

Hannah Meacher 090121696 (hannahmeacher@gmail.com)
St Joseph's Hospice, Mare Street, Hackney, E8 4SA
Supervisors: Dr Abigail Wright and Dr Harriet Roebuck
Dates: 22/4/2013 – 7/6/2013

ELECTIVE REPORT

Describe the types of conditions that may lead to a patient accessing palliative care, and consider how this may differ in other countries.

Palliative medicine is an approach to care for those with a life-limiting or chronic condition, and is focussed on treating symptoms rather than curing a disease. Historically it is associated with oncology patients, particularly during the terminal phase of their condition. However, palliative medicine can be used in other conditions, and at any stage of illness. Examples of other conditions that patients may have include chronic obstructive pulmonary disease (COPD), motor neurone disease, dementia, heart failure, renal failure and multiple sclerosis. Patients with non-malignant conditions can be just as symptomatic as patients with malignant conditions, which is why palliative care expertise is required. Common symptoms that patients described included pain, breathless, nausea, vomiting, loss of appetite, constipation, fatigue and anxiety.

The provision of palliative care varies greatly between countries, and this is mainly due to how the role of palliative care is interpreted rather than the conditions patients die from, particularly in developed countries. In developing countries, such as in Africa, more patients die from HIV/AIDs rather than cancer, and the World Health Organisation has published a report about how these people can be reached through a community approach.

How is palliative care organised in the UK – compare and contrast with other countries.

Palliative care can be provided to both inpatients and the community, and palliative care specialist teams can be based in the hospital or at hospices. Hospices have existed in some form for centuries, but the first purpose-built modern hospice was St Christopher's Hospice, built in 1967 and founded by Dame Cicely Saunders. St Joseph's hospice was opened in 1905 by the Irish Sisters of charity, and in the 1950s Dame Cicely Saunders worked here developing a foundation for modern day palliative medicine.

Palliative medicine is a comparatively new speciality and, in the UK, was recognised by the Royal College of Physicians as a Speciality in 1987. Most hospitals have specialist palliative care teams, who will review patients and suggest management plans. Inpatient care at hospices is for anyone with a life-limiting illness and can be for respite, symptom control or terminal care. Hospices are funded jointly by charity and the NHS, but the restructuring of the NHS may mean that there is an increased reliance on charity.

I had the privilege of meeting a visiting Palliative Medicine Consultant from Brazil, which made me realise how a country's culture can impact how the role of palliative care is interpreted. There are no hospices in Brazil, and a patient is only referred to when they are imminently dying. However, these patients will already be attached to ventilators, and most are artificially fed. The pictures of the palliative care ward looked more like an intensive care unit. The consultant explained that patients are referred very late to a palliative care physician, and often the role was to choose when to switch off the life support – which to some families was very difficult and was seen as being the cause of death.

I attended a session on Namaste care, during which Joyce Simard gave a brief introduction to how hospice and palliative medicine is organised in the USA. In the USA palliative medicine and hospice medicine are split, with hospices being strictly for the terminal phase of a disease. Hospices are supported by the government under the Medicare scheme. Hospices funded by the Medicare scheme can only offer care to patients over the age of 65 and with less than 6 months to live, which is obviously inadequate for people under the age of 65. More than half of the hospitals offer palliative care programmes, however, the smaller hospitals are less likely to offer this.

Discuss the importance of multi-disciplinary team in management of a patient receiving palliative care. How are friends and family supported?

At St Joseph's hospice I witnessed effective multi-disciplinary team working. The team consisted of specialist nurses, health care assistants, physiotherapists, occupational therapy, psychological therapies, social workers, complementary therapy and doctors. In addition to this there are many volunteers, who provide a range of skills from gardening, and art work to aromatherapy. In addition to staff and volunteers within the hospice itself, the hospice team has to communicate with professionals outside of the hospice. An example of this would be oncologists who are deciding the best course of treatment for their patients and the hospice helps keeps on top of the symptoms. The hospice also liaises with anaesthetists to arrange nerve blocks where necessary.

The hospice and the community palliative care team also work closely with GPs, who will already know the patients and prescribe the patient's medication.

Physiotherapists play a role in helping patients to maintain or improve their function and mobility. Physiotherapists can also provide coping strategies to help deal with breathlessness, in which anxiety often compounds the problem. This can be delivered on a one to one basis, or in groups such as ICON (In Control of my Breathing).

Friends and family are supported by all of the team. The most important foundation for this is effective communication. The psychological therapies team provides counselling and bereavement support, and delivers this in a variety of ways such as one to one, or group therapy. Sometimes relatives still struggle to come to terms with how their loved one died, and it is appropriate for a consultant to meet with the relative and the counsellor to go through how the patient had been managed when they were dying.

By reflecting on my experiences, improve my knowledge and skills so that I can better manage a patient who has reached the end of their life, and also how to support their friends and family.

I feel that the aim of an elective placement is to gain exposure to a healthcare environment to which we gained little exposure during the rest of medical school. Most people interpret this as experiencing healthcare abroad, whereas I chose to use this opportunity to gain experience in a hospice. During foundation training and beyond we will be dealing with patients who have unresolved symptoms and some who may have reached the ends of their lives. I have learnt more about the role of specialist palliative medical team, and when to consider referral to them. I also learnt more about the role of the Liverpool Care Pathway, and how to recognise a dying patient.

I have built upon prescribing awareness with regards to analgesics, and reinforced principles of how to convert different opioid analgesics and how dose needs to be altered with route of administration. I also gained some understanding of the role of continuous subcutaneous

infusion in providing relief for pain, sickness and anxiety when a patient can't tolerate oral medication.

When patients are deteriorating it is important to exclude reversible causes, such as hypercalcaemia, sepsis and iatrogenic causes. However it is appropriate to accept when disease progression is the cause and to keep patients and their families informed if they wish.

I saw the benefits of anticipating situations, such as whether a patient wishes to be transferred to a hospital, or receive antibiotics. Discussing these issues early allowed decisions about ceilings of care to be made calmly rather than during an emergency situation.

1225 words