Palliative Care

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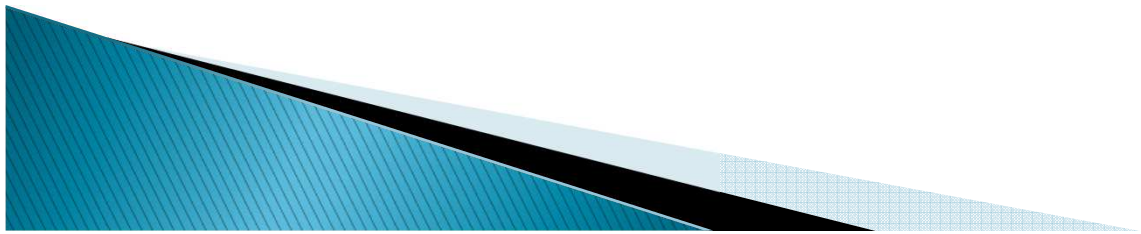
mf211
Ext 1870

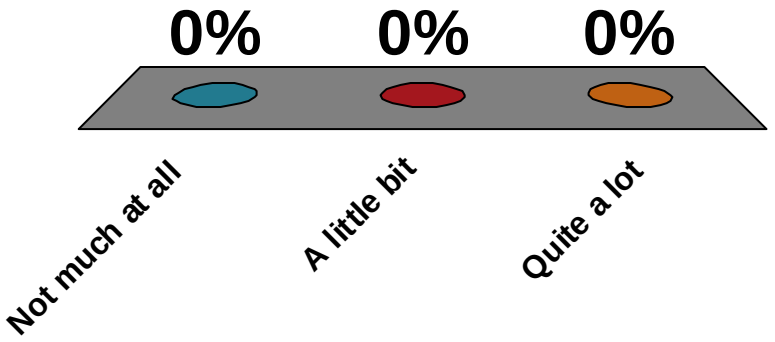
Learning Outcomes

- To demonstrate an awareness of the role of Palliative Care
- To identify the range of symptoms experienced by Palliative Patients
- To demonstrate an understanding of Advance Care Planning
- To practise skills in clinical reasoning



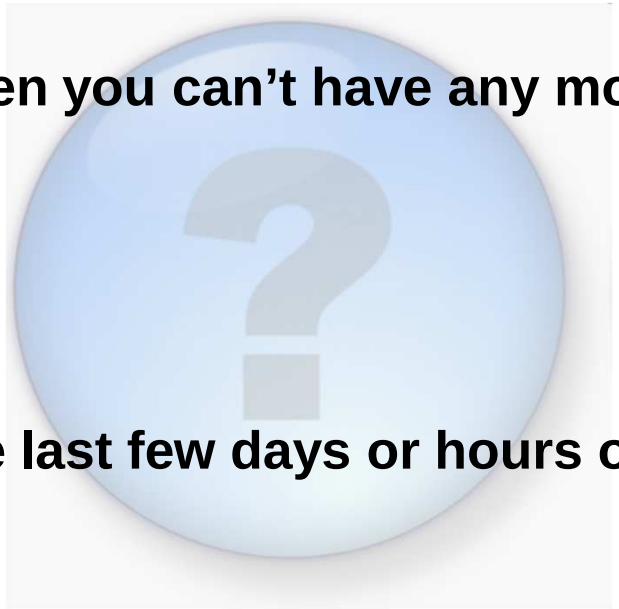
What do I know about Palliative Care?

1. Not much at all
2. A little bit
3. Quite a lot



It’s only looking after people with cancer, isn’t it?

It’s what happens when you can’t have any more treatment



Is it only palliative in the last few days or hours of life?

You need to be in a hospice, don’t you?

It’s only palliative when you need morphine or a syringe driver

- Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness.....

- ..... through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual

World Health Organisation

What are our aims?

- Relief of physical symptoms
- Relief of psychological / spiritual distress
- Enhance quality of life
- Support families / carers

Multidisciplinary team

- Specialist nurses
- Occupational therapists
- Dieticians
- Doctors
- Physiotherapists
- Counsellors
- Chaplain

- Good links with the community

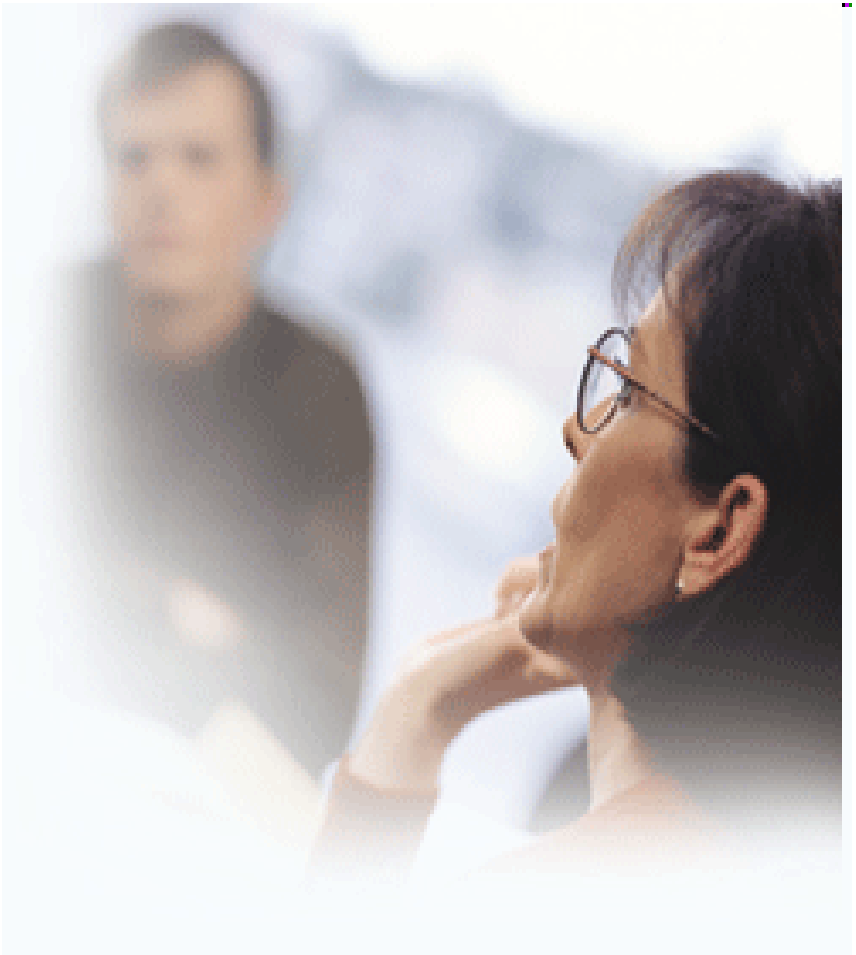
Physical Symptoms

- Pain
- Dyspnoea
- Nausea / vomiting
- Anorexia / weight loss
- Constipation
- Fatigue
- Cough etc, etc……

- Medical / surgical emergencies

Psycho-spiritual distress

- Exacerbates physical symptoms
- Multifactorial
- Remember to consider:
  - Uncontrolled physical symptoms
  - Alcohol / drug withdrawal
  - Depression
  - Other medical causes e.g. hyperthyroidism

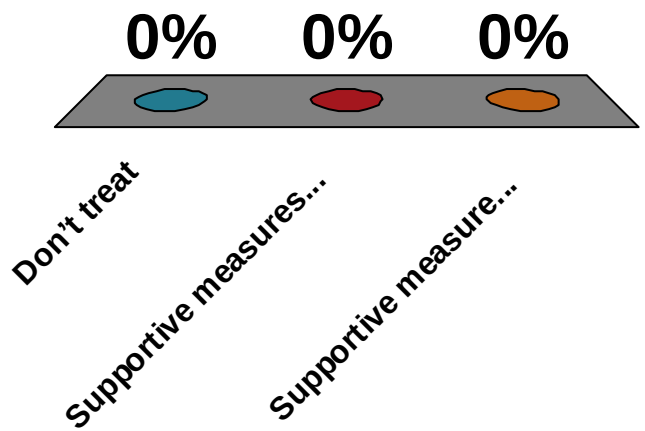


- John Smith- 65 yrs old
- Lung carcinoma- bony spread
- Shortness of breath / chest pain / cough
- RR 28 HR 110 BP 108/60 Temp 38.6^{o}C
- Dehydrated
- PMHx- Chronic chest problems / angina / hypertension

- Disease inoperable at diagnosis
- Symptoms worsening for 5 days
- 3 chest infections this year
- Doesn't want to be in hospital
- Family- wife, son, 3 grandchildren
- You suspect another chest infection. Sputum shows MRSA

What will you do now?

1. Don't treat
2. Supportive measures (e.g. fluids/ analgesia) only
3. Supportive measures and antibiotics



Justify your reasoning.....

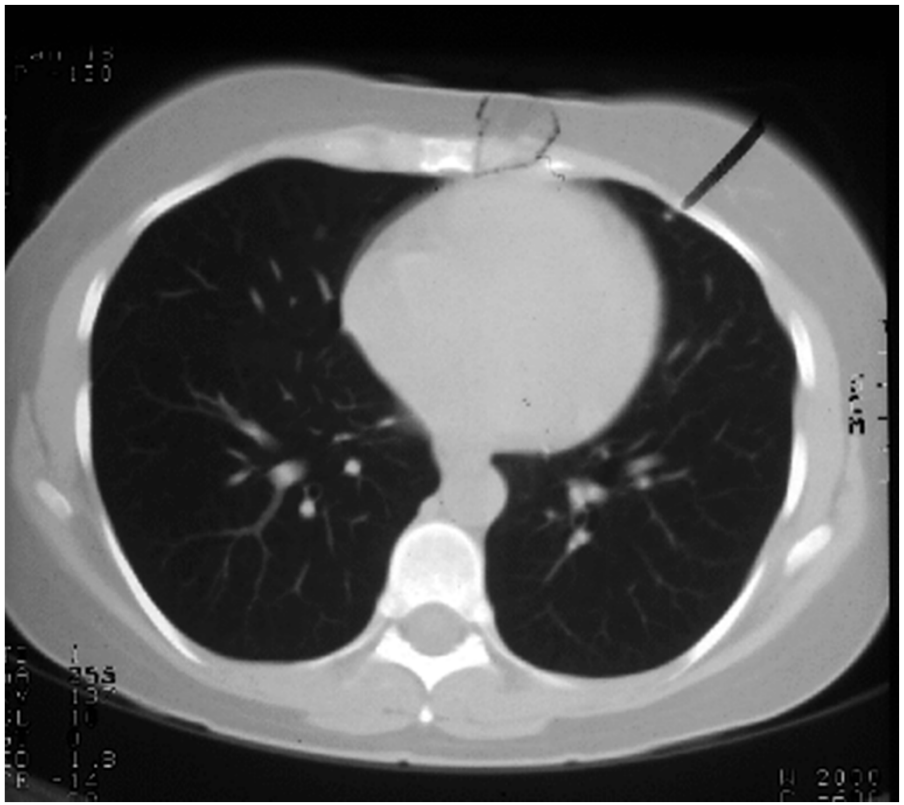
Why wouldn’t I treat him?

That’s a stupid question - I’m a doctor – ‘do no harm’

Not sure – will he get more infections even if I treat this one?

Ask him what he wants and go with that

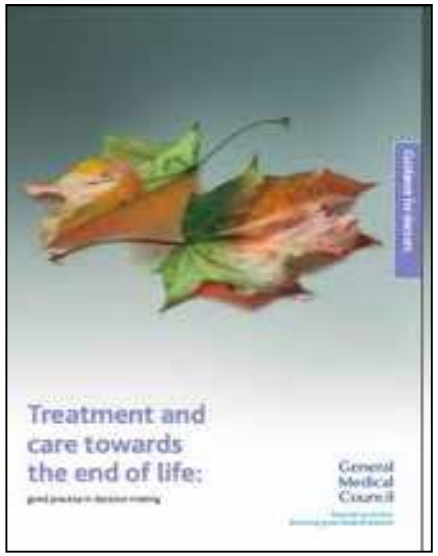
Where do I start with this one!?

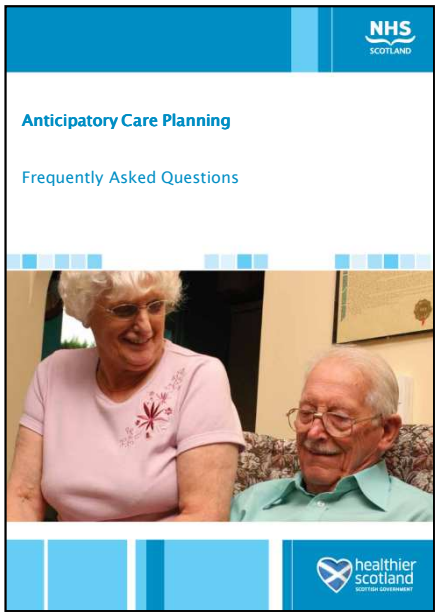


- Attends oncology appt for scan result
- CT shows progressive disease
- Pt and wife devastated
- Symptoms worsen

- 2 weeks later, well enough for home
- Waiting for care package first
- Develops cough- becomes septic
- Son is a GP and wants treatment started
- Blood cultures-very resistant infection
- Wife brings in a ‘Living Will’

End of life decisions





- General Medical Council guidance July ’10
- Anticipatory care – Scottish Government
- Advance care planning including treatment requests / refusals
- Information sharing

Advance care planning

- Wishes / preferences / fears about care
- Feelings/ beliefs / values that may influence future choices
- Who should be involved in decision making?
- Emergency interventions e.g. CPR
- Preferred place of care
- Religious / spiritual / other personal support
- Formalising requests
  - Legal proxy / Advance Directive

Advance requests

- Explore reasoning
- Request will be given weight
- BUT…future decisions can't be bound by their request
- Treatment must be of overall benefit to the patient

Advance Refusals

- Valid and applicable requests must be respected
- In written form = Advance Directive
- Legally binding in England / Wales
- Potentially legally binding in Scotland / Northern Ireland
- Non-legally binding refusals still taken into account

How do I know it's valid?

- Is it clearly applicable?
- When was it made?
- Did the patient have capacity when it was made?
- Was it an informed decision?
- Were there any undue influences when made?
- Has the decision been withdrawn?
- Are more recent actions / decisions inconsistent?

Pros and cons

- Pros
  - Enhances autonomy
  - May encourage / improve discussions on end-of-life decisions
  - Avoid breaching patient's personal / religious beliefs
  - Death with dignity
- Cons
  - May not be valid
  - May not be applicable
  - Attitudes may change with onset of serious illness
  - May have been advances in medicine since being made

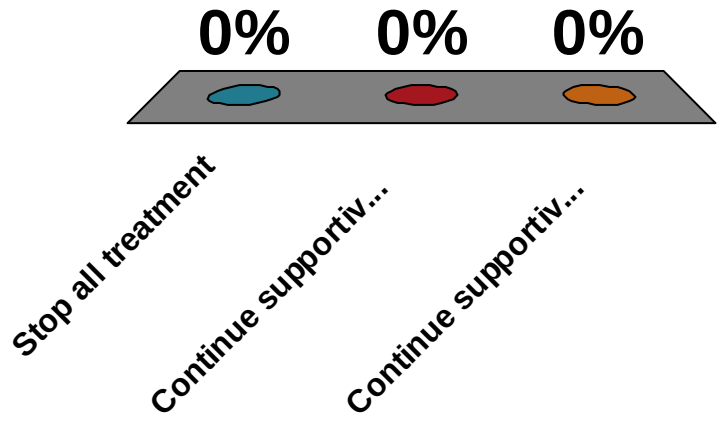
Back to the case....

- Patient incapable of choosing
- Advanced and progressive disease
- Recurrent chest infections – now difficult to treat
- Quality vs quantity of life
- Ultimately a choice of when and how to die

- Differences of opinion within family
- What are your own feelings?
- Decision made must be in the patients best interests

What will you do now?

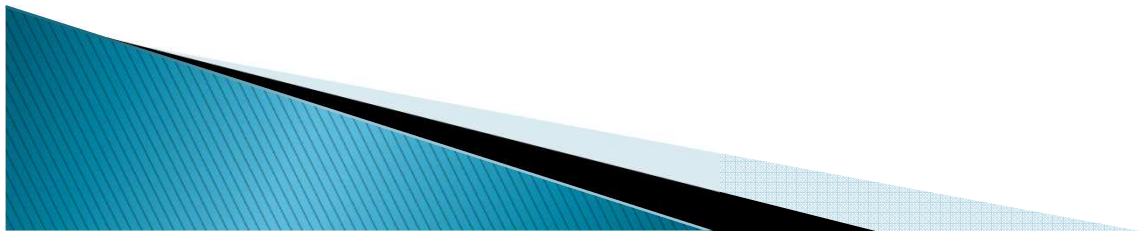
1. Stop all treatment
2. Continue supportive measures (e.g. fluids/ analgesia) only
3. Continue supportive measures and antibiotics



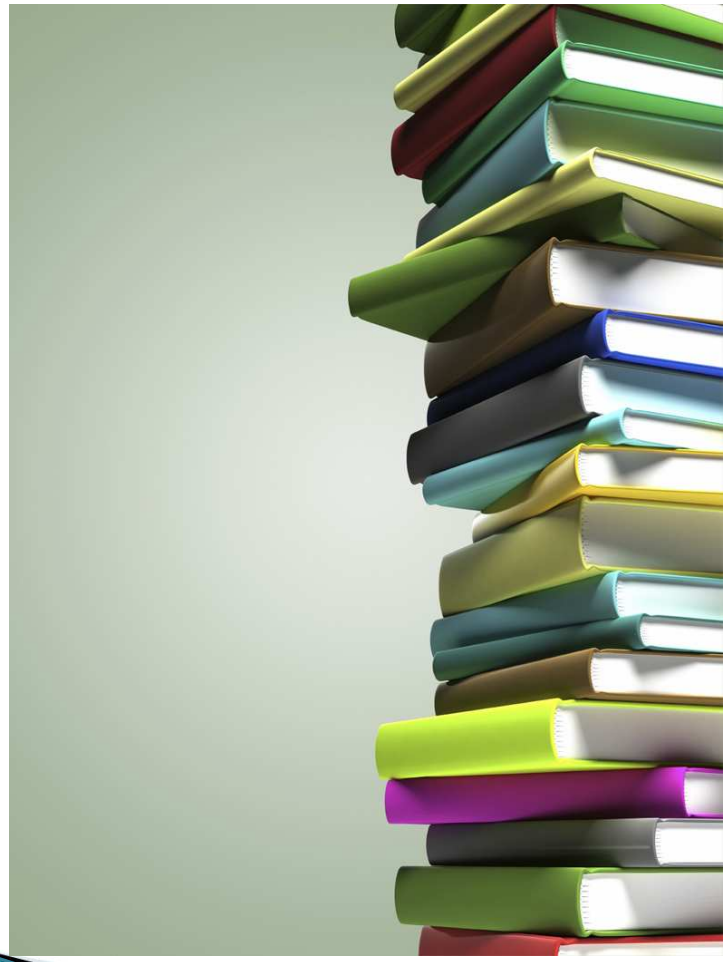
Management

- Good communication
- Explain the patients wishes
- Explain the medical situation
- Discuss the options
- Agree a way forwards
- Usually an agreement can be reached, but if not:
  - Independent advocate
  - Second opinion
  - Case conference
  - Further legal options

- In this case we agreed to:
  - Stop iv antibiotics
  - Continue iv fluids until iv access lost
  - No further invasive procedures- bloods / intravenous cannulation etc.
  - Treat symptoms only
- The patient passed away comfortably 4 days later



Further reading



- Oxford Handbook of Palliative Medicine (2005)
  - Available via link on Galen
  - Chapter 16 –Advance Directives
- ‘Treatment and care towards end of life’ – General medical Council
  - Available via link on Galen
  - Pages 6 – 41