

ESMO Palliative Care Fellowship

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Gaurav Kumar

FINAL REPORT

Home Institute: Tata Medical Center

Host Institute: Alaw Unit, North Wales Clinical School

Introduction

Palliative care is a specialised form of medical care for people with life limiting conditions, focusing on excellent symptom management and support for patients and families during a time of immense stress whatever the diagnosis may be. Palliative care is now thought to supplement, rather than be mutually exclusive of ongoing treatment of the underlying disease. As people live longer, they are also more likely to develop numerous health conditions, which may include cancer, and thereby multiple co-morbidities are becoming the norm to manage.¹ Palliative care is a holistic approach to care and support, and takes into account emotional, psychological and spiritual needs as well as physical needs of patients. Good symptom control is central to the concept of palliative care and freedom from pain and other symptoms allows people to live with as good a quality of life as possible. Cancers figure among the leading causes of morbidity and mortality worldwide, with approximately 14 million new cases and 8.2 million cancer related deaths in 2012. It is expected that annual cancer cases will rise from 14 million in 2012 to 22 within the next 2 decades.² This has significant implications for how services are organised, as models of care based on specialisation around a particular condition may not be appropriate to multiple needs and individual wishes. To meet the needs of patients and their families, providing palliative care at home is the need of the hour. Palliative care at home embraces what is most noble in medicine: sometimes curing, always relieving and supporting right to the end.³ Palliative care in the community has been regarded by many healthcare workers as the best form of medical care, bringing together the clinical, holistic and human dimensions of primary care. ⁴ The community based primary care physicians know their patients well and are in key position to provide the best support for them and their families at the most crucial stage, with backing of specialist palliative care.⁴ However, due to a number of reasons e.g. inadequate advance care planning, breakdown in communication, difficulties in symptom control, sudden change in symptoms (including medical emergencies), non-availability of specialist advice during out of hours, lack of care support to provide hands on care, community based palliative care can break down or work sub-optimally. Hence, strengthening community based palliative care services is vital part of integrated palliative care, with the potential to reduce hospital admission rates, both for malignant and non-malignant diseases

Goals or aims

Through this observership my goal was to develop a better understanding of organizing care for patients with cancer who are receiving palliative care in specialized in-patient settings as well as in the community. My major goals could be outlined as: 1. To broadly learn about symptom management in a Palliative care unit in United Kingdom. To learn and discuss regarding the recent changes in clinical practices while making decisions for patients in the terminal phase of their disease. I also intended to learn the art of collaborative decision making, emphasizing 'priorities' over 'pathways' using standardized decision tools and methods³. To know various training methods used for training in palliative care for on-specialist clinicians⁴. Exposure regarding simple audit standards that could be used for bench-marking palliative care services

Description of the time spent at host institute

I started my fellowship in the Palliative care department of Alaw unit, Ysbyty Gwynedd, Bangor on 10th of November 2016. My mentor Dr Gemma Lewis Williams greeted me at the entrance of the hospital and was very kind to take me to a short tour of the ward and hospital. We discussed regarding my learning objectives and we formalised a plan as to how to meet majority of my goals. Dr Gemma introduced me to the Palliative care team which included Dr Elizabeth Williams, Associate Specialist and Dawn, Mike and Mel who were Palliative care specialist nurses stationed at Ysbyty Gwynedd. I was thrilled to know regarding the strong community based network that palliative care had in North Wales. Dr Gemma gave me a holistic idea regarding the organisational framework of healthcare in North Wales. North Wales had 3 hospitals based at Wrexham, Rhyl and Bangor. All the three centers were very well connected and patients were treated jointly across various specialities. Across North Wales, there are three hospices, all of which receive some funding from the National Health Service but are largely funded by charitable donations. Palliative care Unit at Ysbyty Gwynedd was linked to St David's hospice, Llandudno and also to a community hospital at Caernarfon. As a routine, the palliative care MDT was held every Tuesday and for the hospice inpatients every Wednesday in St David's Hospice. My introductory meeting with Palliative care team was followed by a short Induction into the general policies and information about the hospital by Ms Cheryl Hindson. She was kind enough to show me around the various wings of the hospital. Ysbyty Gwynedd is a 300+ bedded referral hospital and caters to a large population in North Wales. I also got myself registered in the library which has a fabulous collection of books and a friendly and helpful librarian. From the next day onwards, my routine started with a Carcinoma of Unknown Primary (CUP) MDT at 8:30 am. As part of the integrated oncology team, palliative care team attends all the cancer specific MDTs, Palliative care representation is expected as part of National Cancer Standards. Cancer MDTs were organ specific meetings which included experts from all clinical specialties across oncology e.g. Medical Oncology, Clinical Oncology, Radiology, Onco-pathology and Palliative Medicine, site-specific surgeons and medical consultants. All cases were discussed and a decision plan mapped out based on common agreement underpinned by national standards of care. Minutes of the meeting were documented and distributed amongst all the attendees. On Tuesdays, the palliative care MDT was scheduled at the community

hospital at Caernarfon. It was half a day's meeting subdivided by the acute hospital MDT and followed by the community MDT. The latter MDT has input from the grass root level work force including the hospice at home nurses, health care support workers, occupational therapists and doctors. Hospice at home nurses would visit the homes of patients who were referred to the palliative care team and provide basic consult with help from the General Practitioner and/or palliative care doctor. All the visits were documented and discussed in the weekly MDTs wherein a further plan for better care of the patient was charted out. It is recommended that all GP practices hold dedicated palliative care registers and have regular palliative care meetings with district nurses and the hospice at home team. On Wednesday, I attended St David's hospice at Llandudno (situated 20 miles from Bangor). St David's hospice is a charitable hospice which has been functioning since the 1999. It has 12 beds for the nursing and medical care of patients under palliation and provides care for both malignant as well as non-malignant cases. Dr Helen Mitchell and Dr Gemma provide consultant level cover and there are 3 doctors who provide cover Monday to Friday 9-5 pm. It was amazing to see how efficiently the hospice was serving the community by caring and supporting patients who were nearing the end of their lives. St David's hospice also had one respite bed which was for patient's caregivers who could leave the patient for a week's time and take a break from the routine care. I also had the opportunity of meeting the Chief executive officer of the hospice and discussed with him the logistic barriers of running a hospice. During my attachment I was able to get some experience of non-malignant disease such as Motor neurone disease, heart failure, end-stage renal disease. This was a good learning experience for me as Palliation in India is mainly limited to cancer. I also had the opportunity to discuss the National End of life care guidelines used to guide palliative care in any care setting (hospital, home, nursing home). Every first Wednesday of the month was scheduled for motor neurone disease clinics. Dr Elizabeth Williams is the lead for MND and runs the MND clinic and MDT. Patients were assessed by Dr Williams along with other specialists, including Occupational therapy, Physiotherapy and speech and language therapy and dieticians. This was followed by a counseling session during which patients and their caregivers were counseled regarding the disease course and the line of management and support to be provided. A plan was formulated to organize future care of the patients to make them as independent as possible so that they are able to carry on their ADLs with ease. I should also note that I was also able to participate in study days focusing on motor neurone disease, palliative care training for the general physicians and the legal and ethical aspects of end of life care.

Conclusion

My interactions with the Palliative care team at Ysbyty Gwynedd, Bangor was extremely beneficial with lots of things to learn. I was allowed to participate in all the inter-departmental meetings of the hospital and also in the various counseling sessions that consultants had with patients. This exposure has given me a new outlook that I shall implement in my practice of palliative care in my home country. I had a wonderful time during my 4 weeks at Wales and feel that I have learnt what I had intended to. I thank ESMO and the Palliative team at Ysbyty Gwynedd for granting me this opportunity to enlighten my knowledge in palliative care and use the skills acquired to empower Palliative care in India.

Acknowledgements

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