Meeting the challenge of palliation beyond cancer

Hospices provide excellent care for people with cancer, but are not set up to meet the needs of the increasing number of patients who die of other diseases. How can palliative care specialists help patients with other advanced illnesses? We can help hospital doctors and GPs identify when their non-cancer patients might benefit from a palliative care approach, and support them to provide top quality end-of-life care in hospitals, care homes and at home. A minority of patients will directly need the services of a specialist palliative care physician or nurse.

In a recent poll in the *British Medical Journal*, readers were invited to vote for the area of healthcare in which doctors could make the most improvement in the next few years. From 200 candidate areas, six were shortlisted and 'palliative care beyond cancer' emphatically won the vote.[1] There is a great unmet need for palliation beyond cancer. The average UK family doctor has around 20 patients who die each year, but only five die from cancer. Six die from various organ failure illnesses – such as heart failure, chronic obstructive pulmonary disease and renal failure – and seven die from physical or cognitive frailty. Yet more than 90% of specialist palliative care currently relates to cancer patients. There are valid historical reasons why this is so, but the article in the *BMJ* highlighted that it is now time to palliate beyond cancer. This is because there is an increasing research base, and because concepts around illness trajectories let us predict multidimensional distress and understand how services might better be aligned with needs.

So what can we do as palliative medicine specialists? The secret is to realise that, in many European countries, behind every palliative medicine specialist, there are around 70 family physicians and around the same number of hospital doctors who all treat patients with advanced diseases. Thus our most strategic role will be educational and supportive. We should influence medical undergraduate and postgraduate training, and continuing professional development, so that all doctors should be able to facilitate a good death. We must help GPs identify, assess and plan for patients who would benefit from supportive and palliative care. Identifying patients can be difficult, but sentinel events – such as hospital admission for heart failure, the 'surprise question' or disease-specific clinical indicators – can be used pragmatically in the generalist setting to do so. The surprise question ('Would you be surprised if your patient died in the next 12 months?') is increasingly used by some GPs and hospital doctors. If the answer is no, then the patient should be considered for supportive and palliative care.

We should also run courses to help generalists assess and communicate with patients once they have been identified, and help them to consider instigating advance care plans that would include where the patient would like to die.

The current challenge is really a call to support and train generalists in the principles of palliative care, so that they can provide holistic and anticipatory care to all their patients. As well as helping them with a framework of care, this approach will help us promulgate core vocational clinical skills: active listening, respecting each patient as an individual, empathic care. Emphasising these as basic clinical skills in dealing with people at the end of life will foster good patient-centred care.

We should not feel overwhelmed but look to help all our generalist colleagues provide palliative care in the community and in hospitals, while we concentrate on providing specialist interventions and hospice care when needed. 'Palliative care for all' is a reasonable clarion call, just as 'health for all' has been in the past 30 years.

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Reference
1. Murray SA, Sheikh A. Palliative care beyond cancer: care at the end of life. *BMJ* 2008; **336:** 958–959. See also http://makingadifference.bmj.com (last accessed 23/07/2008)