



## Control of pain and other symptoms

No patient should die in pain or with other treatable symptoms. Indeed, before social, psychosocial and spiritual problems can be properly addressed, good symptom control must first be achieved: it is difficult to contemplate spiritual issues or to reflect on life's accomplishments when in pain or with kidney basin in hand. The under-treatment of pain and other symptoms is well documented, but aside from inadequate training of health professionals<sup>20,21</sup> the causes are complicated and not well understood. On occasion, physicians may be concerned about balancing good symptom control with the risk of hastening death. Guidelines have been developed to assist physicians in distinguishing appropriate analgesia from euthanasia by lethal injection.<sup>9</sup> Controlling other symptoms, such as nausea, fatigue and breathlessness, may be even more challenging than controlling pain, but effective approaches have been developed.<sup>22</sup>

Physicians must keep in mind that the problems of dying patients have their genesis at an earlier time in the trajectory of illness. Thus, palliative care should not be isolated as simply an end-of-life option; it must be intermeshed with therapies aimed at prolongation of life or cure. As in other areas of medicine, prevention or early control of a symptom is preferable to a rescue attempt on preventable, but now out-of-control, suffering. Every physician who cares for

dying patients should ensure that he or she has adequate skills in this domain, as well as access to skilled consultative help from palliative care specialists. A list of leading journals and other information sources is given in the sidebar.

## Use of life-sustaining treatments

To the extent possible, the patient and his or her family should be able to choose the site and nature of the care that the patient will receive in the last days of life and should be encouraged to discuss in advance their desires regarding life-sustaining treatments and personal care. Physicians should facilitate this advance care planning<sup>5,23-26</sup> and guide and support the patient and the family through the process of giving consent to treatment and arranging for substitute decision-making.<sup>4</sup> A key skill here is the communication of bad news.<sup>27</sup> In addition, physicians need to develop an approach to the opposite problem — when the patient or the family demands treatment that the physician feels is inappropriate.<sup>5</sup> A key skill here is the ability to negotiate a treatment plan that is acceptable to the patient, the family and the health care team.<sup>28</sup>

## Support of patients and their families

The support that each patient and his or her family needs from the physician is unique. The best way to find

## Resources for physicians providing end-of-life care

### Comprehensive textbook

Doyle D, Hanks GWC, MacDonald N, editors. *Oxford textbook of palliative medicine*. 2nd ed. New York: Oxford University Press; 1998.

### Palliative care manuals

MacDonald N, Boisvert M, Dudgeon D, Hagen N, editors. *Palliative medicine: a case-based manual*. Oxford: Oxford University Press; 1998.

Regnard C, Hockley J. *Flow diagrams in advanced cancer and other diseases*. London: Edward Arnold; 1995.

Twycross RG. *Symptom management in advanced cancer*. New York and Oxford: Radcliffe Medical Press; 1997.

Weller A, Caroline NL. *Handbook of palliative care in cancer*. Toronto: Butterworth-Heinemann; 1996.

Woodruff R. *Palliative medicine: symptomatic and supportive care for patients with advanced cancer and AIDS*. 2nd ed. Melbourne: Asperula; 1996.

### Palliative care standards and policy statements

Canadian Palliative Care Association Stan-

dards Committee (Ferris FD, Cummings I, editors). *Palliative care: towards a consensus in standardized principles of practice* [first-phase working document]. Ottawa: Canadian Palliative Care Association; 1995.

Committee on Care at the End of Life, Division of Health Care Services, Institute of Medicine (Field MJ, Cassel CK, editors). *Approaching death. Improving care at the end of life*. Washington: National Academy Press; 1997.

### Journals

*European Journal of Palliative Care*

*Journal of Pain and Symptom Management*

*Journal of Palliative Care*

*Pain*

*Palliative Medicine*

*Psycho-Oncology* (journal of the psychological, social and behavioural dimensions of cancer)

*Supportive Care in Cancer* (official journal of the Multinational Association of Supportive Care in Cancer)

### World Wide Web sites

[www.ama-assn.org/EPEC](http://www.ama-assn.org/EPEC)

American Medical Association Education for Physicians on End of Life Care

[oris.microtec.net/~AQSP](http://oris.microtec.net/~AQSP)

Association québécoise des soins palliatifs

[www.islandnet.com/deathnet](http://www.islandnet.com/deathnet)

DeathNET

[www.palliative.org](http://www.palliative.org)

Edmonton Palliative Care Group

[www.gwu.edu/~cicd](http://www.gwu.edu/~cicd)

George Washington University Center to Improve Care of the Dying

[www.multi-med.com/oncology/oncopain](http://www.multi-med.com/oncology/oncopain)

Oncopain, a forum on pain management open to health care professionals only

[www.soros.org/death.html](http://www.soros.org/death.html)

Open Society Institute Project on Death in America

[lastacts.rwjf.org/default\\_home.htm](http://lastacts.rwjf.org/default_home.htm)

Robert Wood Johnson Foundation Last Acts Campaign

[www.pallcare.org](http://www.pallcare.org)

University of Ottawa Institute of Palliative Care

[www.utoronto.ca/jcb](http://www.utoronto.ca/jcb)

University of Toronto Joint Centre for Bioethics (includes the full-text version of the centre's living will and links to other end-of-life Web sites)