Approaches to palliative care

Palliative approach refers to the provision of a holistic care for patients who are no longer responsive to curative treatment and dying. The approach provides primary care services to improve the quality of life of the dying patients through addressing pain and other distressing symptoms and integrating physical, psychosocial and spiritual care to ensure a good death for the patients (Koutoukidis, Stainton and Hughson 2013, p. 865). It also offers support for families of the terminally ill patients to cope with grief and bereavement in the end-of-life stage of the patients (ACT Health 2014). In palliative care, nurses are directly involved in ensuring a holistic care for the patients and liaising with the patients’ families. They deal with pain relief, provide emotional support for both the patients and families and communicate the patients’ disease conditions with other care specialists through regular team meeting and clinical discussion. They also carry out assessment, care plan and bereavement follow up with families and friends of the patients to help them cope with grief and loss (Tasmanian Palliative Care Service 2013, p. 9).

An advanced care directive is a written statement about the wishes of the patients regarding their medical treatment choices and future health care. It is a way that individuals, especially those who are in chronic or life-limiting condition like Mr. Guzman, communicate their wishes to the carers when they are unable to make decision on their health care choices, which can help avoid unwanted treatment and reduce family stress in any emergency situation (The Advance Care Directive Association 2012). The advanced care directive is implemented within the legal framework of Victoria. The Medical Treatment Act 1988 allows the patients to refuse medical treatment that are not consistent with their cultural or personal beliefs in most of the circumstances, and The Guardianship and Administration Act 1986 enables the patients to appoint an enduring guardian to make decision on their health care (Victorian Department of Health 2014, p. 53). According to the Victorian legislation, medical practitioners must usually seek for the patients' consent regarding their health care choice in the advanced care directive before providing any medical treatment to the patients (Victorian Department of Health 2014, p. 54).

The current best practice regarding pain management for palliative care patients consists of both non-pharmacological and pharmacological approaches. The non-pharmacological approach in palliative care is primarily enabling the patients to regularly access to family members or religious leaders to ensure their psychological, spiritual and religious needs are met. This approach may help address the emotional components of pain and improve the psychological wellbeing and physical health of the terminally ill patients (Hughes 2012, p. 26). Pharmacological approach involves using drug therapies to effectively manage the pain. Hughes (2012, p. 25) suggests that the first attempt of analgesia may not be able to fully control the patients' pain, and ongoing commitment to assess and adjust the pain control technique can give the patients confidences, which thereby reduces pain. Therefore, patient-centred care is important as it enables health practitioners to assess and decide on specific doses and forms of analgesia that should be given to the patients. It is also mentioned that health practitioners do not normally use opioid analgesia to their full potential though they are safe and cost effective medications. For effective pain control management, does, duration of treatment and the patients' current condition, such as renal and hepatic function, should be taken into account to ensure the patients receive adequate pain relief with less side effects (National Institute for Health and Clinical Excellence 2012).

Filipinos believe in bahala na, which means leaving one's fate to God. They also believe that a person's suffering is the God's will, and only prayer can save the person's life. Families and friends of the dying patients should, therefore, pray for the patients rather than discussing advanced care directive and terminal prognosis with them as it frustrates the patients and makes them feel hopeless. Discussing end-of-life issue with the patients is also believed to bring unwanted outcome to the patients' health condition (Mazanec and Tyler 2003, p. 54). Such attitude to dying conflicts with modern health practices in which the dying patients are provided with full disclosure of the fact of illness and treatment and are able to make decision on their future health care. Patients with Filipino decent may also want to die at home or die in their home countries. Those who are catholic may require a priest to perform ' sacrament of the sick' and may not allow the nurses to wash their dead bodies, making it difficult for health professionals to provide holistic care for the patients before and after death (Mazanec and Tyler 2003, p. 54).

When a person is dying, numerous common symptoms may occur in the last day or the last few hours before death. Confusion and delirium may usually occur during the end-of-life stage due to metabolic and electrolyte imbalance, hypoxemia and toxin accumulation. The patient also demonstrates increased weakness, fatigue and drowsiness and requires more sleep. In addition to decreased oral intake including food and fluid, they are also presented with the symptoms of decreased cardiac output, cool extremities, cyanosis and decreased urine output due to diminished blood perfusion and renal failure. Breaths become shallow and accessory muscle is used as the patient is struggling with breathing. They also have raised temperature and urinal and faecal incontinence (INCTR Palliative care 2009). Nurses know that patients are close to death as they become less interested in food, and their mouths become very dry. They have trouble swallowing pills and medicines and are unable to cooperate with caregivers. Their skin become dark or pale, and heart rate is fast and irregular. Nurses also realize that they become confused, disoriented and restless (American Cancer Association 2014).

Last offices are performed as soon as Mr. Guzman passed away. Though different hospitals may have different policies regarding this procedure, the dead person’s body is usually straightened, arms are placed at the side of the body, pillows are removed, eyes are closed, denture is placed in the mouth if available, and a rolled towel is placed under the jaw to prevent sagging. All jewellery and personal stuffs are removed and kept at a safe place unless the families wish to keep it with the patient (Funnell and Koutoukidis 2008, p. 175). Nurses also apply a firm pressure on the lower abdomen of the body to drain all the fluid and prepares the death body for removal to a hospital mortuary or holding area by removing all tubes and drainage, washing, dressing, wrapping and labeling the body appropriately. Other specific cultural or religious practices concerning how to care for the body after death must be adhered to as fully as possible. If there is no specific requirement, two nurses should carry out a post-mortem care, and the body is subsequently taken to the hospital mortuary (Funnell and Koutoukidis 2008, p. 175).

Grief has a negative effect on families and friends of the dead person though the death is anticipated. Some families may become shock, while others may become angry, anxious and resentful. They may also feel a whirlwind of emotions from intense grief and loss to relief and comfort from the fact that someone they love will no longer be suffering (Koutoukidis, Stainton and Hughson 2013, p. 873). Grief also affects health professionals, particularly nurses, who provide direct care for the dead person. Stress, loss of motivation to continue providing health care for other terminally ill patients and social withdrawal may be commonly seen, which negatively affect their work performance and socialization (Wilson and Kirshbaum 2011, p. 560). Some recommendations for nurses to deal with grief and loss include talking to someone they trust about how they feel and the difficulty of trying to coping with the problem, discussing it with other carers and health professionals at the facility or contacting the National Carer Counseling to gain advice on how to deal with grief and loss effectively (Carer Victoria 2005).

The sense of loss and grief may not ease with time for some families and carers. Prolonged grief can be a serious concern and require further support to prevent negative consequences from happening. Supports that are available for families and health professionals to cope with grief and loss include counseling and bereavement support services provided by the Australian Centre for Grief and Bereavement in Victoria, which offers a range of bereavement support programs and experienced counselors including social workers, psychologists and psychotherapists to help individuals cope with grief and loss (Australian Centre for Grief and Bereavement 2014). Hospital and community health care center, palliative care agencies, volunteer groups and church and religious organizations are also available sources from which families and health professionals can seek support. National Association of Loss and Grief Victoria also offers supports for families, clinicians and stakeholders in the health and community service sectors to deal with grief and loss such as providing a package of loss and grief resources and making a discussion with counselors, psychologists and general practitioners available for those who find it difficult to deal with grief and loss (National Association for Loss and Grief Victoria 2011).

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