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LETTER TO THE EDITOR

Experience on palliative medicine clinical clerkships: Reflections of two sixth-year medical students

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Dear Editor,

We recently completed palliative medicine (PM) clinical clerkships, as established by the National Agency for Quality Assessment and Accreditation of Spain (ANECA) and the Association of American Medical Colleges (AAMC), for undergraduate medical education (UME) (ANECA, 2005; AAMC 2008), and we had the chance to experience the essence of this specialty. We had the opportunity and privilege of working with a domiciliary care unit (DCU) daily, which included a doctor and a nurse.

The first time we visited a home with the unit, the following occurred to us: (1) even though the patient and family were really comfortable and thankful for being able to stay at home, they perhaps had doubts about whether it would be more appropriate to be hospitalized, and (2) the DCU was working out of their usual comfort zone (a hospital or health care center).

Afterwards, we understood the following: (1) the patient and loved ones were grateful for being taken care of at home, and (2) the DCU turned the home into a safety zone, if necessary providing hospital resources or medications required during progression of the disease. Therefore, a connection that included intimate trust and respect was established between the patient and family and the DCU staff that is not usual (in our humble point of view) in other specialties.

During the clinical clerkship, we visited a patient's home (let's call the patient Mr. X for the sake of privacy), who had been suffering from a neoplasm with a bad prognosis since June of 2013. Mr. X was terminally ill and in the stage of decline. His relatives always greeted us cordially but with what seemed to be an uneasiness that goes along with expecting to have their worst fears confirmed. We were surprised by how naturally they handled the possibility of Mr. X passing away sometime in the near future. The doctor, who had superior communication skills, knew how to deal with the feelings of family members.

During one visit, Mr. X was in bed and appeared to be in very bad shape. His clinical profile suggested a systemic inflammatory response syndrome. We thought about how dramatic it would be if a patient (or, in the worst case, the family) asked for sedation in order to "stop the suffering." That measure was not requested on this occasion, but we often considered the issue, so that when we found ourselves in such a situation, as residents or as doctors, we would be able to defend our posture in spite of the pressures involved. We believe that being a good doctor must be based on, among other things, the capacity for sound judgment, self-criticism, and serious reflection about end-of-life care.

Certainly, Mr. X and his relatives were suffering. We asked ourselves several questions as this point: "So now, how should we proceed?" "Will they take him to the hospital?" "Would the prognosis or the therapeutic attitude change if complementary tests were made?" "What benefits would such tests provide?"

The doctor, with that characteristic good judgment that comes with experience, combined with solid scientific knowledge, medicated the patient via intravenous administration (due to loss of the oral therapy): corticosteroids, broad-spectrum antibiotics, and ondansetron.

We soon revisited Mr. X. He welcomed us sitting in his living room, surrounded by family. He was very communicative, and, of course, he didn't look like the person we had encountered two days earlier. He

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had overcome his fears and, for now, was living his days with the best possible quality of life, which is one of the main objectives of palliative medical treatment (WHO Expert Committee on Cancer Pain Relief and Active Supportive Care, 1990).

Foremost, among our concerns during our clinical PM clerkships was the need to respect and protect the rights of terminal patients (Benítez del Rosario, 2000; Benítez del Rosario & Asensio, 2002; Walsh, 2010). All members of the team (students, residents, and doctors) should be devoted to these rights, be they dedicated to PM or not, since terminal patients are not exclusive to the family practice or to domiciliary care.

To sum up, experiences like ours confirm the importance of including patients receiving palliative medicine in undergraduate medical education (ANECA, 2005; AAMC, 2008). This knowledge can be approached via family practice and oncology classes (Ferreira Padilla, 2012), but this kind of experience, which we believe every student must have, cannot be obtained in a book.

Finally, we acknowledge the DCU and Oncology Service at the Hospital Arnau de Vilanova in Valencia (Spain) for their willingness to cooperate, their humanity, and their professionalism.

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