Palliative medicine: medical and psychological aspects

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Abstract

Palliative medicine is a speciality aimed at controlling symptoms for patients with life-limiting illnesses. Palliative medicine is not just for people who are dying; rather it is a component of care for patients with a life-limiting illness. It manages symptoms in a holistic manner addressing a patient's physical, psychological, social and spiritual needs. This article gives an overview of the principles of palliative medicine and guidance on management of frequently seen symptoms, emergencies and end of life care.

Keywords End-of-life care; Palliative medicine; Symptom control

Introduction

The Royal College of Physicians recognized palliative medicine as a speciality in 1987. It evolved from the hospice movement and a desire to improve symptom control for patients with cancer, but it is now offered to all patients with a life-limiting illnesses.

World Health Organization definition of palliative care

Palliative care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain, and other problems, whether physical, psychosocial or spiritual. Palliative care respects the choice of patients, and helps their families to deal with practical issues, including coping with loss and grief throughout the illness and in case of bereavement.[1]

Palliative care

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten or postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Offers a support system to help the family cope during the patient's illness and in their own bereavement.

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Triggers to refer a patient to palliative care services

- At the time of diagnosis of a life-limiting illness
- Patient likely to die within the next 12 months
- Difficult to control physical or psychological symptoms
- Need or desire to plan future healthcare
- Complex care needs
- Frequent unscheduled admissions to hospital
- Patient request

Box 1

- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
- Will enhance quality of life, and may also positively influence the course of illness.
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
- Benefits healthcare systems by reducing unnecessary admissions to hospital and use of healthcare services.

Palliative care is now offered to patients from the moment of diagnosis of a life-limiting illness. It is estimated that 80% of patients could benefit from palliative care input earlier in their illness.[2] A randomized control trial showed that cancer patients who were offered palliative care alongside standard therapy not only had better quality of life, but also lived longer.[3] The triggers to refer a patient to palliative care are shown in Box 1. A basic model of how palliative care is integrated into standard care is shown in Figure 1.

Every patient and each of their symptoms should be approached using the four domains of palliative care (Figure 2).

For example if a patient has shortness of breath:

- Physical: pleural effusion, hypoxia, bronchial obstruction?
- Psychological: fear of suffocating to death?
- Spiritual: why is this happening to me?
- Social: loss of work and income and difficulty with personal care?

In order to manage different symptoms a multidisciplinary team (MDT) approach is taken which includes:

- doctors:
  - surgeons
  - oncologists
  - palliative medicine physicians
  - GPs
- specialist nurses and district nurses
- physiotherapists
- occupational therapists
- social workers
- counsellors (for patients and families).

Palliative medicine is no longer confined to a hospice. It is also delivered in the hospital and community setting. Within the community it usually delivered in a patient's home or in nursing homes, which is where they spend the majority of their last year of life.

Palliative care promotes a patient-focused approach to care. Helpful questions to ask patients are shown in Box 2.

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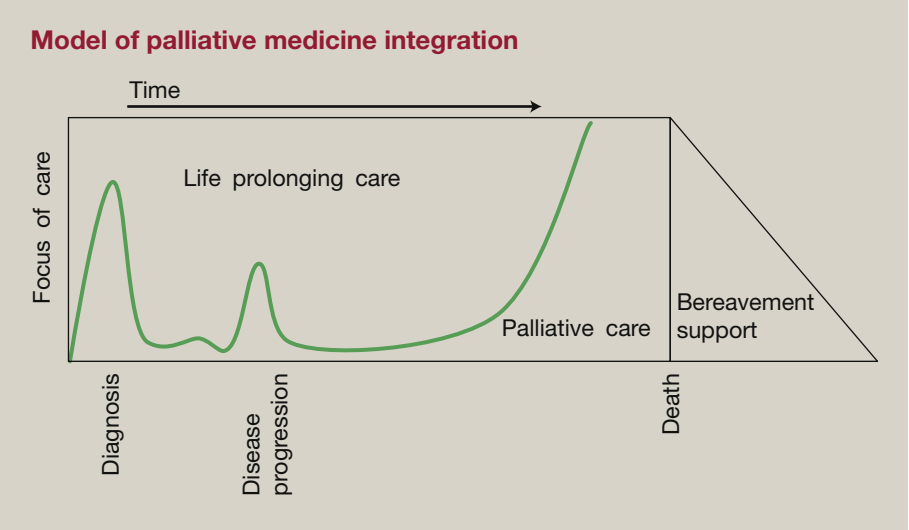

Figure 1

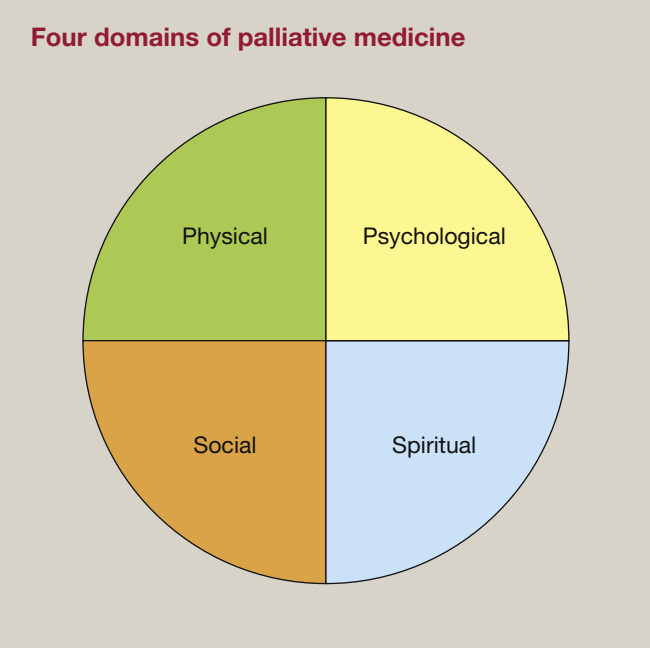

Figure 2

Physical symptoms

Pain

This is a common symptom but it is not experienced by every patient.[4] As discussed above, it should be managed considering the four domains of contributory/causative factors. We can then break down the management into pharmacological and non-pharmacological.

Pharmacological management of pain should be carried out based on the World Health Organization pain ladder;[5] however, the evidence for its use in cancer-related pain is poor.[6] In choosing drugs to manage pain it is important to consider the physical cause of the pain. For nociceptive or 'normal' pain (caused by tissue injury), the ladder can be followed step-by-step relying mostly on the non-opioid and opioid analgesics. Non-opioid analgesics include paracetamol, NSAIDs and nitrous oxide (entonox). However, for neuropathic pain (pain caused by damage to nerves by compression or injury) adjuvant analgesics such as tricyclic antidepressants or anti-epileptics should be considered. For pain caused by bony metastases, a bisphosphonate should be considered as an adjuvant.

It is important to appreciate the equivalent strengths of opioids when prescribing. The potency of commonly prescribed 'weak' opioids may have their strength underestimated, leading to side effects in opioid naive patients. Relative potencies of some common analgesics are given in Table 1.

Helpful questions for patient-focused care

- What would you like to know about your disease?
- What are your main concerns?
- What is the hardest thing for you at the moment?
- What are your priorities?
- What are your sources of strength?
- How can we help make today a 'good' day?

Box 2

Common analgesics

Opioid	Oral morphine equivalent
Co-codamol 30/500 2 QDS	24 mg
Tramadol 100 mg QDS	50–80 mg
Oxycodone 15 mg	30 mg

Table 1

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