

Caring, not curing

For Dr. John Swift, working with patients who have terminal illnesses isn't about the process of dying. It's about the affirmation of life.

"People don't need to die unsupported and alone," says Swift, the chief of palliative care and medical director of the Palliative Care Unit at the Parkwood Hospital in London, Ont. Instead, he and colleagues at the Parkwood and at the London Health Sciences Centre (LHSC), where he's a consultant, strive to ensure that patients who can't be cured receive care and compassion instead.

Swift, an associate professor of family medicine at the University of Western Ontario, also provides in-home palliative care and serves on the board of Hospice London. He is worried that medical advances and the resulting emphasis on acute care and curing mean that palliative care takes a back seat in terms of medicine's priorities.

The reality, says Swift, is that caring for dying patients doesn't attract the same level of enthusiasm among most health care professionals as caring for those who can be cured.

Swift's own passion for this type of work was sparked by his mother's struggles with multiple sclerosis, which began when Swift was a teenager. Over time "she was less and less able to care for herself ... yet quality of living remained so important to her."

Eventually left a quadriplegic, she would still light up when someone read poetry to her. Today, Swift's own face lights up when he talks about caring for dying patients.

Trained in family medicine in England, Swift later left his residency at Queen's University so that he could care for his mother. After her death, he completed his residency requirements and practised family medicine; he was on the faculty at Queen's until he left to start Hospice Kingston.

He bases his approach to palliative care on 3 things: knowledge, compassion and caring. Although he recognizes the need to remain current on developments in the palliative care field, Swift also makes compassion and caring priorities in meeting patients' needs. Without the pain and symptom management that are critical to his practice, says Swift, patients' quality of life will deteriorate.

"Our focus is on the whole person and the quality of life," Swift says of the palliative care team he works with. It in-

cludes nurses, occupational therapists, physiotherapists, social workers and chaplains; a pharmacist is also available. Volunteers, many of whom have had a family member in the Palliative Care Unit, round out the team.

To best meet patients' needs, Swift says roles often overlap. "I'll sometimes sit and pray with the patient. Sometimes, the chaplain will say, 'This patient is in pain.'"

Family members are always welcome. Swift tells of the tremendous pride and solace one woman took in spreading out and serving the Indian food her son brought her. "That is the type of thing that make it more than good physical care," he says.

Several nurses in the unit practise therapeutic touch, which Swift calls a "very useful adjunct for relaxation and pain relief." Although some physicians challenge him about its use and ask for evidence supporting it, Swift responds:

"The evidence is [before] my eyes."

In fact, Swift worries that medicine is losing its own sense of touch as it relies more and more on modern technology and also has to deal with concerns that the meaning behind a personal touch will be misconstrued. When little medical help can be provided to a dying patient, says Swift, physicians can still touch that person's hand or put a comforting arm around her shoulder.

Swift's work puts him in contact with people of diverse faiths and he finds this contact enlightening and rewarding. One of his patients died surrounded by her humming family — their way of praying for her and supporting her.

"To my Western ears, it was unusual," he recalls, "but you could see her relax. It was very moving. I think we're all spiritual beings, whatever our religious persuasion. Touching that spiritual side is so important."

Over time, Swift has seen patients recover and return home to families and careers after tests had indicated that they should not survive. And he has also witnessed treatments that couldn't cure patients but could destroy their quality of life.

"Medicine isn't just the physical," he says. "You have to take the emotional and social into account. I think we have to be careful that we don't make medicine God." — *Lynne Swanson*, London, Ont.



Dr. John Swift: touching the spiritual side

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