Dr Joanne Lynn (Medical Officer, Centers for Medicare and Medicaid Services, US) presented the Stanley Davidson Lecture. The challenges of planning end-of-life (EOL) care were discussed. The importance of assessing individual patients and anticipating the way their illness will progress was stressed to allow the identification and proactive management of potential problems.

The typical mode of death has changed dramatically over the past century: previously, fit young adults died suddenly; now, progressive chronic illnesses strike in older age causing debility for a number of years before death.

Three distinct illness trajectories for these modern causes of death were presented:

- **Cancer**: a plateau of high functional ability, followed by short decline before death.
- **Chronic organ failure**: gradual background deterioration in function with exacerbations of illness reducing functional ability, any one of which could result in sudden death.
- **Frailty and dementia**: a dwindling course of generally low functional ability for a prolonged period before death.

One of the challenges in providing care for those with fatal chronic illness is the uncertainty of an individual’s prognosis. Care ought to be given according to the severity of the illness and need, not the prognosis. Different models of care should be provided, taking into account the likely course of the patient’s illness, their wishes and needs:

- Those with cancer may require intensive treatment in hospital, then a shift in care to home or hospice for the last few days.
- With organ failure, teaching self-care of exacerbations and the provision of a trained person to attend home in an emergency may prevent unnecessary and unwanted readmission to hospital, avoiding over-investigation and over-treatment.
- For those with neurological decline causing reduced function, longer-term care needs to be provided, either in care homes or at home with adequate caregiver support.

When planning care, it is important to remember the reduction in family caregivers: people generally have fewer offspring who often live further away and, as people are older when they die, their offspring may be too elderly and frail themselves to be able to care for their parents.
SESSION 2 SYMPTOM MANAGEMENT

The typical treatment of nausea and vomiting was questioned by Dr Ian Back (Consultant in Palliative Medicine, Holme Tower Marie Curie Hospice, Penarth, and Pontypridd and Rhondda NHS Trust). It was claimed that there is little evidence for our current rationale for antiemetic choice. Dr Back maintained that we are often unable to identify the pathways involved or the receptors in these pathways from our history and examination, and we also have an incomplete understanding of the pharmacology of antiemetics.

A summary of the receptors, including subtypes, identified to date (binding dopamine, serotonin, substance P, histamine, acetylcholine, endorphins, gamma-aminobutyric acid and cannabinoids), and some drugs that antagonise at these specific sites, is provided in a recent update on antiemetics. Dr Back postulated that the mechanism of nausea and vomiting involves different receptors and pathways in different people, which possibly explains why some patients respond to one drug while others do not, despite having an apparent similar source of symptoms. This is clearly an area in need of further clinical research.

Although there may be little or no evidence for some therapies, this does not mean they are ineffective. It seems prudent to continue in the meantime with standard management of empirical antiemetic therapy in adequate regular and breakthrough doses, by the parenteral route if necessary, while treating the cause (where possible). In the case of intractable symptoms, it is reasonable to try combining antiemetics that act at different receptors. Research has shown the benefit of combining a serotonin (5HT3) antagonist with dexamethasone, and a neurokinin (NK1) antagonist for chemotherapy-induced vomiting, and, to a lesser extent, nausea.

Other less conventional drugs may also be beneficial for the treatment of nausea and vomiting, for example the antipsychotic olanzapine, which blocks multiple receptors, and, in the future, synthetic analogues of ghrelin, a protective peptide secreted by the gastric mucosa that stimulates gastrointestinal motility and appetite. The antisecretory agent octreotide has been shown to reduce vomiting in malignant bowel obstruction and is a potential alternative to surgery in such patients. Nausea and vomiting from other distinct causes are not very well researched and hopefully this will be addressed in the near future.

Numerous palliative care patients experience renal impairment, varying in severity from mild impairment to end-stage renal disease (ESRD). Estimated glomerular filtration rate (eGFR) can help assess renal function; however, this is less accurate in the cachexic or those suffering mild renal impairment (like countless palliative care patients).
Many people with ESRD have considerable symptoms. Dr Jo Chambers (Consultant in Palliative Medicine, Southmead Hospital, Bristol) urged us to become confident in treating patients with impaired renal function, despite their resultant altered handling of many drugs.

For pain, the principles of the WHO ladder should be followed with some adaptations. Non-steroidal anti-inflammatory drugs (NSAIDs) should be avoided if preservation of renal function is desired. Non-renal side effects of NSAIDs are increased in patients with ESRD. If a step two analgesic is required, tramadol can be given (reduced dose). Fentanyl and alfentanil are the favoured step three drugs in severe renal impairment.

The choice of therapy for other symptoms depends on symptom severity, previous treatments, concurrent medication, prognosis, coexisting symptoms, evidence of efficacy, availability and the burden of the proposed treatment and the toxicity profile of the planned therapy. Such toxicity can be limited by individualised care and close monitoring to facilitate titration using short acting/immediate release preparations. Reduced doses and an increased dosage interval may be required.

Guidance on drugs to be avoided or dosage modifications in renal impairment can be obtained from several resources.

**SESSION 3 WHAT’S BEST FOR PATIENTS?**

An appealing, interactive presentation on narratives at the end of life was given by Professor Trisha Greenhalgh (Professor of Primary Health Care, University College London). Using a thought-provoking example, Professor Greenhalgh clearly demonstrated how stories are open to interpretation, with the audience proffering their different analyses of the narrative under discussion. Examining patients’ narratives can help us in EOL care as it allows understanding of patients’ feelings and experiences in context. Clinicians have a duty to display narrative competence by ‘acknowledging, absorbing, interpreting and acting on the stories and plights of others’. Professor Greenhalgh has co-edited an excellent book concerning narratives in medicine.

Dr Jo Hockley (Research Fellow/Clinical Nurse Specialist (Palliative Care), University of Edinburgh) compared cancer palliative care with EOL care in nursing homes, and discussed the challenges of such provision in care homes. There are greater consequences of ‘living with’ rather than ‘dying from’ chronic illnesses, and it can be difficult to identify dying. The ethos of functional rehabilitation, where death is viewed as failure, contrasts with that of palliative care, where natural dying is accepted. There are difficulties of recruitment and retention of staff in care homes, which are generally staffed by carers who are untrained in palliative care and commonly isolated from medicine of the elderly and specialist palliative care. The Bridges Initiative (1999–2004), an interesting action research project involving eight nursing homes, identified these obstacles when trying to implement a care pathway at the end of life and concluded that both local and national policy changes are needed to promote quality EOL care in nursing homes. The EOL Care Intervention Study (2007–8), involving seven care homes in Midlothian, aims to improve anticipatory care planning and reduce inappropriate hospital admissions in the last weeks of life. Previous qualitative research has shown that successful planning, including communication between those involved in caring for patients out-of-hours, was appreciated. The acute health service was thought not to facilitate the provision of quality palliative care, and alternative care and support services were not readily accessible.

**SESSION 4 PUTTING IT INTO PRACTICE**

Discussion of resuscitation with patients and information regarding the newly updated national resuscitation guidelines was covered by Dr Juliet Spiller (Consultant in Palliative Medicine, Marie Curie Hospice, Edinburgh, and West Lothian Palliative Care Service). Any patients at risk of cardiorespiratory arrest should have their resuscitation status considered: a medical decision can be made not to attempt resuscitation where this would be futile. This should be discussed with the patient (unless the overall impact on the patient of having such a discussion would be likely to be negative) in the context of future care planning. For patients who would like to have their family present when they are dying, a decision not to resuscitate would facilitate their wishes without compromising other aspects of their care. If resuscitation may be successful this should also be discussed with the patient. Many people have a falsely elevated expectation of the success of resuscitation attempts following dramatisation on television and, only after being given accurate information, can they make such an important quality-of-life decision.

The question of who should have such discussions with patients was also addressed, the most appropriate person being whoever the patient chooses to discuss end-of-life matters with. This may be a doctor or, now, an experienced nurse.

The importance of ensuring communication of resuscitation decisions to all other professionals involved in the care of the patient and the patient’s family was emphasised so that inadvertent scenarios, such as sudden-death situations at home where police become involved, can be avoided.

The day ended with the presentation of three cases by Dr Kate Henriksen (Palliative Medicine Specialist Registrar), Dr Peter Henriksen (Cardiology Specialist Registrar) and Dr Rayessa Rayessa (Stroke Medicine Specialist Registrar).
Specialist Registrar). These were discussed by a panel of Professor Ellershaw, Dr Spiller, Dr Chambers and Dr Back. Interestingly, patients with malignant spinal cord compression may be suitable for neurosurgical palliative intervention, such as transcatheater arterial embolisation of tumour. In keeping with earlier themes, it was recommended that patients with implantable defibrillators inserted should have their use reviewed as part of EOL planning discussions. Magnets are available from A&E departments to switch off defibrillators out of hours if necessary.

REFERENCES

3 http://www.goldstandardsframework.nhs.uk
7 http://www.mcpcil.org.uk
13 Wood GJ, Shega JW, Lynch B et al. Management of intractable nausea and vomiting in patients at the end of life: ‘I was feeling nauseous all of the time... nothing was working.’ JAMA 2007; 298(10):1196–207.

CONCLUSION

This stimulating day, with many excellent speakers, was of relevance to professionals from most specialties. Good EOL care is something we should all be able to achieve. In order to provide this effectively in the twenty-first century we need to plan care around the individual, taking the patient’s pattern of illness and wishes into account.

Acknowledgments The symposium was organised by Professor SA Murray, Dr K Boyd, Dr P Cantley and Professor N Turner.

23 http://www.emc.medicines.org.uk
24 http://www.palliativedrugs.com
32 British Medical Association, the Resuscitation Council (UK), the Royal College of Nursing. Decisions relating to cardio pulmonary resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007. Available from: http://www.rscresus.org.uk/pages/dnarpdf.pdf