



# Blog of the Month

AMPJ Blog of the Month: February 2023 Edition

Zoe Rubins is a final year medical student at the University of Sheffield. For this month's APMJ blog post, she shares with us her AMPJ medical student essay competition winning piece on the theme 'thinking ahead.' Thank you, Zoe!

Interested in submitting something yourself, have any comments or questions on this piece? Email [submissions.apmj@gmail.com](mailto:submissions.apmj@gmail.com) or tweet us [@APMJuniors](https://twitter.com/APMJuniors)

## **Thinking Ahead – An opinion piece from my time spent in Palliative Care**

Chasing. That's what we're all doing.

Whether it's chasing the bus, the next deadline, that to-do list, we're all looking forward and we're all steaming ahead. But if your days are limited, then what are you chasing? Maybe looking ahead to the next appointment or the next big milestone but most probably, chasing the next hit of pain relief.

'I feel I'm constantly chasing the pain'

This is probably the most heard sentiment when working in the Hospital Supportive Care team. But why? As doctors are we not always thinking ahead? Always creating a plan, aiming for a discharge, and looking toward the next patient. What is it that differentiates our palliative patients, often making it so difficult to involve palliative care early and chasing our patients' symptoms and psychological wellbeing as a result?

The research is there, it supports what many can already guess – that early palliative care input improves patient reported quality of life. It also improves mood and supports patients more effectively through their illness journey(1-3). By nurturing the relationship between healthcare provider and patient, we can better support the psychological and symptomatic burden of terminal ill-health from the outset, resulting in improved outcomes and cost benefits(2, 4, 5). Through more regular contact we are able to better respond to the needs of our patients during a turbulent phase of life, as well as for their family, friends and carers, by reducing 'stress and dysfunctional grief'(2). In this unknown territory, it appears to be only beneficial to intervene sooner.

Palliative medicine offers an opportunity to respond to the patient. It is removed from the focus of an organ or the motive to surgically intervene. The patient is the focus. Yet palliative medicine does need to be gifted the opportunity to get involved. Only then can we get on top of symptoms and stop grappling to make up for lost time. To truly think ahead, we need to look within, refocus our chase, and trample down the barriers.

Misconception. Reluctance. Fear.

Just a few words that bring to the fore the barriers faced when attempting to intervene earlier in palliative care (2, 6). Those in palliative medicine know what they're up against, so often choosing to mask their interactions with deception. By using the camouflage of the term 'supportive care', we may be able to increase consultations (7), however we may also be causing more confusion, often needing to revert to the label we are familiar with. This label of palliative care, can make patients feel as if we are 'shutting the door'(8) and doctors can therefore feel reluctant to refer to services, attempting to protect their patient's fragile emotions and not appear to be giving up (2). Anyone not comfortable with the notion of mortality would not be blamed for feeling fearful of portraying a loss of hope (3). Instead, preferring to shy away from the topic - blocking palliative input mentally and therefore also physically.

The answer could be education, it could be normalisation or removing the separation that exists between palliative and conventional medicine (9), for patients and maybe even more importantly for healthcare professionals. However, it is the opinion of this essay that until we can address why those not part of the palliative workforce find it difficult to engage with the end of life and disseminate this information widely and accessibly, we are not truly thinking ahead. We are left tentatively engaging with symptom management, frequently unable to provide the expert communication, care planning and holistic support that makes palliative medicine a powerful tool in our healthcare system.

As doctors, we do know to look ahead, but sometimes, we just aren't able to do so. Whether we're hesitantly knocking at the door of a patient unwilling to address the brevity of their remaining time or trying to convince doctors who are scarcely exposed to dying patients to make more referrals or begin conversations – we're still all chasing. This essay urges further narrative research (10), to understand how we truly experience our own mortality and might begin to approach the end of life akin to ordering a full blood count – routinely and without fear.

Clearly, the idea of death is frightening for many people - patients and doctors alike.

We can change the system; we can improve commissioning and increase the workforce; but, before we can all sit down with a cup of tea and discuss our own mortality, we can't truly harness palliative care. Unless we can engage early, we can't ever get ahead and quit the chasing.

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