SUBMISSION:
"PROPOSAL FOR INTEGRATED PALLIATIVE CARE"

SUBMITTED TO:
THE PARLIAMENTARY COMMITTEE ON PALLIATIVE AND COMPASSIONATE CARE

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The deVeber Institute for Bioethics and Social Research
Submission to the Parliamentary Committee on Palliative and
Compassionate Care, “Proposal for Integrated Palliative Care.”

Executive Summary

Palliative care as currently practiced in Canada has not yet achieved all the benchmarks set by the World Health Organization. Palliative care in Canada is predominately practiced only after a patient’s likelihood of total recovery vanishes. The World Health Organization, however, proposes palliative care be introduced at the time of diagnosis. Furthermore, research indicates that palliative care introduced earlier into a patient’s treatment plan, even while curative treatments are ongoing, can be highly beneficial to patient recovery and/or long lasting remission from illness. This submission proposes the Parliamentary Committee on Palliative and Compassionate Care recommend to the federal government that palliative care be integrated earlier in the patients’ treatment.

I. Introduction

It is frequently stated that palliative care is a poorly understood discipline. This misunderstanding results both from popular perception and current status quo. The oft cited World Health Organization (WHO) definition describes palliative care as “improv[ing] the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support...from diagnosis to the end of life and bereavement.”¹ The WHO further clarifies that palliative care “begins when illness is diagnosed, and continues regardless of whether or not a [patient] receives treatment directed at the disease.”² While the WHO indicates that palliative care commences at the illness’ diagnosis, such may not be the case in practice, and such is certainly not confirmed through medical literature.

Stages of Treatment

Consider that there are three stages throughout the prognosis of many patients diagnosed with potentially terminal illnesses. These stages are determined/classified by the primary aim of treatment.³ Respectively, the stages are curative, palliative, and terminal.⁴

The curative stage of treatment is characterized by a realistic chance of curing of illness, or at least placing illness into long lasting remission. At this stage, the survival of the patient is

² Ibid.
³ Note: The World Health Organization limits its definition of palliative care by classifying it primarily as cancer care. Palliative care is practiced in a wide range of illnesses other than cancer, typically considered terminal.
prioritized. While medical treatment may be a challenge, it is often lifesaving to the patient. While treatment may be considered difficult, it is provided with the understanding that benefit exceeds risk.

In many situations, the **palliative** stage of treatment (under current practice in Canada) commences when the likelihood of curing the patient is reduced. Palliative care often begins at the time when those professionals assigned to curing a patient consider "there is nothing more [which they] can do"\(^5\) to cure the patient. As a stage of treatment subsequent to the curative stage, palliative care is counterintuitive in medical practice because it requires medical professionals to prioritize care over cure.\(^6\) By providing palliative care at an earlier stage in the disease process, integrated palliative care allows for the provision of comfort measures, psychosocial and spiritual support alongside of potentially curative treatment.

Finally the **terminal** stage of treatment is characterized by all unnecessary treatments being withdrawn. These are the last days of the patient’s life. During this time, the only treatments provided are those required to keep the patient comfortable. During the terminal stage, palliative care seeks intently to neither prolong nor hasten the patient’s death.\(^7\) While the following is not the case, popular perception associates palliative care *exclusively* with the terminal stage of treatment.

**Confused Situation**

Palliative care as defined by the WHO requires that it be offered to the patient at the time of diagnosis. However, palliative care *in practice* is only introduced after the patient’s chance of recovery is unlikely. This may be the case that patients, families, and physicians may be reluctant to communicate the reality of the patient’s prognosis, should the patient’s likelihood of being cured lessen. Unless the disease is diagnosed at a very late-stage, there is no discussion of the possibility of death. Only with a late-stage diagnosis is acknowledgment of death communicated with the patient. However, palliative care can be integrated throughout the patient’s stage of treatment, when symptoms of the ongoing disease or side effects of treatment occur. Physicians normally do not give unrealistic expectations on curative treatment to patients particularly if disease is in the late stage.

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\(^5\) Ibid., pg. 21.

\(^6\) **Note:** In the context of palliative care as it is practiced currently, the emphasis of *care over cure* implies that techniques endemic to palliative care prioritize making the patient comfortable *over* the former priority of techniques practiced to make the patient healthy. While palliative care techniques are not necessarily detrimental to a patient’s health, they do not seek to alleviate disease, they seek to alleviate discomfort. Integrated palliative care as proposed, can seek to both alleviate disease and alleviate discomfort.

\(^7\) Ibid., pg. 32.
II. Proposal

There is often dissociation in practice between curative and palliative treatments. It is quite possible, and actually beneficial for palliative treatments and curative treatments to overlap. By its very nature of balancing risk with benefit, it stands to reason that palliative care is concerned with more than providing comfort measures during the process of dying. Curative treatments may be ongoing throughout the palliative process. Much of this is determined by the patient, physician, and family. Even if the likelihood of curing a patient lessens, quality palliative care may aid in achieving long lasting remission. Such will lengthen a patient’s life favourably. That is to say that an ultimately terminal-patient’s final months may be extended given the practice of quality palliative care. With the practice of quality palliative care, this lengthening of the terminal-patient’s life is experienced without significant decrease in quality of life.

Palliative care must be recognized as more than medical treatment. Administration of analgesic is only one part of the broad discipline called palliative care (albeit a significant component). For this reason, palliative care programmes in Canada will be strengthened through integration earlier into patients’ prognoses. Consider that palliative care is also concerned with the psychosocial and spiritual wellbeing of the patient. People of all walks of life benefit from psychological and emotional council. Assisting a patient in fortifying emotional and psychosocial wellbeing forms a bulk of palliative care’s portfolio. These expressions of care may be integrated at any stage. Earlier integration of palliative care with curative care is effective in providing ideal and holistic care for the patient. For the purpose of this submission, integrated palliative care refers to palliative treatment which is integrated with disease-modifying treatment. Simply put, integrated palliative care is palliative care practiced concurrently with the curative stage of treatment, and also those stages following.

Patients who receive curative and palliative care separately are more likely to experience a sense of abandonment by physicians. Furthermore, physicians may experience a sense of failure when illnesses become incurable. If palliative care is integrated throughout the curative, palliative, and terminal stages of treatment, the sense of purpose is amplified for patient, physician, and family.

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9 Ibid.
10 Ibid.
Professional Opinion

Integration of palliative care earlier into a patient’s prognosis is suggested by the University of Western Ontario’s University Hospital’s Palliative Care unit’s director Dr. Sharon Baker.\(^{11}\) Dr. Baker believes there is too wide a divide between curative treatment and palliative treatment. Dr. Baker believes that a more gradual transition into the palliative stage of treatment is required. Patients are likely to feel most hopeless during the palliative and terminal stages of treatment because palliative care is perceived as a last option, the final chapter. If palliative care is introduced earlier into the patient’s prognosis – during the curative stage of treatment – the patient will respond more favourably to the transition. This care must be interdisciplinary, multi-professional, and multifaceted even at its introduction. Finally, Dr. Baker suggested that hospital is the best venue for the offering of integrated palliative care.\(^ {12}\)

Advantages of Integrated Palliative Care

Consider that in hospital, palliative care can be best integrated earlier into a patient’s prognosis because of accessibility to multi-faceted care in that venue. In hospital, terminal patients can receive treatment which is curative and palliative concurrently.\(^ {13}\) Such treatment characterizes the integrated palliative care service proposed. Providing palliative care which is integrated earlier into the patient’s treatment schedule ensures patients receive timely and appropriate palliative care. This is achieved through integrated palliative care’s emphasis on coordination, control of symptoms, and continuity of care and treatment.\(^ {14}\) A patient’s earlier familiarity with palliative care procedure is of further benefit as such can ease the patient’s transition into more intentional symptom control care.\(^ {15}\)

III. Implementation

Palliative care is an acknowledged component of medicine and nursing, and not as alternate care. Palliative care must be provided even when curative treatment is provided, regardless of curative treatment’s success or failure.\(^ {16}\) Throughout a patient’s disease trajectory, communication

\(^{11}\) **Note:** While Dr. Sharon Baker has granted permission to the deVeber Institute to quote this material, Dr. Baker is not otherwise affiliated with the deVeber Institute.

\(^{12}\) Sharon Baker (Director of Palliative Care at London’s University of Western Ontario University Hospital/Health Sciences Centre), Telephone Interview. Interview conducted Monday, July 27, 2009.


\(^{16}\) Gwyther, pg. 517.
between patient, physician, and family must be prioritized. These three parties cooperate in management of symptoms and treatment. The physician is responsible for keeping the patient and family informed. Especially significant is communication of risk versus benefit of treatments during any stage. Integration of palliative care throughout a patient’s prognosis and treatment, coupled with the most intentional communication, cooperate to provide the best of palliative care, and offer the most realistic hope for patients.

Conclusion

Should the Committee find this submission useful, it is suggested that palliative care be implemented earlier with communication sessions between patient, physician/palliative care professional, and family. These communication sessions between a multi-disciplinary team, the patient’s physician, patient and family must be unique, in that they emphasize the physician’s role in educating patient and family with respect to the patient’s prognosis and treatment stage. Furthermore, these sessions should inform the patient of his/her palliative options, including introducing the patient to psychosocial support even during the curative stage of treatment. These sessions, and no doubt other improvements which the Committee will implement, will require the medical profession to adopt a palliative care philosophy in earlier stages of the disease process. Moreover, a significant increase in funding available to palliative care programmes is necessary. The goal of these sessions is to provide curative stage patients with palliative care options. Many curative stage patients are unaware of such options. Immediate implementation of these sessions will furnish curative stage patients with the knowledge of the palliative care to be made available. After introduction of psychosocial support, these sessions will naturally lead to the implementation of appropriate palliative care measures.

Palliative care cannot be viewed as exclusively a medical discipline. It cannot be overstated that palliative care is more than the provision of analgesics. All of the services provided through palliative care must fall under the umbrella of standard healthcare. Psychosocial support as well as pain and symptom management must be provided throughout the treatment stages. These advancements can only be achieved through increased funding to Canadian palliative care programmes. It is the hope of this Institute that palliative care can be improved in Canada so as to provide globally leading standards of care.

As a global leader in palliative care, Canada has no excuse but to toil tirelessly in developing a template for higher quality palliative care.

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18 Gwyther, pg. 517.
References

Sharon Baker (Director of Palliative Care at London’s University of Western Ontario University Hospital/Health Sciences Centre), Telephone Interview. Interview conducted Monday, July 27, 2009.


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