Advances in palliative care relevant to the wider delivery of healthcare

Phillip D Good

ABSTRACT

- The availability of a variety of opioids, together with the discovery of new uses for old drugs (such as ketamine), assists individualised pain management in palliative care.
- Experience in palliative care provides reassurance that the effective use of opioids and sedatives does not accelerate the approach of death.
- In taking patient histories, recognising the spiritual component of life experience enlarges the focus of care.
- Interdisciplinary care brings many different insights to care situations in a prospective and cooperative way.
- Models of bereavement care established in palliative care units deserve wider implementation in medicine.
- An "experiential" model of medical student education encourages a focus on the whole experience of patients and their journey with their carers.

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PALLIATIVE CARE PRACTICE emphasises the holistic approach to patient care, embracing the individual's physical, psychological, spiritual and social needs. Over the past decade, developments have been made in all these areas to enhance and support the care of patients and their families.

Individualised pain relief

The increasing range of opioids available has meant that patients have a better chance of satisfactory pain relief without experiencing side effects such as drowsiness, delirium, nausea or vomiting. Opioid rotation recognises that the individual response to different opioids varies and that a change to an alternative drug may yield a better balance between analgesia and side effects. The reasons why individuals respond differently to opioids are unclear, but proposed mechanisms include differences in opioid receptor profiles, opioid receptor subtype binding, and genetically determined drug metabolism, as well as the mechanism of pain influencing opioid receptor affinity.[1,2]

Choice of different routes of administration enables the patient to receive the best medication with the least discomfort. The availability of continuous subcutaneous administration and slow-release oral morphine was a big advance, and more recent innovations have included the transdermal or buccal administration of fentanyl and the intranasal administration of sufentanil (particularly useful for incident pain).[3] All areas of medicine and pharmacy can benefit from looking outside the traditional approaches to drug administration.

Ketamine is a good example of a drug that has been used in anaesthetic medicine for a long time but has undergone a resurgence in use in palliative care for treating refractory cancer pain. A recent trial has shown its benefit in treating many different types of pain, including somatic (eg, incident pain and mucositis), neuropathic and possibly visceral pain.[4] Use over a short term (3–5 days) can have a long-lasting effect on pain control (up to 8 weeks in one instance) and may overcome some practical difficulties of access and cost.

Use of medication at the end of life

Most palliative care physicians are comfortable with the routine giving of opioids (for pain) and sedation (for terminal delirium) as well as the less common administration of sedation for "refractory symptoms". The most common symptoms that are refractory to standard palliative treatments are delirium, breathlessness and, less often, pain.[5] Traditionally, there has been a fear in the medical fraternity that opioids and sedatives hasten a patient's dying phase. This has meant some patients have been left to die an uncomfortable death. However, recent research suggests that using these medications does not influence length of life and that their use should be encouraged in the terminal phase.[5]

Medical practitioners should not be afraid to use medications to relieve suffering if they are initiated in response to a specific symptom or sign and are titrated in response to the symptom or sign. This is appropriate and compassionate treatment for patients at the end of life. Consultation with specialist palliative-care medical or nursing staff may give medical practitioners greater knowledge and confidence, particularly when dealing with unfamiliar doses of medication. However, increasing doses of opioids and sedatives with the aim of deliberately hastening death is not part of palliative care practice.

There is a community perception that morphine treatment is the "last resort". Experience in palliative care shows this is far from the truth. Patients can function well on opioids for long periods of time.[6] This fact needs to be communicated to all areas of medicine to allay the fear that symptom control will compromise length of life — a particularly relevant message for palliative care practitioners as they become more involved in symptom control for non-malignant diseases.

Spirituality

Spirituality is a dynamic, personal and experiential process whose features include a quest for meaning and purpose, transcendence (a sense that there is someone or something

Department of Palliative Care, Newcastle Mater Misericordiae Hospital, Newcastle, NSW.

Phillip D Good, MB BS, FRACP, Palliative Care Physician.

Reprints will not be available from the author. Correspondence: Dr Phillip D Good, Department of Palliative Care, Newcastle Mater Misericordiae Hospital, Locked Bag 7, Regional Mail Centre, Newcastle, NSW 2310. Phillip.Good@mater.health.nsw.gov.au

"HOPE" questions for spiritual assessment[9]

H: *Sources of hope, meaning, comfort, strength, peace, love and connection:*

- What are your sources of strength?
- What sustains you and keeps you going?

O: *The role of organised religion:*

- Are you part of a religious or spiritual community?

P: *Personal spirituality and practices:*

- Do you have personal spiritual beliefs?
- What aspects of your spirituality or spiritual practices do you find most helpful?

E: *Effects on medical care and end-of-life decisions:*

- How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months?
- Would it be helpful for you to speak to a pastoral care worker?

greater than ourselves), connectedness (with a transcendent power) and values (eg, love, compassion and justice).[7] Spirituality plays an important part in people's lives, and many patients, especially when very ill, would like to talk to their doctors about some of these issues.[8] Exploration of the area of spirituality can be therapeutic in itself, but it does not easily lend itself to the history/examination/therapeutic approach taken in mainstream medicine. This may be one of the reasons why doctors can be uncomfortable entering this area. There are, however, guides available for clinicians to assist in making spiritual assessment part of history-taking (Box).[9] Talking to patients about their spirituality can help doctors learn about the most important goals patients have, especially as death approaches.

Interdisciplinary care

Interdisciplinary care is based on the concept of interdependence and the belief that the whole is greater than the sum of the parts. Clinicians from a range of relevant disciplines meet prospectively as a group with equal membership to discuss the issues of care planning and agree on care strategies. A core feature of palliative care is the individualising of care and therapy for each patient, whether the issue be drug choice, route of administration or place of care. To facilitate this individualised care, roles within a team may be somewhat fluid and boundaries between disciplines blurred, as the overall goal is the best possible care for the patient. Teams may comprise purely medical personnel or a mix of disciplines; contributions may be sought from psychiatrists, anaesthetists, oncologists, nurses, allied health staff and volunteers, bringing together a mix of different backgrounds to provide a broad view of patient care.

Bridging the divide

Palliative care is delivered in various environments, including hospitals, hospices and the home. Sometimes, hospital care can seem to be given in isolation of both medical and non-medical community care. As a result, a patient's general practitioner may not be informed of a diagnosis, such as cancer, until the time of discharge. An important emphasis of all those who work in palliative care, both GPs and specialists, is good communication, ensuring that they keep each other informed of a patient's progress. Junior doctors, who are often delegated this vital job, must be educated about its importance and the need to carry it out in a timely manner. Modern technologies, such as electronic summaries and email distribution, are simplifying information sharing, and communication will continue to improve as such means are adopted more widely.

Bereavement

The morbidity of bereavement as a major healthcare cost is now recognised. Although death occurs in all areas of medicine and in all hospitals, it is only in the field of palliative care that there are bereavement programs to provide care for families of deceased patients and to assess those at risk of difficult bereavement. The challenge for the general hospital community is to introduce bereavement care into the mainstream care of dying patients. The experience of palliative care services shows the value of a family-focused approach, beginning the "bereavement journey" when the patient is admitted to a palliative care service.[10]

Education and training for medical and other health disciplines

Teaching of medical and other students is often undertaken using a "learned" model of experience, in which the students learn from their interactions with teachers, doctors and patients. In contrast, an "experiential" model (such as that used at the University of Newcastle) attaches a student to a palliative care patient and the family carers, to journey with them over a period of three months. Often, during this period, the patient dies and family members start their bereavement process. This gives students a different understanding of illness and allows them to experience at close hand the social implications of disease and dying. The hope is that this will help them to adopt a more understanding and empathetic approach to all areas of care in their future medical practice.

Conclusion

Palliative care offers a number of unique contributions to the advancement of care at the end of life. Perhaps its most valuable contribution is in providing a model of care that addresses the physical, psychological, spiritual and social needs of all patients. This holistic approach deserves wider implementation in other fields of medicine.

Competing interests

None identified.

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Complementary medicine: is it more acceptable in palliative care practice?

Allan Kellehear

ABSTRACT

- Some complementary health modalities have found a well-accepted place in palliative care.
- The interdisciplinary nature of palliative care underlies the common acceptance of complementary therapies in this field of care.
- The experience of the interdisciplinary approach in palliative care may presage current changes in attitude towards complementary therapies in other areas of medicine.
- Growing collegiality and interdisciplinary teamwork in healthcare is encouraging the medical profession to see beyond scientific reservations and view complementary modalities as providing supportive roles.

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PALLIATIVE CARE makes a full-time occupation of the art of caring. For people whose disease is incurable but for whom health and hope remain important goals in life, palliative care meets the interdisciplinary challenge of care in the very shadow of death. It combines the best symptom management practices that scientific medicine can offer with a multidisciplinary approach to caring. It recruits the traditions of bedside medicine, counselling, pastoral care and community volunteer work, as well as social supports and public health services.

In these styles of care, the palliative approach goes a step or two further than many other branches of medical care. Palliative care has a working relationship with what has been variously called "alternative", "complementary" or "traditional" healthcare. How has this situation arisen in a broader culture of medical scepticism and resistance to complementary therapies, and are there lessons to be learnt regarding practice and attitude in the wider medical world?

Palliative care: the interdisciplinary imperative

Palliative care, having its formal origins in religious history, has had a pastoral and social dimension from its earliest inception. Modern palliative care services have continued this tradition, first through the pioneering work of Cecily Saunders in the United Kingdom[1] and later in the World Health Organization's philosophy of "whole-person care" and the acceptance of the natural inevitability of death and dying.[1] Whole-person care has been central to the mission and philosophy of palliative care. To assist a person to "die as they have lived" is to commit to a service approach that reflects the social, spiritual and psychological complexity of a life lived in community. The final physical illness is only one part — perhaps the health-related prompt to reorganising other aspects of a person's community life and identity at the end of life.

In this multidisciplinary context, medicine has become a vital but equal player among other acknowledged contributors to quality of life at the end of life. Effective physical

Palliative Care Unit, Faculty of Health Sciences, La Trobe University, Melbourne, VIC.

Allan Kellehear, PhD, Director, and Professor of Palliative Care.
Reprints will not be available from the author. Correspondence: Professor Allan Kellehear, Palliative Care Unit, Faculty of Health Sciences, La Trobe University, 215 Franklin Street, Melbourne, VIC 3000.
a.kellehear@latrobe.edu.au