

## **Appreciating our Standards of Care**

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Over the years those of us doing palliative care in Edmonton have worked very hard to improve our assessment and management of palliative care patients. Those of us who have the opportunity to visit other palliative care programs around the world as invited speakers or visitors, often return with a renewed enthusiasm and appreciation for what we have accomplished.

Recently a hospice program in the USA invited me, to give presentations both at two acute care hospitals in the area, as well as to staff of this hospice organization. I was asked to speak on the use of "Rehydration and Dehydration in Palliative Care", as well as on "Pain Assessment: Beyond the Basics". The main points I made in these presentations are a well-known routine part of our clinical management in Edmonton. We have learned how essential it is to make a multidimensional assessment of pain that incorporates the psychosocial and spiritual dimensions of suffering in planning a comprehensive approach to patient management. While in many other areas palliative care educators are still struggling with the basic message of appropriate opioid prescribing, we have learned the lesson of over reliance on pharmacological management alone and the extremely unpleasant side-effects that can be visited on patients by an overly simplistic management approach. In addition we have understood that ignoring the fact that decreasing oral intake will inevitably result in deterioration in renal function and potential accumulation of medications, will expose the patient to potentially very unpleasant side-effects. While the benefits of parenteral hydration in terminally ill patients may still be somewhat controversial for some practitioners, the need to at least decrease medications that will be accumulating, is generally well understood by the palliative care community in Edmonton.

My physician hosts invited me to join them on a ward round of their in-patient hospice facility. At that point in my visit they had all had the opportunity to hear my presentations. We encountered the following clinical situation: -

A man in his 70s with lung cancer and bone metastases had been admitted to the hospice a few days previously. As a result of persistent pain and difficulty taking oral medication he had switched to a continuous subcutaneous infusion of morphine, which was running at 20 mg per hour. He had a large attentive family, of whom two to three were always present at the bedside. Over the previous 24 hours the patient had required increasing use of prn morphine, and had received nine prn doses during this time. I was asked to express my opinion on the most effective approach to this apparent pain crisis. I inquired as to the location of pain as described by the patient, information regarding the cognition or evidence of delirium such as hallucinations, the presence of myoclonus, oral intake and possibility of dehydration and renal impairment. The attending physicians indicated that the patient was unable to localize his pain, which was "all over" because of his bone metastases. They thought his cognition was reasonably good, and that they assumed he was likely dehydrated as his oral intake was minimal but they never measure urine output or considered laboratory investigations. A subsequent visit with the patient and history obtained from the family at the bedside was very revealing. The family indicated that the

patient had been complaining of increasing hallucinations over the previous week, and they had also noted increasing myoclonus during this time. They also indicated that his cognition had decreased to the point that he barely recognized them, and they described agitated behavior associated with some moaning which they interpreted as increasing pain. The clinical examination revealed a minimally responsive patient who was intermittently restless, and could certainly not provide any useful information. Further discussion with the family outside the room suggested unresolved psychosocial issues involving the patient and his family. The patient's family expressed severe distress with regard to the apparent discomfort of their relative. Prior to entering the patient's room, the attending physicians had intended to increase the morphine dose further in response to the increasing prn use. My questions, the family's answers, and my previous presentations (I would like to think!) resulted in ready agreement to a different approach. The morphine was discontinued and replaced with hydromorphone with a 50% reduction in dose. The family was also provided with an explanation of this approach, as well as the need to differentiate as best as possible pain from agitated delirium.

It was apparent that the approach of the staff in this hospice organization to increasing opioid use was almost always to continue to increase the opioid without a careful reassessment of underlying causes. Any resulting toxicity would then be treated with increasing antipsychotics and benzodiazepines. Many of us will have seen this practice approach in many other settings that we have visited. In Edmonton we have worked hard to educate both ourselves as well as our colleagues, for whom palliative care is a smaller part of their practice, on the value to patients and families of a more sophisticated assessment and management approach. We now often take for granted the wide acceptance of the need to consider opioid changes and the possible consequences of renal impairment that is well known and incorporated into practice patterns in Edmonton. Certainly we need to avoid complacency and continue our educational efforts and work hard to maintain and improve our practice standards. However an appreciation for what we have achieved and a sense of pride in our Edmonton Palliative Care Program is I believe, well deserved.