Short communication

The overwhelming contribution of women to the development and establishment of palliative care as a recognized medical specialty

Silbermann M*1, Baider L2, Saleem A3, Gafer N4, Tang L5, Fadhil AR6, Rassouli M7, Hassan A8, Fernandez-Ortega P9, Brant J10, Kebudi R11, Respini D12, Muckaden M.A13

1 Middle East Cancer Consortium (MECC), Israel
2 Assuta Medical Center, Tel Aviv, Israel
3 National Center for Cancer Care & Research, Doha, Qatar
4 Radiation and Isotope Centre, Khartoum, Sudan
5 Children’s Welfare Teaching Hospital, Baghdad, Iraq
6 Shahid Beheshti University of Medical Sciences, Teheran, Iran
7 Weill Cornell College of Medicine, Doha, Qatar
8 Catalan Institute of Oncology, Barcelona, Spain
9 Billings Clinic Inpatient Cancer Care, Billings, MT, USA
10 Istanbul University Oncology Institute, Istanbul, Turkey
11 Associazione Mareluce Onlus, Siracusa, Sicily
12 TATA Memorial Centre, Mumbai, India

*Corresponding author: Michael Silbermann, Middle East Cancer Consortium (MECC), Israel, E-mail: cancer@mecc-research.com

Received: July 12, 2018; Accepted: July 26, 2018; Published: July 30, 2018

Introduction

The first homes that were specifically assigned for institutional care for the dying were initiated in the nineteenth century by religiously and philanthropically inspired women. Because this work was an essential precursor of hospice development in the twentieth century, their place in palliative and hospice history is assured. It served as a massive inspiration to Cicely Saunders’ pioneering work in the 1950s and 1960s. The focus of endeavor in most of these homes was on saving lost souls from sin, on caring for the ‘deserving poor’ and on reaching into deprived communities to offer the glimpse of a better life beyond poverty. While attending physicians offered help, support and guidance with the management of distressing symptoms, daily care was traditionally the concern of female nurses, many of whom were in religious orders.

The short review presents a brief salute to these women, who were principal founders of a movement that gained rapid momentum after their death: Jeanne Garnier, who formed L’Association des Dames du Calvaire in Lyon, France, in 1842 is the earliest founder so far identified.

Mary Aikenhead of the Irish Sisters of Charity opened St. Vincent’s Hospital, Dublin, in 1834. Her activities extended to England, where the Sisters developed St. Joseph’s Hospice, in the East End of London. This hospice gained an essential place in the narrative of modern palliative care history. Frances Davidson founded the first home for the dying in Britain in 1885.

A Catholic woman, Rose Hawthorne established premises in New York’s Lower East Side, where she opened what was purportedly the first home in America for the free care of “incurable and impoverished victims of cancer.” Under the title Mother Alphonsa, Hawthorne formed the Dominican Sisters of Hawthorne, and like her contemporaries, she was part of the increasingly common tendency for middle-class women to engage with charitable work among the poor, sick and disadvantaged. Florence Nightingale promoted in the USA what is known today as palliative care [1].

All these distinguished women shared a common purpose in their concern for the care of the dying, and in particular, the dying poor, thereby creating some preconditions for future developments in modern hospice and palliative care which got underway in the decades after World War II [1]. The early hospices and homes associated themselves with three main concerns: religious, philanthropic and moral.

The originator of the contemporary practice of palli-
Dr. Samaher Razzaq Fadhil of Iraq offers ongoing challenges and discrimination. Societies shared their opinions as to how they cope with these shared insights into how women combat social, economic, or professional disadvantages. Essential, they are forced to become strong and independent and learn how to convert their disadvantages into advantages by thinking out of the box: By looking “at the other side” of the discriminatory situation, they find clever ways to manipulate circumstances to their benefit. For example, if a man with inferior qualifications is appointed to a senior position over a better qualified woman, the latter—unburdened with bureaucratic tasks—will use the extra time at her disposal to pursue her career goals. “They have to work harder and learn skills to overcome these obstacles,” says Dr. Gafer.

Discussion

The hard work of hospice and palliative medicine: A glimpse at a few pioneer women

More flexibility is required in these difficult areas. Palliative medicine is an exceptionally hard discipline. Medicine has worn down resilience [3]. Consequently, dedicated strategies are needed to overcome the challenges facing women in clinical medicine and global health professions. Their advancement requires empowerment of women in leadership positions and the establishment of support systems on local, regional, and global levels. In this review, 12 prominent professional women from different societies shared their opinions as to how they cope with ongoing challenges and discrimination:

Dr. Samaher Razzaq Fadhil of Iraq offers a personal viewpoint that hard work and academic degrees are the means to assist women's professional progress in the complicated mosaic that characterizes today's Iraq. Conversely, Dr. Nahla Gafer of Sudan offers some intriguingly original insights into how women combat social, economic, or professional disadvantages. Essentially, they are forced to become strong and independent and learn how to convert their disadvantages into advantages by thinking out of the box: By looking “at the other side” of the discriminatory situation, they find clever ways to manipulate circumstances to their benefit. For example, if a man with inferior qualifications is appointed to a senior position over a better qualified woman, the latter—unburdened with bureaucratic tasks—will use the extra time at her disposal to pursue her career goals. “They have to work harder and learn skills to overcome these obstacles,” says Dr. Gafer.

Specialization in various fields can benefit women professionally. Drs. Azza Adel Hassan and Azar Naveen Saleem of Qatar report that globally 78 percent of the healthcare workforce consists of women, with higher percentages predicted for the future. Their experience is in the realm of palliative care medicine where women predominate. She indicates that women provide a superior level of empathy and better care than men in aiding hospice patients suffering from severe physical and psychological stress. Moreover, female hospice patients prefer to have female staff care for them. Hassan concludes that women have an innate advantage over men in this specialty: “Women are better than men at taking other people's perspectives, feeling their pain and experiencing compassion for them.”

Similarly, Prof. Maryam Rassouli of Iran highlights the prominence of women healthcare professionals in the fields of gynecology and midwifery. Interestingly, Iranian governmental policy of limiting these areas of medicine to women has promoted the advancement of highly qualified women within the field. Moreover, Prof. Rassouli feels that the significant 60 percent admission rate of women to Iranian universities in the last three years “can play a significant role in changing men's attitude towards women, their socialization, and the quantity and quality of their presence in society.” She suggests that promoting public discussion of "women's role in society and social management," and sociological analysis or "studying the influential factors" for women's success can identify and overcome socio-cultural challenges.

Prof. Lea Baidor of Israel offers pragmatic suggestions that focus primarily on empowerment through education. Stressing the necessity of community acceptance, Baidor advocates enhancing the motivation of unskilled women who need psychological boosting by training “women leaders within their society or/and community,” while respecting traditional systems of belief.
and values. She emphasizes that women in developing societies need basic training such as “electrical skills, computer, mechanics,” could join advanced healthcare occupations such as medicine, nursing, dietetics and physiotherapy. Moreover, successful professional women should serve as models in the preventive healthcare and health education fields and also act as “front line advocates” for promoting female health and wellbeing. National and international seminars and workshops must be developed for different educational levels to impart acquisition of new practical skills.

Prof Lily Tang of Beijing, China, criticizes “unjustified inequalities in the workplace,” and notes that women in China face more challenges and have fewer opportunities than men, since they still bear most of the burden of childcare and eldercare. Lack of daycare for children under three and earlier retirement typify the problems they face. Judiciary reforms are therefore needed to promote equal status. Prof. Tang not only advocates “practical and psychological support” systems for Chinese women on the community level and in the workplace, but a policy of affirmative action to redress gender discrimination.

Prof. Paz Fernandez-Ortega, from Barcelona, Spain, argues that “Life is a changing pattern for a woman practitioner in health science today, inherent to a career that implies caring for others. For a long time the prevalent view was that doctors and nurses should have total control over their feelings or suppress them, hiding their emotions. This contradictory behavior implies a conflict between one’s logic and emotions, but for human beings managing both was always a perennial conflict. In our Mediterranean context, the struggle has historically been linked to cultural, family and social values.”

“What does it mean today to take care of others without mixing emotions and logic? Certainly this is a concept that is different for women than for men, not only in those activities related to health, but also in everyday life.”

On one hand, women are more sensitive to emotions, so their patient care involves both an “emotional interchange and a readiness to meet their spiritual needs. Part of end-of-life care is the ability to recognize and respond to both physical and emotional needs of patients. Because the educational and health systems do not include these factors in their priorities, doctors and nurses have many conflicts when they have to face these issues in clinical care.”

“A combination of a logical mind and of emotional management skills is crucial for facing the challenges of real life. Most end-of-life patients realize the relativity of some issues, and the importance of others. Do not be afraid to use your feelings to take care of patients in a more creative way, and to innovate in your team-work discussions and care plans!”

Dr. Jeannine Brant from Montana, USA, commented on balancing career and family: Balancing a career and family has been a significant challenge for me during my 35 years of nursing and my 27 years of being a parent. It helped to have my career somewhat established before I had kids. The balance has been compounded by my passion for cancer and palliative care and my desire to make a significant contribution.”

“But there was always this teeter-totter effect. While I was at work, I desired to be home with my kids, and I felt incredible guilt because I had also chosen to have a career. However, I made some very good decisions early on that allowed me to sustain and excel in both the career and family world. All along, the entire family contributed to the overall functioning and success that we had.”

For my 50th birthday, I gathered 10 of my closest friends and showed them some of my work. I remember crying during the presentation, because I did not think they realized my passion and the work I do. I also still had some of that left-over guilt. It was a time of healing for me, as some of their words to me were, “Your kids turned out amazing! Many of our kids are struggling, and yours have stayed the course.” So, while the balance was often difficult and exhausting, the reward has been great, and I am truly blessed to live in both worlds.

Prof. Rejin Kebudi from Istanbul, Turkey strongly endorsed Dr. Brant’s views concerning the balance between professional career and family life. Already in high school Prof. Kebudi realized her inner desire towards a career whereby she could develop relationships while supporting people. Following her specialization in Pediatric Oncology, she understood the importance of palliative care throughout the trajectory of the malignant disease. “As a wife and mother of two children, I had to balance my academic life and family life.” This year Prof. Kebudi was awarded by the American Society of Clinical Oncology (ASCO) the 2018 International Women Who Conquer Cancer (WWCC) prize, and in the award ceremony she thanked all her mentees, most of who were women. Her motto has been: “Females can combine an academic medical career while raising a family, only if they are well-educated, self-confident, well programmed and work very hard.” She continues: “In Turkey, we women are fortunate to dominate Pediatrics and Pediatric Oncology”.

As far as the interrelationship: Palliative care - Women, Dr. Daniela Respini, a psycho-oncologist from Sicily stated: “Dealing with terminal patients often raises the question: What is the meaning of life if you have to die? It also makes you see life differently. On such occasions you feel that there is something that goes beyond human being, something very strong and intense that accompanies you every moment and gives you inner strength. Dr. Respini continues: “Staying next to the patient and his suffering pushes you to review your own life, makes you deal with your conflicts and makes you think that death is not just an idea but is part of your life.”
Dr. Respini added: “Probably my passion for psycho-onco-
logy has been facilitated by my being a woman, as in my
daily work I use my maternal protection.” Moreover,
“Being a woman has given me an extra step in establish-
ing an empathic relationship with the patient, as time has a
different meaning, and for me it is an honor to enter the
soul of a patient and read his/her emotions.”

Professor Mary Ann Mukaden from Mumbai, India
believes that “Palliative care looks at holistic care of
mind-body and spirit; and as a part of close families, espe-
cially in Asia, where I come from that is what women do as
part of their daily lives. Would that equip us to be good
palliative care physicians, nurses and carers from other
para-clinical branches to take care of families undergoing
multi-dimension suffering? Yes, yes, yes.” Professor
Mukaden continues: "Teamwork begins in a family at a
very young age to give our best to help others in the family.
As a woman, I believe the pivot is the mother; and it is no
wonder that there are more women than men in the field of
palliative care”.

"As a radiation oncologist I could very easily empa-
thize with a feelings of a patient and family, but when there
is no more treatment to be offered, they would need to go
away devastated. That was when I switched my career to
become a palliative care physician. As a multi-specialty
team, we are able to do so much in the hospital and at home
to help patients and families cope with their grave situa-
tion".

"We are as competent as men in education and research,
and we are in the process of integration into mainstream
medicine – all kudos to women!"

"Economically also, more women stay at home to take
care of their family. When children are grown, they make
the best volunteers and counsellors for the palliative care
team. “Time and money is often of no consequence on the
job”. And she concludes: "Personaly, as a woman, pallia-
tive care has given me an opportunity to grow tremendous-
ly as an individual, both as a person and a family caregiver.
Our patients and families teach us resilience, and we have much to learn from them, to emulate
even in our personal lives. I salute our patients and their
caregivers who have made me what I am; a strong and
dedicated female palliative care physician".

After taking these varied views into account, we
believe that advocating for women's professional develop-
ment on the micro or community level, whether clinical or
scientific, will in turn contribute to broader and beneficial
changes worldwide.

Hospice and palliative care female nurses feel that it
is a privilege to spend time with the dying, to be allowed
into a person’s and a family’s life when they are at their
most vulnerable, and when they most need help. Some
nurses believe that easing patients into death makes them
the closest you can get on earth to the presence of God,
while Elisabeth Kübler-Ross’s book “On Death and
Dying” brought to public attention the idea of a “good
death.” Moreover, women are more adept at figuring out
conflicts and rivalries between family members, their
unresolved feelings of bitterness, grief and anxiety about
how to take care of the patient and what to do. Females for
the most part understand better the importance of touch-
ing the patient [4].

As societies age, and governments attempt to manage
their constrained health budgets by shifting more care into
community settings, women will be called upon to
provide more palliative care at old age.5 Women world-
wide will have to shoulder a significantly heavier caregiv-
ing burden as a direct result of their governments’
Attempts to move palliative care into the community. How
will this disproportionately affect women? [5].

The current situation indicates a significant gender
inequality at the heart of palliative care. Literature
indicates that the duty of provision of care falls consider-
ably more on women than men. Differences in the
construction of gender across countries and cultures have
reinforced the power of normative ideals of gender on
how people conduct themselves and explain their actions
and behavior. All studies show that women were more
likely to be carers than men.

Further research should take into account that gender
is a malleable product of particular sociocultural contexts
and influenced heavily by the distribution of power within
societies. Other identity-shaping factors, such as age,
ethnicity and class can modify normative conceptions of
gender [5].

This review shows how women mainly shoulder
caregiving responsibilities. Further, it outlines the impor-
tance of health professionals developing gender-sensitive
strategies. For that reason, there is a need for more gender
analysis in palliative care literature.

Palliative care, although extremely important to the
care of sick patients, and which has for decades struggled
for recognition as a medical specialty, gained an addition-
al great supporter in Barbara Bush. Bush possessed cour-
age, vision, charisma and humanity. She told the world
she was opting for “comfort care,” or relief of suffering,
which in many places, and for many physicians, is not
considered medical therapy. Bush’s aim was not to
prevent her death, but to enable her to live her life fully
until death arrived. Like her great female predecessors,
Bush’s decision, revelation and acts strengthened the
notion that palliative care should be available on demand
for the millions who struggle without it. With that, Bush
joined the Hall of Fame of palliative care’s most distin-
guished persons, by offering hope of relief from anguish
to suffering patients [2].

Medical careers are hard on women. Gifted physi-
cians are forced to choose between family and career,
because the system is not designed to accommodate both.
The system is damaging for both genders, and exists in part because the current family structure is built on one parent spending more time at home, to enable excessive work hours and expectations for their partner.

**Summary**

Hospice and palliative medicine seem much more balanced than oncology. Thus, women in palliative care have a better shot at changing the culture, because the specialty is new. Women have a unique opportunity to negotiate and define these roles as they become part of the fabric of healthcare. Women here may be a beacon of hope that can become a model for other outdated specialities [3].

Young women such as Lucy Watts (14 years old) from the UK and Huyaam Samuels (19 years old) from South Africa have tirelessly advocated for hospice and palliative care for all who need it. Both owe their lives, quality of life and success to the support of palliative care. Huyaam, who is also a founding member of Palliative Care Voices, declares: “Through Palliative Care Voices, we aim to address needless suffering by empowering ourselves to raise our own voices to demand quality palliative care for all.” And, “as a palliative care recipient, I know from experience the struggle of the failure to recognize the importance of palliative care myself in my country. It took years for a doctor to believe how much pain I was in daily, how I needed my lifestyle adapted, and most importantly that I needed palliative care” [6].

**Conflicts of Interest**

The authors state no conflict of interest.

**References**

5. WHPCA. On world health day meet the young women demanding equality healthcare for everyone, everywhere.