VIEWPOINTS

Palliative Care Is Everyone's Business, Including Pharmacists

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The one assured outcome of a person's life is that it will end, and in developed countries there is a high probability that death will occur with warning as a result of chronic disease or malignancy. Public health initiatives and scientific advancements have us living longer and living and dying differently than in centuries past. An increasing burden of chronic disease and an aging population bring growing demands for palliative care, seeing it expand beyond end-of-life cancer care to a broad practice that is independent of diagnosis. To meet this social need, strategies have been implemented at individual and population levels to integrate principles of palliative care across disciplines and care settings, promoting palliative care as "everyone's business."¹

Concurrent to changes in palliative care, primary health reform has resulted in more patients being cared for and dying in their home or community-based facility. Pharmacists care for patients with palliative needs from the beginning of their career, making the principles of palliative care an essential component of a robust pharmacy education.

Optimizing medication-related outcomes is one strategy to assist a person with achieving their end-of-life goals. These goals are inherently subjective and relate to optimizing function in all domains of personhood. That is, all of the elements that provide a person with their sense of self, including physical, psychological, social, existential, and financial. Depending on a person's position on the disease trajectory and their overarching goals of care, drugs may be prescribed to actively treat disease, reduce or eliminate symptoms, stop or slow a disease process, or prevent a disease or symptom. A patient approaching the terminal phase who does not wish to have life-prolonging measures may elect to have antibiotics to treat their symptomatic urinary tract infection but not to have antibiotics to treat a recurring episode of severe pneumonia.

Reportedly, 20% of people take at least 8 medications at the time of referral to a specialist palliative service. Currow and colleagues found that among the majority of people admitted to palliative care services, the number of prescribed medication increased as death approached, with reductions in long-term medications often surpassed by initiation of drugs for symptom management.²

People's right to access adequate medical care applies whether they have 60 years or 60 minutes to live. Frail and vulnerable people have diminished capacity for withstanding insults such as adverse drug reactions and their risk for iatrogenic harm is increased. Limitations of time and functional capacity require efficient optimization of drug therapy, balancing benefit and risk in the context of a changing clinical picture to ensure prescribed medications remain appropriate and a person's period of functional independence is maximized.

Prescribing ineffective medication, even without adverse effects, represents significant workload for a person who is managing a complex therapeutic regimen. This includes drugs prescribed in the knowledge that "time to desired outcome" exceeds the patient's prognosis, such as primary prevention. Gallacher and colleagues explored patient-reported components of treatment burden in chronic heart failure.³ They identified and described 4 components of patient "work" relating to burden of treatment rather than the illness itself: learning about treatments and their consequences, engaging with others to organize care, adhering to treatments and lifestyle changes, and monitoring treatments. Medication use contributed significantly to this workload, suggesting actions that promote rational prescribing could positively impact these patients' overall quality of life.

Many medications for chronic conditions are continued in spite of changes in a person's condition or prognosis that may render the initial intentions unnecessary or inappropriate. Changes in body composition and eating habits may impact blood glucose levels, requiring adjustment of diabetes management such as frequency and targets of monitoring and appropriateness of medication indication and dosage.

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Cessation of long-term medications often occurs as a result of suspected adverse drug reaction or loss of the oral route of administration rather than planned care. Unconsidered cessation or dose reduction of long-term medications carries potential for both physiological and psychological harm. Pharmacists are well placed to promote proactive review of pharmacotherapy and facilitate discussion with patients to reset therapeutic goals to ensure they understand reasons for, and are happy with, any proposed changes.

Pharmacotherapy is a key treatment modality for managing symptoms such as pain, dyspnea, nausea, and confusion – all commonly experienced by palliative patients regardless of underlying disease. The heterogeneous palliative care population are often excluded from clinical trials; the best available evidence may therefore be principles-based application of pharmacology, physiology, and understanding the experience of the patient in front of you. Interpreting this “grey” evidence base requires pharmacists to apply both technical and humanistic knowledge and skills.

Outcomes of even the most well-designed medication regimen are ultimately determined by a person’s understanding and implementation of a therapeutic plan. Around half of patients do not take their medication as directed. Up to two-thirds of nonadherence represents specific decisions and actions of patients to alter their medication regimen, demonstrated across patient groups and conditions including advanced cancer.⁴ Schumacher and colleagues’ 2002 qualitative study found that cancer patients for whom adequate pain regimens had been prescribed often had difficulty using them to their full potential. The authors proposed that coached problem solving that meets the patient’s needs could fully or partially resolve most of the issues identified.⁵

All domains of personhood potentially impact a patient’s use of medication. Concern about symptoms may be outweighed by concern about addiction, side effects, or how it looks to be taking lots of medicines. As a result people with severe symptoms may not use medicines even when effective management is available. Pharmacists have an opportunity to positively influence medication taking behavior and improve patient outcomes.

Team-based multidisciplinary care is considered integral to palliative care because of the complex biomedical and psychosocial needs of palliative care patients. Effective collaboration requires pharmacists not only to contribute skills and knowledge, but also recognize and enhance contributions of other team members. Similar to palliative care, optimizing medication outcomes is “everyone’s business.” All health professionals play a role in medication management and influence patients’

medication experience. Pharmacists must understand their role in creating a system that supports effective medication use in addition to providing individual patient care.

The issues we have outlined are not unique to pharmacists practicing in palliative care. Ongoing optimization of drug therapy to ensure medication regimens and therapeutic goals remain appropriate is necessary throughout a patient’s life. Sound understanding of the principles underpinning pharmacotherapy is essential to critically interpret and put evidence into practice. Respect for patient autonomy and right to self-manage is equally fundamental to evidence-based clinical practice; “an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.”⁶ Finally, achieving optimal patient outcomes on a broad scale requires pharmacists to effectively collaborate and actively participate in interdisciplinary healthcare teams.

Palliative care is “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”⁷ Consider this alongside pharmaceutical care; “the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life.”⁸ Both practices intrinsically require clinicians who demonstrate cognition, humanism, and effective collaboration.

Palliative care provides an ideal setting to explore issues relating to pharmaceutical care that can be challenging to address in pharmacy education, such as the complexities of clinical decision making, patient-centred care, and working effectively in healthcare teams.^{9,10} A pharmacy education program that develops pharmaceutical care providers will by nature prepare pharmacists for roles in palliative care; pharmacists who value acquisition of humanistic skills as much as technical expertise.

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