

Reflecting on End-of-Life (Care)

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ABSTRACT

Near the end of my medical school training, I participated in a two-week elective on a palliative care consult team. I found the experience uniquely enriching, as it combined the physical and psychosocial aspects of medicine in a manner unlike most other fields of medicine. I observed and managed complications of terminal illnesses while also comforting patients - and their families - at the end of their lives. Reflecting on the experience helped me understand the privilege of being a healthcare provider, a worthwhile lesson that will stick with me throughout my career.

RÉSUMÉ

Vers la fin de ma formation en médecine, j'ai participé à un stage de deux semaines au sein d'une équipe de consultation en soins palliatifs. J'ai trouvé cette expérience particulièrement enrichissante, car elle combinait les aspects physiques et psychosociaux de la médecine d'une manière différente de la plupart des autres domaines de la médecine. J'ai observé et géré les complications des maladies terminales tout en réconfortant les patients - et leurs familles - en fin de vie. En réfléchissant à cette expérience, j'ai compris le privilège d'être un fournisseur de soins de santé, une leçon précieuse qui me suivra tout au long de ma carrière.

In my final year of medical school, I participated in a two-week elective with a palliative care consult team. Palliative care is a medical specialty geared towards improving the quality of life for patients with incurable illnesses, mainly through symptom-directed treatment and psychosocial support. I anticipated a rewarding experience but quickly learned that the service was full of unique medical and psychosocial learning opportunities that could help me in any field of medicine.

The service was like other medical consult services; we would meet in the team room, 'run the list,' round on our patients, and then see new consults. The consults were interesting because they were a challenge from both a medical and psychosocial perspective, almost like a blend of internal medicine and psychiatry. I enjoyed this because I could spend time getting to know my patients while also reviewing and managing complex medical issues.

I found both the medical and psychosocial aspects of palliative care unique compared to other fields. On the medical side, I would see the most extensive stages

of disease that exist in medicine and how they interact with common co-morbidities to produce and exacerbate symptoms. Although it was emotionally draining to see my third 'mets-to-the-brain' patient of the day, I still found the pathophysiology fascinating. 'Disseminated metastatic cancer with mets to bone and brain, chronic obstructive pulmonary disease (COPD), heart failure with reduced ejection fraction (HFrEF), hypertension, dyslipidemia, dementia ...' was not an uncommon identifier for these patients. I enjoyed the challenge of understanding a patients' various diseases and how they interacted to produce their illness; it forced me to use both my medical knowledge and critical thinking skills. Seemingly innocuous symptoms like shortness of breath quickly became a challenge to manage. I'd ask myself,

Is their dyspnea related to COPD, thus requiring puffers and supplemental oxygen? Or is it from congestive heart failure, and would they instead benefit from diuretic optimization? Is this really shortness of breath, or instead, a by-product of restlessness, related to pain from metastases to

bone, neurological compromise from metastases to the brain, or their underlying dementia. Would they benefit from opioids? Benzodiazepines? First-generation antipsychotics?

In most other patient populations, you could ask your patients to help elucidate the source of their symptoms, but many of our patients could not speak. Instead, I relied on non-verbal cues and nursing notes. Back pain from metastatic disease might look like restlessness, writhing, insomnia, or moaning. Agitation, physical aggression and numerous as-needed (PRN) medication use might instead reflect hyperactive delirium. Pruritus might look vaguely like itching but also present as agitation or simply a grimace/frown. Managing these symptoms was further complicated when being mindful of the patients' goals of care. I often found myself asking, "would this patient (and their caregivers) prefer to be more comfortable at the expense of being less awake and alert?" Symptom management in end-of-life care was often a very complicated medical endeavor but was incredibly rewarding when successful.

Beyond medical knowledge, palliative care demands strong 'soft skills'. Akin to psychiatry, the patient interview is both a means of gathering information and a therapeutic measure. I also noted how there could be a negative stigma towards the field and experienced the challenge of overcoming stigma to provide care. Many patients and families felt that accepting non-curative treatment meant giving up on life, even if treatment was unlikely to significantly prolong their life but very likely to leave them with uncomfortable symptoms. In my opinion, this is a feature of Western society where we fear death because we have extraordinary life-prolonging technologies. These technologies are so advanced that curative treatments have become our expectation, and with that, the assumption that we will retain our quality of life. In my experience, many patients don't recognize the importance of quality of life until it suffers, and in some cases, regained with palliative care. Physicians need to communicate this with patients, but having meaningful discussions around such a personal subject requires good rapport and a trusting relationship. 'Soft skills' also extend to interactions with patients' families, who sometimes feel like your own patients because of the support you provide. Families sometimes struggle to agree on clinical decisions, even when they are not medically indicated, such as keeping a nasogastric tube (NGT) in place for a dying

patient who does not want to eat. This leads to the ethical dilemma whereby you need to balance patient/caregiver autonomy with medical paternalism rooted in experience. You do not want a caregiver to feel that they gave up on their partner with dementia, but at the same time, you do not want your patient to be in restraints to keep from pulling out an NGT that is not benefitting them. The goal for caregivers at the end of life is to create as positive a life (and subsequent death) as possible. Handling the more difficult situations often involves assistance from the interdisciplinary team, including Social Work, Occupational Therapy, Physiotherapy, and Speech-Language Pathology. In some cases, an Ethicist is consulted, further adding to the unique challenge of providing palliative care.

My palliative care experience was incredible and one that I would recommend to anyone in medicine. I built upon my knowledge of pathophysiology while also working on the 'soft skills' that can't be taught in the classroom, all in a nurturing environment. I often hear others talk about the privilege of providing medical care, and my palliative rotation was the first in which I truly began to appreciate that aspect of medicine. Our patients were incredibly trusting of us, quick to share stories of their lives and their deepest worries, despite having just recently met us. For those that were at the end of life, they were choosing to use their last moments and dwindling energy to share their lives with us. The privilege of providing care exists in all aspects of medicine, but it took an experience in palliative care for me to understand it. Although I'm unsure if my future career lies within palliative care, the lessons learned and experiences had will apply to any field of medicine.