



Pioneer Scheme Day-release programme

Wednesday 26th April 2017

Horselethill Road, Glasgow

Palliative care in the Deep End

With Euan Paterson

Questions asked:

- What is palliative care?
- What is end of life care (EoLC)?
- What is the GP role in EoLC?
- What makes it different at the deep end?

Although on first glance these seem easy to define, they are surprisingly complex, defying easy assignment to rigid definitions. Having an awareness of the 'lay understanding' of terms such as 'hospice', 'terminal' and 'palliative' is important to help practitioners communicate effectively with patients and their families, and to understand their concerns at the end of life.

The characteristics of EoLC

Definitions such as "life threatening conditions" (WHO) and "the last year of life" (GMC) are not the most useful. It is more helpful to think of palliative care as *supportive* care and to ask, *for any patient with any condition*, "When have you reached your ceiling of comfort/competence?" and "when do you need specialist input?"

Symptoms that are associated with the end of life include: SOB, apnoeic episodes, shallow breathing, increased secretions, increased pain, agitation, and family distress.

Causes of agitation

There are many possible causes of agitation at the end of life: pain, N&V, SOB, constipation, psychological, drug toxicity, urinary retention, infection, fear/religious distress, finances/family concerns, and metabolic abnormalities.

→ Correct the reversible and consider what can be treated within the wishes of the patients (how active should the Rx be? e.g. Hospital/hospice for IVFs)

The GP role in EoLC

- Stopping what's not needed
- Symptom control – including 'just in case' meds – think about route of meds
- Signposting to other support / Supporting the family
- Discussing trajectory
- Diagnosis and Treatment planning
- Decision-making, e.g. DNACPR, admission (if reversible causes), ceilings of care, morphine
- Forward planning – e.g. wills, POA, DS1500, funeral plans, etc
- My Thinking Ahead and Making Plans <http://www.palliativecareggc.org.uk/wp-content/uploads/2014/09/245080-My-Thinking-Ahead-and-Making-Plans-booklet.pdf>
- Communicating – aiding understanding, use of EKIS, verification of expected death
- Narrative & context
- The healing role i.e. affirming, understanding and bearing witness

Particular challenges for EoLC at the deep end

- Different cancer types more prevalent; more non-cancer conditions (COPD, HF)
- Socio-economic deprivation - poor housing, poor nutrition, lack of financial security
- Younger, more multi-morbidity and social complexity (as above)
- May be children involved
- Lower expectations & health literacy
- Language/cultural barriers
- Logistical issues, e.g. transport
- Positives include: less movement of relatives, more openness, more experience of death/bereavement

Useful resources

<http://www.palliativecareggc.org.uk> (app for mobiles)

<https://www.goodlifedeathgrief.org.uk/>

<http://www.dyingmatters.org/>

<https://www.finalfling.com/>

Also discussed Alan Kellehear's 'compassionate communities' and Harvey Chochinov's 'dignity in dying'

KEY SUMMARY POINTS:

- Palliative care is perhaps best considered as supportive care
- Good communication is key – with patients, relatives, and other members of the healthcare team
- Think about forward planning – eKIS, DNACPR, POA, 'JIC' meds, verification of expected death
- Good care at the end of life matters greatly to families – you only get one shot at it – it takes time