Blog of the Month

APMJ Blog of the Month- July 2021

Starting F1 in August? Or now have your first year under your belt and about to hit the wards as a SHO? Then this is the blog post for you! For the July edition of the blog of the month, we at the APMJ have asked the Twitter world of Palliative Care for their top tips, golden rules and best pieces of advice for new doctors. Starting in August can be daunting but read on for some helpful guidance from the experts in Palliative Care, from Consultants to Patients and everyone in between!

Any questions? Want to join in the conversation? Then say hello @APMJuniors

Prescribing

- If you're asked to prescribe a syringe driver and you have no idea what you're doing, please ask for help! And when you call us for advice, it's useful if you've already reviewed the patient, know the history and have reviewed the drug chart - we can give better advice then.
- Most hospitals have intranet links to guidance eg the 'PANG' (palliative adult network guidelines) https://book.pallcare.info But if in doubt always call....
- Not all opioids are made equal, for example, oxycodone is twice as potent as morphine. You're not alone when calculating opioid conversions, call the team for a walkthrough/side by side check.

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Well-being

- We all have other stuff going on outside work. Some patients remind us of that. If this wee wifie reminds you of your recently dead granny, it is ok to ask someone else to see her unless it is incredibly urgent. And if you are the one somebody asks, look after your colleague.
- And most importantly, the cake and tea will be either on the shelf or in a drawer in our office. There are a wide range of biscuits. Come in and ask questions.
- Be kind. To your patients and your colleagues.
- Matron is always right. Don't be a horrible person. Listen to your patients.

Advice

- The CNSs are fire and frankly incredible. Make friends with them early.
- Know the contact numbers of the Palliative Care team out of hours. I am more than happy to answer the "is it weird or is it me"? question at 3am. Rather be woken up to help you to the correct answer than wonder what went on overnight which could have been avoided.
- Palliative care teams are friendly. Look up dose conversions. 5mg is not a prn alfentanil dose. Before you have to do it for real, listen to a dead person's chest. With the air mattress still on. It isn't silent!
- (In reply to above) Yes, we are likely to want similar info to if you were calling another specialty-most recent bloods, meds, what has been given (and whether it worked), and a history of the symptoms/thoughts on what is causing them.

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Communication

- Get comfortable with silence & giving time to the person. How they are looking on outside is usually opposite to how they are feeling on the inside, so gently ask. What matters/what is most important to you/what do YOU think might help also so important. You'll love it!
- Dr Kathryn Mannix is almost all they need to know/read! She has great insights on how to talk to dying patients and their families and offers fantastic advice in using 'proper' language around death and dying.
- Some patients are sick enough to die. They may pull through. They might not. Say 'sick enough to die' to pt & family. Not 'serious.' Not 'critical.' Not 'unstable.' Name death as a possibility, & plan good #eol care in parallel with current treatment
- From a patient: the single most powerful thing you can do for your patient is to connect with them, to let them (& their family) feel heard & seen. It's not always easy but if you can, it will light the darkest of corners
- If you're discharging a patient who might be in the last year of life, consider flagging this up to the GP on the discharge summary. Even better if you let us know if any ACP has taken place!

Clinical Assessments

- Look in patient's mouths (we all have torches nowadays on our phones) and at their feet for any cause of discomfort/agitation. Two areas easily overlooked
- If a patient is reported to be feeling nauseous or vomiting. Go review them, look at their recent bloods and drug chart. Just prescribing an anti-emetic rarely works.
- On the list for me is recognising death and dying phase. Have witnessed Drs not just juniors continuing with blood gases, x-ray etc to rule out acute stuff when clearly patient is dying

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and has been on ward for a while. Death is part of life and honest, sympathetic conversations had

- Generally, don’t be afraid of being an advocate for DNAR/escalation limits/ palliative care. Easy to leave this to seniors but often as an FY1 you have a prime opportunity to get to know your patients and learn what it is they really want when it comes to their dying experience.

Thank you to all those who contributed. For more helpful advice and information, we recommend following:

@existential_Doc

@drkathrynmannix

@doctor_oxford