Letters

Are we overcomplicating the palliative care process?

The recent article published on palliative sedation in the *Australian Journal of General Practice* (*AJGP* December 2019) raised, but did not clarify, a number of issues that would be of concern to any general practitioner (GP) intending to continue in, and especially those considering starting to provide, palliative care in the community.

The first issue raised but not clarified is the relative frequency of patients requiring palliative sedation during their palliative care. The authors comment that the literature states that the percentage of people receiving palliative sedation varies from 1% to 88%.

I would have expected these authors – from a well-resourced palliative care service working within a tertiary centre – to be publishing their own data on frequency, which I would expect them to be keeping records of given their identification of this as an issue worthy of publication.

GPs working in a community setting may have a different frequency, but the lack of any relevant figure creates uncertainty for those of us intending to work in this area.

The bigger issue is the introduction of several pharmaceutical agents that are unlikely to ever be needed by a GP involved in providing palliative care in the community, including residential aged care facilities (RACFs).

I am an experienced GP of nearly 40 years working mainly in an outer metropolitan area with a sizable number of patients in RACFs and a small community hospital.

I have been supported by the local palliative care service publishing this article over that period, and attending ongoing education to maintain currency of my palliative care practices, which – including home, RACF and community hospital – can involve up to 30 patients per year.

The agents levomepromazine, phenobarbitone and propofol are not part of the essentials drug kit for palliative care carefully developed in recent years.

In my own experience of hundreds of palliative care cases, and in discussion with colleagues working in similar settings, these agents have not been necessary. Excellent palliative sedation has been consistently achieved purely with the essentials drug kit.

In fact, there has only been one solitary case out of these hundreds in which the essential drug kit was not sufficient to achieve adequate sedation. In that one case, levomepromazine was effectively added in a non-tertiary setting. There has not been any case in which phenobarbitone or propofol has been required.

Again I would like to ask the palliative care consultants involved to respond to the questions of what percentage of their patients either in the community or their tertiary hospice facility fail to achieve adequate sedation with the essential drugs?

Finally, I do accept that it is relevant to identify instances when we are purely providing sedation without any other intention than relieving the perceived or identified distress of our patient. However, over hundreds of palliative cases it has appeared to me in a primary care setting that providing just palliative sedation in isolation is rare, without the concurrent need to address co-existing symptoms of either a physical or psychiatric nature.

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References

1. Patel C, Kleinig P, Bakker M, Tait P. Palliative sedation: A safety net for the relief of refractory and intolerable symptoms at the end of life. Aust J Gen Pract 2019;48(12):838–45.

Reply

Thank you for inviting us to respond to the comments put forward by the reader [Dr Graham James Lovell] on 22 January 2020. We value feedback and appreciate the opportunity to clarify the points raised.

The case and discussion within the article discuss the context of a patient supported by a specialist palliative care service within an inpatient palliative care unit. Our intent in this article is to provide information for general practitioners (GPs) on the additional options that exist within the acute sector, for those patients with refractory symptoms that are difficult or unable to be managed.

We want to reiterate that this article is not intended to provide a guideline for GPs to use in the rare circumstances leading to the use of deliberate, continuous sedation for refractory and intolerable symptoms, nor is it an audit of the process. Instead, it is a review of this specific option for those rare patients in this situation. Additionally, it is important to reiterate the distinction between treating a symptom (eg anxiety or pain) at the end of life with proportionate dosages and the unintended but foreseeable consequence of sedating the patient, and the practice of deliberately sedating a patient with sedative (disproportionate) doses of those same medications. We would expect that even the most experienced practitioner in palliative care may never need to resort to this treatment and that any practitioner (even a highly experienced palliative care consultant) should make such decisions regarding deliberate, continuous sedation with appropriate collegial support and multidisciplinary evaluation.

We can share the reader's concern regarding the vague nature of the frequency of use of palliative sedation therapy, and the use of the non-essential medicines identified in the article (levomepromazine, phenobarbitone,

propofol) in the literature when compared with our own practice. As a service, we audit the frequency of deliberate palliative sedation therapy and openly acknowledge that this is an extremely rare event. We are cognisant that quoting numbers from one unit is unlikely to be useful given the international literature shows how variable the uptake of palliative sedation therapy is.

In writing this article for the community of GPs, our goal is to emphasise that a patient approaching the terminal phase of a life-limiting illness need not suffer a refractory symptom without any meaningful hope of relief.

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