Introducing oncology registrars to palliative care

Sir,

About 350,000 patients in India suffer from cancer pain, and one of the stated aims of the National Cancer Control Programme is to provide pain relief and palliative care. But few oncologists in the country have formal training in palliative care and only a small proportion of terminally ill patients receive skilled pain management.

Instead, a significant number of patients dying in hospitals have investigations and interventions that are futile and expensive. Earlier in the illness trajectory too, many families incur large debts to finance expensive palliative chemotherapy, often under the mistaken impression that a cure or sustained remission will be attained.

There are many reasons why such practices continue in a country with limited health care resources. These include inadequate knowledge about palliative care, as well as a lack of reflection on ethical concepts of futility and the need to balance the benefits and burdens of a suggested course of treatment. Another problem is that of poor communication between doctors and patients. Most training programmes in India do not include teaching on communication skills and palliative care.

We arranged for radiation oncology postgraduate trainees at the Christian Medical College, Vellore to have a one-month placement in palliative care. The learning objectives were pain management, communication skills and decision-making at the end of life. The registrars were given handbooks and guidelines on these clinical and ethical issues. They were given opportunities to observe consultations where prognosis and treatment options were discussed. They then applied these communication skills to other patients, discussed the clinical encounter with the consultant and reflected on how they could improve their own communication skills. The importance of active listening was stressed.

For example, when meeting a patient with incurable malignancy, registrars were encouraged to learn about the family tree, economic status, the patient’s understanding of his/her illness, and expectations from treatment. They were asked to discuss prognosis, so that the patient and family were aware of the benefits and burdens of treatment; palliative chemotherapy in a patient with incurable lung cancer could improve median survival by a few months, but at significant cost. Such discussions often helped patients to make an informed choice relevant to their financial situation and personal priorities. Families were given time to discuss psychosocial concerns.

The patient’s pain and symptom control needs were addressed in accordance with literature guidelines. When registrars worked with patients who were very close to death, ethical issues that were discussed included the scientific use of opioids for palliating terminal dyspnoea and how this differs from euthanasia; and the need to weigh benefits and burdens before performing investigations and interventions in those dying of advanced malignancy. Some registrars also made visits to see dying patients in village homes. For them, this was a sensitisation to the problems the family experienced in caring for a dying patient in a poor home, and the difficulties involved in travelling long distances to hospital.

The value of the posting was ascertained through individual interviews at the end of each registrar’s placement, and through an anonymous feedback form after the first six registrars had completed this programme. On a 0-10 scale the mean ‘value’ scores were pain management (8.3), communication skills (8.5), reflective case study (8), and thinking about appropriate versus inappropriate interventions (8). All six registrars felt that this introduction to end-of-life care was very relevant to their oncology training.

Areas that many found emotionally difficult were not being able to help patients with social and financial problems and refractory symptoms. The majority however did not find it difficult to avoid doing investigations and interventions they would have routinely done before the placement. In fact, for many, one of the valuable aspects of the placement was learning to question the relevance of futile interventions when the patient was terminally ill.

The clinical work was largely within the oncology department of a teaching hospital. Palliative care training in this setting is probably more relevant to future oncologists than in the special environment of a hospice. We hope that such an arrangement will promote better integration and understanding between oncology and palliative cancer care. We also feel that some experiential training in palliative care, ethical decision-making and communication skills would be of relevance to postgraduate trainees in other clinical disciplines.

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References

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