



Symptom control in palliative care: essential for quality of life

The World Health Organisation (WHO) defines palliative care as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering and the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

From this it can be seen that symptom control is one of the key elements in palliative care and that accurate assessment of symptoms and their causes is essential for good palliative care.

Debbie Norval¹ has researched the prevalence of symptoms in HIV care and in particular comments that international studies have shown that 80% of HIV-positive patients experience inadequate pain management. With this in mind, we recognise the challenge as clinicians to respond to the WHO charge for 'impeccable assessment and treatment of pain and other problems'.

David Cameron² has researched the use of sedation in managing refractory symptoms in a palliative care unit. The need for sedation in different circumstances is powerfully described in this paper. Many areas of potential confusion are highlighted and clearly defined: what is sedation, what is palliative care, what are 'intractable symptoms'? How do doctors balance the tensions between not prescribing a lingering death in dying patients, and yet not assisting patients in suicide?

Sedation may occur as a secondary side-effect from a particular course of treatment, acceptable following the doctrine of double effect provided there is clarity on the intent of initiating this course of treatment. The intended effect must be a good one. The bad effect may be foreseen but not intended. The bad effect must not be the means of bringing about the good effect and the good effect must outweigh the bad effect. This, however, should not be acceptable practice without discussion with patient and carers before initiation of treatment, thus respecting patient autonomy and protecting the patient against the risk of abuse of the doctrine of double effect. The other important ethical consideration is that of balancing benefit against risk and only initiating treatment if it is going to be of benefit to the patient. We keep in mind the goal to optimise comfort with adequate relief of symptoms for our patient and preservation of function in the face of the patient's deteriorating condition. Titration of the medication dose to relieve symptoms can achieve this goal without shortening life. David Cameron refers to studies documenting that there is no difference in survival between sedated and non-sedated patients.

Sedation may in some instances be a primary treatment for

intractable symptoms, or used, for example, in managing massive catastrophic haemorrhage, which is often a terminal event where it is not appropriate to resuscitate the patient.

Use of sedation should be a management plan undertaken after all key features of a particular case have been considered; it should never be done as part of a protocol or pathway but as individualised management. One of the key features of palliative care has been meticulous attention to detail in patient care. For any symptom, attention to reversible causes is vital in the decision making process, irrespective of the stage of illness. Palliative care should not be a passive withholding of treatment; for many it requires intensive review and decision making. Attention to patient and family wishes is vital in the provision of holistic care, focusing on quality of life. Patients have a right to relief of intolerable symptoms and to choose their treatment option.

Palliative care is the holistic care of patients whose disease is no longer curable. It is not simply care of patients as they die; it can be applicable at any stage of incurable illness, with the focus of care being to enhance quality of life. Debbie Norval makes the recommendation that the false dichotomy of curative versus palliative care needs to be supplanted by a more integrated model of care.

Key characteristics of holistic care are a continuing need for skilled application of clinical medicine, a profound understanding of ethical principles and exemplary communication skills.

Training in palliative care for health care professionals will equip us to manage the symptoms of terminal illness effectively, and with the relief of physical and psychological symptoms we are able to ease the distress of both patients and families facing the diagnosis of terminal illness.

As palliative care develops further, audit and research will provide a timely evidence base and information on service evaluation. Debbie Norval's and David Cameron's articles are a valuable contribution to the foundation of evidence-based medicine in the field of palliative care in the South African context.

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1. Norval DA. Symptoms and signs of pain experienced by AIDS patients. *S Afr Med J* 2004; **94**: 450-454.
2. Cameron D, Bridge D, Blitz-Lindeque J. Use of sedation to relieve refractory symptoms in dying patients. *S Afr Med J* 2004; **94**: 445-449.