Palliative care in the 21st century

AUSTRALIA LEADS THE REST OF THE WORLD in developing the relatively new medical discipline of palliative care. Two of the many reasons for this are behind the genesis of this supplement:

- the mutually supportive relationship among the diverse centres for delivery of palliative care; and
- the high level of government support for palliative care initiatives over the past two decades.

The supplement is jointly sponsored by the Australian Department of Health and Ageing and by Palliative Care Australia, an independent body representing all the states and their numerous palliative care institutions and programs. The supplement seeks to inform the health professions of the status of palliative care in Australia and to stimulate interest in the philosophy of palliative care among healthcare professionals, many of whom may be involved in the care of people dying from advanced disease.

Specialised palliative care teams are composed of a range of medical, nursing and allied health staff and volunteers.[1] While they are directly responsible for the care of a relatively small number of difficult patients, their principal role, for the majority of patients, is to support and encourage the care provided by primary and specialist healthcare services, to help assess the physical, emotional and spiritual discomforts of people with advanced illness, and to frame comprehensive and practical suggestions for care. A palliative approach can be adopted by every potential carer to help patients, families and carers work with the reality of imminent death and achieve the best outcome for all.[2,3]

The benefits of palliative care are not limited to the final days and weeks of dying. Palliative care is relevant to managing symptoms in many clinical situations and can contribute to care decisions early in the course of any eventually fatal illness (eg, advanced respiratory, cardiac or neurological conditions; HIV-AIDS[2]). It can enhance the wellbeing of people in aged-care facilities who, approaching death, risk being inappropriately transferred to an acute-care hospital and dying away from the place they regard as "home".

Palliative care physicians are generalists, comfortable in sharing care responsibility with medical and radiation oncologists, surgeons and other specialists, general practitioners, hospital and community nurses and allied health workers in hospital, home or hospice settings.[3] Of particular importance are the interactions with GPs and with staff of aged-care facilities.[4]

Academic units in palliative care have encouraged both medical Colleges and university medical schools to promote palliative care as a discipline in its own right and have gradually made important contributions to the discipline's evidence base.[5]

Specialist palliative care nurses are expert managers, assessing individual, family and home-care needs and taking action to ensure that such needs are met. They support and enthuse their generalist colleagues in positive and practical approaches to care. Some are skilled at defusing family tension or in caring for the desperately ill child or the young family coping with bereavement.[6] The quiet confidence emanating from a well trained nursing colleague can sometimes do much to calm seemingly frantic or impossible situations.

Allied health workers in palliative care exercise their skills in particular ways. Physiotherapists may give gentle massage; pastoral counsellors help with life review, and psychologists with assuaging anger and denial; social workers establish bereavement care or welfare support for affected family members; while volunteers are a vital pillar of many palliative care programs, reminding us of the importance of human support in dying.

The teamwork evident in palliative care management is a model that many other disciplines regard with envy.[2] In palliative care, the hierarchies of medicine are diffused; the value to the patient of the careful nurse, the attentive volunteer or the sensitive pastor may well exceed that of a physician's prescriptions. Team care is comprehensive and continuous, addressing the full range of discomforts and suffering of patients and their families and friends, avoiding the gaps in support that can arise through changing phases of illness or sites of care. Potential barriers between hospital and home care are minimised by comprehensive discharge planning and the willingness of many team members to work wherever care is required and to facilitate home deaths where possible and desired.[7]

A recently compiled national planning guide for service provision, with suggested standards for the palliative care workforce and facilities,[8] exemplifies palliative care's innovative approach to promoting frugal and effective best practice.[8]

Palliative care has engaged successfully with complementary therapies, finding value in simple, safe techniques without abandoning a critical stance.[9] New uses for old drugs and uncommon uses of drugs used in other fields of medicine can improve comfort for dying patients.[10] The delicate and difficult matter of sexuality for old, frail or sick people is faced with a cautious and sensitive openness.[11] Openly acknowledging spiritual need in patients may allow family members and also staff to begin to contemplate the awe and mystery of death.[12]

Palliative care still has a long way to go in areas such as improving services to Indigenous and ethnic communities,[13,14] increasing regular contact with aged-care facilities, and accumulating an evidence base for palliative therapies.

The contributors to this supplement are all leaders in the field. They invite your interest and encourage you to participate in ensuring that care of Australians with terminal illness is managed with skill, sensitivity and confidence.

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