

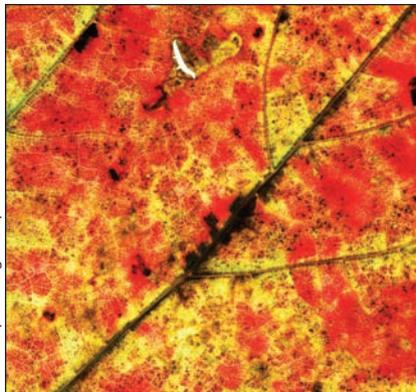
Palliative care 101

I visited Mrs. D every morning at 8:30. She had come to the ward because of excruciating pain in her spine, which the radiation had helped, but she still barely ate anything. For the week following treatment, while her nausea was being managed aggressively, no one was too surprised. A week after that, as I saw her cheeks thinning each day, her family was just starting to understand what was happening. There would be no feeding tubes. Her pain was controlled. She had no more nausea. She just wasn't hungry anymore.

I struggled at first with her family, to suggest something that might give her an appetite: Some fresh air? A hamburger? Maybe even an appetite stimulant? Nothing helped. But I tried to stay positive: "She says she's feeling better." "She looks better." I realized my optimistic statements were encouraging false hopes, given that the stage of her illness wasn't really appreciated, or at least acknowledged, by her family. But I didn't want to upset anybody.

It was during the second family meeting, with the attending palliative physician, that we all got the point: it's okay for her to die. Yes, she's always been a fighter, but now she's just fighting herself. It was time for everyone to understand that. She told us she'd denied the severity of her back pain as long as possible before coming to the hospital, trying to avoid having this very conversation. Yet all along she wanted her doctors to be straightforward with her. In tears, Mrs. D thanked the physician for everything, the hospice arrangements were made, and the end-of-life work could get underway.

While Mrs. D and her family figured out the details with the social worker (Will there be air conditioning? Can my cat come?) and my preceptor moved on to the next patient, I wondered: What did he just do? The palliative physician's presence, gentle voice, confidence and focused attention had transformed a room bristling with worried agony to a peaceful calm. He had helped Mrs. D and her family through this incredibly



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difficult but inevitable part of life. Mrs. D was now ready for the next step, and she and her family could contemplate her life without pretense, look at old photos, tell stories and make arrangements. Mrs. D finally asked what everyone wondered: How will I die? Will I choke? How much will it hurt? My mentor answered knowledgeably, reassuringly and addressed the uncertainty inherent to death as it is to life.

As my palliative elective went on I learned about opioids, nerve blocks, antiemetics, community resources, PleurX tubes, etc. Much of this was new and exciting, but what has really coloured my subsequent medical training are the concepts of palliation. The sanctity of death as a natural part of life. Not giving up on any patient, or person. Consistency of health care throughout the life cycle. Whole-person care. Some invasive procedures that had seemed reasonable during my first medical rotation started to seem unnecessary and damaging. On other services I've seen some painful, expensive, heroic care plans that proved futile, and could likely have been avoided if someone had dared a frank discussion with the patient and her family. I've begun to initiate these discussions myself when I find it's appropriate.

With the burgeoning of the palliative model in recent decades, I thought this meant more palliative wards, more palliative doctors and teams. I don't think that's the only answer. Many dying patients with complex palliative

needs do require specialized palliative units and skills, but most patients just need their doctor to be able to provide basic pain management and to be comfortable in a discussion about death and dying. Despite guidelines that recommend advanced care planning for patients with a prognosis of less than one year, there is good, recent evidence that physicians tend to delay these conversations.¹ Patients will die in every medical specialty; palliative concepts need to take a place in medical curricula as central to every discipline, not just segregated as a specialty practice.

Growing education about palliative principles and treatments has social benefit beyond cost-cutting and patient satisfaction. As Balfour Mount argues so passionately,² good palliative care negates many of the arguments for physician-assisted suicide. My grandparents are longstanding members of the vocal Dying with Dignity organization. In discussions with them I find that much of the physical or even spiritual suffering they fear at the end of life and that they see as inevitable, can be avoided with good palliation. As a family physician I plan to incorporate palliative care into my practice. With or without an official title of palliative care physician, I'll make use of my experience — for my patients' sake, but also for the meaning and intensity that the contemplation of mortality adds to my own life.

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