



Killing George with kindness

Is there such a thing as too much palliative care?

Geoff Mitchell, MBBS, FRACGP, FChPM, is Associate Professor, Discipline of General Practice, University of Queensland. g.mitchell@uq.edu.au

Early referral and anticipatory planning are central tenets of good palliative care. Each case, however, needs to be considered on its merits. Too many supports put in place at the wrong time may have adverse consequences for some patients. A clear understanding of the patient's understanding of their illness and prognosis, and appreciation of their mental state at each stage, are important in determining how much palliative care is enough.

One of the tenets of good palliative care is that the anticipation of problems will minimise or delay their impact. It is often easier to prevent symptoms than it is to rein them in. Preparation for the more debilitating phases of illness is a common reason for early referral to palliative care services, indeed, this is encouraged. In addition to symptom control, such preparation includes the patient getting to know the team, appropriate equipment being made available, and contact being established with relevant experts such as therapists and pastoral care workers. It is simply accepted that this is a prudent and good practice. But is it possible to have too much of a good thing?

The case

George was a 72 years of age and suffering from mesothelioma. Six months before diagnosis he developed vague, right sided chest pain which persisted and steadily worsened. He was investigated for atypical ischaemic heart disease and cholecystitis by his former general practitioner before a chest X-ray was finally ordered. Based on the abnormalities seen, mesothelioma was diagnosed by a respiratory physician who continued to review the patient, but who left pain control to the GP. Unfortunately, the prescribed combination of paracetamol and

codeine medication was not adequate. After several weeks of slowly increasing doses, George was changed to a low dose of long acting morphine. He was still in pain and his bowels had not moved properly in weeks – he had not been prescribed a laxative. Night time pain was particularly troublesome and sleep eluded George, who was highly anxious. In spite of this, he continued to lead a reasonably active life.

I first saw George in March, and reviewed his situation weekly. It took 8 weeks before a combination of adequate oral analgesia (with input from a local palliative care specialist) and a recently discovered chemotherapeutic regimen arranged by the respiratory specialist improved his symptoms.

He was a proud man, quietly spoken, who was always meticulously groomed and thoroughly prepared for his consultation with written records of pain medication dosage and timing, and bowel movements. He was clearly a man who liked to be in control – his out of control state distressed him. George was happily married with three adult children. He was loved and respected by his family, who shared his desire to be as prepared as possible for what was to come. At their insistence, palliative care services were called in early including an occupational therapist (OT)

to assess the adequacy of the house for a dying patient. I was a little reluctant to bring them in while he was still so active, but could not change their minds.

One Thursday he arrived for his consultation and for the first time in months he reported no pain. His wife was delighted, as was I. George seemed somewhat flat, and didn't share in the uplifted mood of the moment. The OT had measured the house for handrails and bathroom modifications on the Monday, and George's wife reported that he had been somewhat sombre after her visit. I made a mental note to check next time to see that his chronic depression was not worsening. My parting words to him were: 'You have a window of opportunity now George, make the most of it'.

That Sunday, George hanged himself. He had spent the morning tidying up the house and sweeping leaves from the garden paths. When his wife went to make lunch, he went to his tool shed, locked the door from the inside, nailed sheets up over the windows, and hung himself from the rafters (not before putting an opaque plastic bag over his head to hide the grisly sight from his wife). He left a distraught and bewildered family.

Discussion

George's final act could be interpreted in several ways:

- George was depressed and suicidal but never told anyone of the depth of his distress
- the OT's visit confronted him with what the rest of his life was going to be like. He could see disability and dependency looming, and could not face them, and/or
- he suddenly realised that the final months meant hard work and heartache for his family, and he wanted to spare them that particular distress.

My interpretation was a combination of the second and third point, with perhaps more of the latter. It was clear what the lack of response to his pain free state meant: he realised that, even though he was pain free and less breathless, this was as good as it was going to get. Could George avoid what he was about to suffer?

I believe the OT's visit was the pivotal event leading to the realisation of the true nature of his imminent lot and triggered the determination to end his life on his terms.

Is there a 'right' time to involve palliative care? Is palliative care everything at once or can it be built up piece by piece? The patient's hopes and aspirations, level of symptoms, understanding of their disease and prognosis, and desire to fight the disease, all have parts to play in making the judgment of when to invoke palliative care, and in what way. How do we balance the needs of the family to do their utmost to make the patient comfortable, with the sometimes contrary views of the patient? I never had the chance to see George on his own – his wife or daughters were always with him. In retrospect, I should have done so to find out what he really thought about his family's actions.

George's last act was probably one of love toward his family, who in turn had loved him too much. Hindsight is a wonderful thing.

AFP

Correspondence

Email: afp@racgp.org.au