

Editorial Reflections
Practice Differences and Finding Common Ground

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The steady flow of European and other international visitors to the Edmonton Program has prompted many queries concerning differences in the way palliative medicine is practiced in different centres. Furthermore, one doesn't have to cross the pond (Atlantic) to discover striking differences in practice patterns: significant differences exist in the practice of palliative medicine across Canada. Some of these differences are more apparent clinically and further exploration of the underlying factors is warranted.

Transatlantic differences in the practice of palliative medicine have been documented [1]. One of the biggest errors made in comparing practices, research studies and other epidemiological data such as some of the outcome measures, is failure to appreciate the biases that operate in the selection of study samples. Many of the research studies that have emanated from the Edmonton program were conducted on a study sample of patients referred to a tertiary palliative care unit, reflecting poorer prognosis in terms of symptom management, particularly in relation to pain control. This parameter has been recognized in the Edmonton Staging System[2], which is now quoted in most of the Edmonton studies. A high percentage of patients admitted to the tertiary level palliative care unit are classified as Stage III (poorer prognosis for pain control), indicating that they have evidence of one or more of the following: predominantly incidental pain, neuropathic pain, opioid tolerance, somatization or depression, or a history of alcohol or drug abuse. Hence, much of the studies and reports concerning opioid toxicity and opioid rotation relate to a relatively select population that is at greater risk of opioid toxicity. Therefore, there is a great need to appreciate the sociodemographic characteristics of our study populations when we attempt to conduct practice comparisons between centres at both a national and international level.

The traditional hospice model grew out of a recognized need on the part of the terminally ill and a willingness and desire to meet their needs in a compassionate and caring way. In addition, there was a sense that the conventional medical model was inadequate in meeting the needs of these patients and their families. As a result there was a tendency to reject the conventional medical model on the grounds that it was primarily cure driven, invasive, cold, and excessively technical. This historical dichotomy has changed with the emergence of palliative medicine as a specialty with its own knowledge base and philosophy. However, it is possible or even probable the remnants of the traditional dichotomy still persist and to some extent account for the practice differences in various centres [4].

Other important reasons for practice differences include cultural influence, fiscal constraints, administrative and legal factors including drug availability. Further exploration of these issues extends beyond the scope of this editorial.

Where can we find some common ground? Clearly, we all share the ultimate goal of patient comfort. In addition, there are four objectives which we can share in the pursuit of this goal.

- We can all share the challenge to further develop evidence based palliative medicine. Pursuit of evidence based practice can help bridge the philosophical gap between therapeutic nihilism on the one hand, and on the other hand, the imposition of high burden interventions that contribute little to patient comfort. Our evidence based practice must promote the use of validated outcome measures [3] that incorporate the existential as well as other demands.
- Informed decision-making at the end of life requires the existence of structured and efficacious patient education programs. The increased use of the internet by our patients and their families carries the risks that such vulnerable people constitute easy prey for unscrupulous peddlers who pose uncensored advertisements in a multitude of web sites. This presents an example of where we share a communal duty to educate our patients in relation to this risk.
- The ethical principle of respecting patient autonomy is a shared core objective. Respect for cultural differences is implicit in relation to this principle and ironically might contribute to the exposition of practice differences between centres.
- One of the most difficult, yet most important challenges is to foster an openness to change in our practices.

In conclusion, therefore, there are many reasons for differences in practices in different centres. Primarily, there exists an apparent difference in the frequency or intensity of certain practices based on selection biases in study patient populations. The historical remnants of the dichotomy between the traditional hospice care and the conventional medical model would appear to have a significant impact on practice differences. Our common ground lies with the challenge to further develop evidence-based palliative medicine which in essence will serve to educate all palliative care practitioners. In addition, more extensive patient education programs will facilitate informed decision-making on the part of patients and their families. The ethical principle of respecting patient autonomy should be upheld in the decision making process concerning our various therapeutic interventions. The pursuit of these "common ground" objectives should assist us greatly in attaining the ultimate goal of patient comfort. This will also facilitate the development of care models that are evidence-based, holistic, acceptable to patients and incorporate the empowering influence of patient education. Finally, our common ground challenge also includes a willingness to change our practices in accordance with the weight of available evidence. Our models of care should therefore be dynamic as opposed to static. Increased similarity between our practices might occur as a result of pursuing these objectives. The dynamic paradigm and sociodemographic differences will prevent absolute similarity, which is arguably an unnecessary or unreasonable goal.

References

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