We should ask why some centres are able to get the same degree of pain control using a fraction of the morphine. These are fundamental questions that need to be examined."

He suspects that his hospital can use low doses because it gets involved with the patient early, uses co-analgesics and takes a "whole-person" approach, attending to the patient's psychologic, social and spiritual needs. But Mount stresses that this is only a hypothesis that needs to be tested.

Although he is a strong advocate of using palliative care to alleviate suffering, Mount is opposed to euthanasia and physician-assisted suicide. As he told a special Senate committee studying euthanasia, "the physician-patient relationship has to be rooted in two fundamental goals — to comfort and to cure. To add a third, 'to kill,' would change the ground of that relationship in a fundamental way. The argument that, in this case, 'to kill' is simply a fulfilment of the mandate 'to comfort' rings hollow when good palliative care, including as it does the option of sedation to alleviate suffering, has not been uniformly made available." He urged Canada to make competent palliative care universally accessible instead of opting for the quick-fix alternative of euthanasia and assisted suicide. [In June, the Senate committee issued a report rejecting the legalization of euthanasia and assisted suicide. — Ed.]

"The health care system, in its fixation with disease processes, has forgotten that its mandate is to alleviate suffering, and we need to recapture that vision," Mount says, adding that there is a cruel irony in our care of the dying. "Although these are the sickest people in our health care system, when medical technology doesn't know what to do, the quality and quantity of care falls away. How can we justify that?" ■