



TEXTBOOK OF PALLIATIVE MEDICINE AND SUPPORTIVE CARE

THIRD EDITION

EDITED BY

EDUARDO BRUERA
IRENE J. HIGGINSON
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THIRD EDITION

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THE DEVELOPMENT OF HOSPICE AND PALLIATIVE CARE

Kate Kirk

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In May 2014, WHO World Health Assembly Resolution 67.19 called for palliative care to be strengthened “as a component of comprehensive care throughout the life course.”¹ This was the first global resolution on palliative care, and the call to integrate it into national health policies and programs was adopted unanimously by the representatives of the 194 Member States attending the Geneva meeting.

The resolution meant that palliative care was now included in the definition of universal health coverage, and in the WHO Global Monitoring Framework and action plan for the prevention and control of noncommunicable diseases 2013–2020. It also meant that medications typically used for pain and symptom control in palliative care would be included in WHO’s Model Essential Medicines lists for both adults and children. From policies to education, and from funding to basic support, Resolution 67.19 called for Member States to integrate palliative care across all aspects of their health systems, and for the Director-General of WHO to drive the necessary programs and projects to help Member States to support implementation.

Prior to this, palliative care had become a recognized human right when the UN Committee on Economic, Social and Cultural Rights adopted General Comment No. 14 in 2000. This General Comment asserted the right to “attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.”² The WHO definition of palliative care, as revised two years later (see Box 1.1), included the family, underscoring a concept familiar to those working in the field, that of “total pain.”

For a medical specialty barely 25 years old where it is recognized, and still unrecognized in many countries, the 2014 WHO Resolution was a major step. And yet, the origins of hospice and palliative care go back centuries.

The first hospices were simply places for pilgrims to rest. Given the rigors of the journeys these guests were undertaking, caring for the sick became an integral part of the comfort hospices provided. The idea of a hospice being a home for the “incurable” took root in the 19th century, when such homes were first established in France and Ireland. So while palliative care has only recently taken its rightful place in the world of medicine, the hospice care it is intimately linked with and derives from is hardly new.

But what is new is the modern hospice, and indeed the invention of the term “palliative care” to encompass all aspects of caring for patients with life-limiting conditions—not just cancer (although that is typically the assumption for hospices) but also

WHO DEFINITION OF PALLIATIVE CARE (REVISED 2002)

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. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.³

conditions such as heart failure, respiratory and neurological diseases, and HIV/AIDS.

As with many leaps of progress, an idea starts to take root in a number of different places and in the minds of different people at around the same time. But it takes a particular individual to shake things up—to challenge the fundamental assumptions around an area of practice or scientific enquiry and cause the necessary paradigm shift by pointing researchers in a new direction and to new sources of evidence.

The history of hospice and palliative care is one such paradigm shift that did, indeed, start to grow in several places in the 1950s. However, it is impossible to write about how the field developed without focusing on the work of my late aunt, Dame Cicely Saunders OM, DBE, FRCP, FRCN.

In his Foreword to a selection of her published letters, Professor Balfour Mount asserted that "Dame Cicely ... has been the catalyst for a paradigm shift in global health care."⁴ When accepting the Templeton Prize in 1981, Cicely herself pointed out that "[t]here are not too many original ideas around but there is often a new pattern to be discovered if we search with ready minds and ask some questions."⁵

Asking questions, as Cicely did enthusiastically throughout her life, underpins the development of what we recognize as hospice and palliative care today.

The “ready minds”

Looking back, it is easy to see a chain of events that led logically, indeed inexorably, to World Health Assembly Resolution 67.19, but without the “ready minds” and questioning stance of a few key individuals, the chain may never have been completed. Indeed, without Cicely’s unusual career path, it might never have been started.

Cicely initially went up to Oxford University in 1938 to study Politics, Philosophy and Economics, but at the outbreak of World War II, she left her studies and trained as a nurse at the Nightingale Home and Training School at St. Thomas’ hospital in London. To her great disappointment, her nursing career was cut short by an increasingly aggravated back injury, and in 1944 she went back to Oxford to finish her degree. After graduating, realizing she could not go back to the nursing she loved, she qualified as what she saw as the next best thing, a Lady Almoner, or Medical Social Worker, and began working in this new role in St. Thomas’ in 1947.

The next key moment was in 1948, when she met David Tasma, a Polish Jew who had come to England shortly before war broke out, but was now dying of cancer. He was alone, having lost contact with his family back in Poland, and Cicely spent considerable time with him. A bond formed between them over lengthy and far-ranging conversations, particularly over how the dying were cared for, and how much better things could be. A vision of a place where death was not a medical failure but instead part of a journey, and deserving of equal care, was born. When he died, Tasma left Cicely a sum of money toward her vision, apparently telling her that “I will be a window in your home.”⁶

After Tasma’s death, Cicely added two more important pieces to her journey and both would inform her next step. First, she started volunteering at St. Luke’s Hospital for Advanced Cases in London. As a Lady Almoner, she had occasionally had to send patients to what were often referred to as “homes for the dying,” and St. Luke’s was one of them. Her nursing vocation remained, and volunteering reconnected her to that vocation. It also gave her time to investigate more closely how dying patients were cared for. In particular, she saw what could be done with different regimes for pain-killing drugs, and the use of the so-called Brompton cocktail, an undefined mixture of morphine, codeine, sodium amytal, alcohol, and other ingredients.

The second crucial change at this time was to combine her duties as an Almoner with acting as medical secretary to Norman “Pasty” Barrett, a consultant thoracic surgeon who played a pivotal role. Cicely discussed her observations from St. Luke’s with Barrett and explained that she was thinking of going back into

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nursing to test her ideas. He pointed out the obvious, that a nurse would not be able to challenge the establishment, and that “it is doctors who desert the dying.”⁷ If she wanted to change things, she should go to medical school.

Cicely was the oldest in her class by almost a decade when she began training as a doctor in 1951, once more at St. Thomas’. During her training, she began monitoring and recording her observations of, and conversations with, dying patients. Most of her “foundational” patients, as she termed them, were suffering from cancer. Her experience as a nurse, social worker, and now trainee doctor gave her unique insights into the constraints and problems around their care, and the wider ramifications of their situation.

In 1958, an article by Cicely entitled “Dying of Cancer” was published in the *St. Thomas’s Hospital Gazette*. In it, she detailed the cases of four dying patients and the issues associated with their care, good and bad. She concluded with her thoughts on the care of the dying and an early vision of how modern hospice care might evolve.

It appears to me that many patients feel deserted by their doctors at the end. Ideally the doctor should remain the centre of a team who work together to relieve where they cannot heal, to keep the patient’s own struggle within his compass and to bring hope and consolation to the end.⁸

Once qualified, Cicely took a position as physician at St. Joseph’s Hospice, another of London’s homes for the dying, where she worked for the next seven years. Over that time, she started to do more detailed research into the use of painkillers. She interviewed and recorded notes on over one thousand patients, building a formidable set of qualitative and quantitative data, and began to write about the benefits of giving regular doses of painkillers in contrast to the established practice of either waiting until the patient could bear the pain no longer or sticking to a strict timetable. She also began to develop relationships with other workers in the field, both in the UK and internationally, principally North America, writing to and talking to as many people as possible about her ideas. These included her concept of total pain—that the dying patient, and their family, should have not only their medical needs addressed, but also their psychological, social, and spiritual needs as well—which reflected her rare combined experience as a nurse, social worker, and now physician. As she wrote in 1966:

...a patient, trying to describe her pain, says simply, “It began in my back, but now it seems that all of me is wrong.” This kind of “total” pain has physical, mental, social and spiritual elements. Neither she in her words nor we in our approach and treatment can deal with any of these separately.⁹

With David Tasma’s legacy still waiting to be spent, Cicely was increasingly focused on how she could establish her own hospice, one where she could combine the best possible care with research and teaching. In 1963, she was awarded a nursing fellowship, which she used to travel to the US, where she visited the National Institutes of Health in Maryland and a number of hospitals, talking to professionals from all parts of the medical spectrum. As she wrote in her report of the trip:

I found it a great asset that I was able to go in my three-fold capacity of nurse, social worker and doctor. It made

my own approach a broad one and also made me “one of them” when I discussed problems with each of the different professions.¹⁰

An additional grant from the Ella Lyman Cabot Trust enabled Cicely to extend her 1963 tour—crucially giving her the time to meet some other “ready minds,” including Florence Wald, dean of the Yale School of Nursing. Subsequent trips to the US included a six-week lectureship at Yale in 1966, which included two more important meetings. She renewed her acquaintance with psychiatrist Colin Murray Parkes, who would add crucial expertise to her plans. She also met Elisabeth Kübler-Ross, who was already conducting the interviews that would inform her seminal 1969 work, *On Death and Dying*. Kübler-Ross would note in her book:

It may not be a coincidence that one of the doctors best known for the total care of the dying patient, Cicely Saunders, started her work as a nurse and is now physician attending the terminally ill in a hospital set-up especially designed for their care.¹¹

That “hospital set-up” that Kübler-Ross referred to was St. Christopher’s Hospice in Sydenham, South London. Fired up by the publication of a 1960 report to the UK Government on the care of the terminally ill by Glyn Hughes, Cicely had redoubled her efforts to raise funds and gather support from a broad range of stakeholders in order to realize her vision.

St. Christopher’s Hospice admitted its first patients in July, 1967. Funded by various philanthropic organizations and individuals, and with a contribution from the UK’s National Health Service, research and education were at the heart of activities from the beginning. Cicely continued the research she had begun at St. Joseph’s, and brought in others to develop new projects.

One of these was Robert Twycross, who joined St. Christopher’s as a Clinical Research Fellow in Therapeutics in 1971. Twycross undertook a series of seminal studies documenting the use of oral morphine, as given to patients in the Brompton cocktail, and also comparing the efficacy of morphine, diamorphine, and methadone in controlling pain. For the first time, there was robust, evidence-based confirmation that controlled doses of morphine could be used to replace the Brompton cocktail.

Many other key developments in the field came after visits to St. Christopher’s. These included that of Florence Wald, who spent four weeks working there in 1969. After going back to the US, Wald and a few colleagues joined forces to plan and develop the Hospice Home Care program in New Haven, Connecticut, which launched in 1974. This first hospice program in the US was initially concerned solely with providing home care but opened its first in-patient beds in 1980.

Canadian physician Balfour Mount was another early visitor to St. Christopher’s. He was inspired to make contact after organizing a discussion group for his church to talk about the Kübler-Ross book, *On Death and Dying*. The description of St. Christopher’s in the book intrigued him and he determined to visit. Cicely famously tried to put him off when he telephoned her in September, 1973. First of all, she refused to take his call, saying she was just going for lunch and he could call her back later. When that didn’t deter and Mount persisted in calling again, she told him:

I know you. You want to come over to London with your wife, see a few plays, have a quick run around the hospice

and then go back. Well, I won’t have it. I’ll tell you what, leave your wife at home; be prepared to come for a week, roll up your sleeves and get to work, and I’ll have you.¹²

Mount visited St. Christopher’s as soon as it could be arranged, and went back again the following year for a longer stay. Having undertaken a review of the care of the dying in his own hospital, the Royal Victoria in Montreal, Mount wanted to develop a way of bringing hospice care into the hospital setting. Eventually, in 1975 Mount set up a pilot project in the Royal Victoria that introduced the term, “palliative care.” The hospital’s Palliative Care Service was the first of its kind.

David Clark points out in his biography of Cicely that, although initially unconvinced by the term, she soon changed her mind and:

...quickly embraced [the term] in the coming years and readily cited Mount and Montreal as its source ... the neologism was to prove hugely consequential as it entered into use across the world and sounded out the message that hospice principles could be practised in many contexts. It was not the setting that was important, but rather the approach to care that was being adopted.¹³

Apart from the many visitors to St. Christopher’s itself who went away inspired to “do their bit” for the care of the dying, there are numerous other incidences where a meeting with Cicely, a lecture she gave, even singing in the same choir, had an impact on the development of palliative care. When Mary Baines (a contemporary of Cicely’s at medical school and one of the first physicians at St. Christopher’s), surveyed a group of doctors prior to attending a Wellcome Trust Witness Seminar on the development of palliative medicine in the UK, she found that half of them had chosen their career in palliative medicine after meeting Cicely.¹⁴ Not surprisingly, therefore, it is impossible to name all of the people who were inspired by Cicely and went on to contribute to the expansion of the modern hospice movement and the subsequent development of palliative medicine. The previous edition of this book provides many more names and details, but it, too, is far from complete.

Global growth of the modern hospice movement

St. Christopher’s served as a model modern hospice, but Cicely never intended it to be copied exactly. Instead, she encouraged any who expressed a desire to create something similar to spend time at St. Christopher’s and then go away and tailor provision to local conditions.

Today, there are around 220 hospices in the UK.¹⁵ Most are independent and rely on charitable funding for over two-thirds of their operating costs. In the US, there were over 3,000 hospice programs by the time of Florence Wald’s death in 2008. The introduction of Medicare hospice benefits in 1980 was a key trigger for the growth of in-patient provision, and in 2017, the National Hospice and Palliative Care Organization recorded 4,515 Medicare-certified hospices operating in the US. It also reported that 1.49 million Medicare beneficiaries had one day or more of hospice care in the same year, over half those days of care were delivered in the home, and around 65% of the recipients were 80 years of age or over.¹⁶

The 2012 Atlas of Palliative Care in Latin America cited an overall figure of 44 in-patient beds per million inhabitants across

the 19 countries in the region.¹⁷ This ranged from a high of 11 per million population in Argentina to zero in Cuba, El Salvador, Honduras, Nicaragua, Panama, and Peru. Similarly, eight countries had no home care provision, and very few had any provision in community centers. A 2017 review of end-of-life care in Latin America found national palliative laws in four countries, and that six countries still had no hospice.¹⁸

Looking more broadly, the 2014 joint Worldwide Palliative Care Alliance and WHO *Global Atlas of Palliative Care at the End of Life* assessed end-of-life-care provision under 4 categories and found that 75 countries were in Group 1, with no known hospice or palliative care activity. Many of these were islands where populations were small and overall health provision challenging, but the list also included countries such as Liechtenstein, Monaco, and Syria.¹⁹ A further 23 countries were in the “capacity building” phase, but only 20 countries had reached category 4b, advanced integration of hospice and palliative care.

Recognition

Hospices are, of course, only part of the picture. In fact, it is the growing recognition of palliative care as not only a human right but also a medical specialism that has arguably had the greatest effect on the care of the dying worldwide.

As with any other medical specialty, in order to be recognized, palliative medicine had to develop the foundations of a profession, including research, peer-reviewed journals, associations of practitioners, education, and certification.

In the UK, the Association of Palliative Care and Hospice Doctors was formed in 1985, and palliative medicine was first recognized as a sub-specialty by the Royal College of Physicians in 1987. Seven years of research, education, and development later, it became a specialty in its own right.

Established in 1991, the position of Sainsbury Professor of Palliative Medicine at the United Medical Schools of Guys and St. Thomas' Hospitals in London was the first Chair in Palliative Medicine in Europe.²⁰ By 2005 there were nine such positions throughout the UK, and three Chairs had been created for palliative care within social sciences.

The UK's National Institute for Clinical Excellence published its first guidance on palliative care, for patients with cancer, in 2004. Its most recent set of quality standards for end-of-life care include not only various forms of cancer but also COPD, chronic heart failure, chronic kidney disease, and dementia.²¹

The European Association for Palliative Care was established at an international congress in Milan in December 1988 and recognized as a nongovernmental organization of the Council of Europe 10 years later. By this time, palliative care was beginning to appear in legislation in several European countries, and in 2003, the Council of Europe incorporated recommendations for the provision of palliative care.

The American Academy of Hospice and Palliative Medicine (originally the Academy of Hospice Physicians) was also founded in 1988 and now claims over 5,000 members.

In the 2006 edition of this book, Ryndes and Von Gunten pointed out that, as of 2004, the US was awaiting a decision on whether palliative care would be considered a medical specialism. A combination of various programs and initiatives supported the claim, and the authors commented that “[f]ormal recognition is seen as likely” at a meeting of the American Board of Medical Specialities in that year.²² In fact, it was two years later, in 2006,

when palliative medicine was finally recognized as a subspecialty of internal medicine.²³

Although the first Canadian Chair of Palliative Medicine was established at the University of Alberta in 1987, an application to confirm palliative care as a specialty in Canada was turned down in 1995. It was only in 2017 that legislation in Canada led to the publication of the *Framework on Palliative Care in Canada* by Health Canada in 2018. The report pointed out that, while there were a number of programs aimed at delivering and improving palliative care in place across the provinces and territories of Canada, there was no national strategy, despite the appointment of a minister with special responsibility for Palliative and End-of-Life Care in 2001.²⁴ The report also noted that the Canadian Institutes of Health Research had put \$16.5 million into palliative care research between 2004 and 2009, and a further \$494 million in funding for aging research between 2012 and 2017 included some funds directed to palliative care. Nevertheless, a fundamental weakness in the advancement of palliative care as a profession remains:

Unfortunately, the core palliative care competencies of skilled communication, expert pain and symptom management, and psychosocial assessment remain, at best, a small part of most medical school and residency training programs in Canada.²⁵

Elsewhere, progress is equally variable. The African Palliative Care Association, launched in 2004, reports that 21 out of 47 African countries have “no identified hospice or palliative care activity,” and only four countries “could be classified as having services approaching some measure of integration with mainstream service providers.”²⁶ Similarly, the Asia-Pacific region sees progress in some countries but barriers in others, particularly associated with availability of opioids.

However, there is some encouragement to be drawn from efforts to at least improve education and training, especially for those in low- and middle-income countries. Online and distance courses, such as the Stanford Palliative Care Always program, aimed at cancer specialists, and projects such as that established by the Lien Collaborative for Palliative Care, to train trainers in order to build capacity,²⁷ at least keep progress moving in the right direction.

The need remains

Despite efforts by national and international bodies to put palliative and hospice care on the health agenda, the unmet need is still high. WHO estimates that “worldwide, only about 14% of people who need palliative care currently receive it.”²⁸ The same WHO Factsheet also points to the increased demand for palliative care as populations around the world age and greater numbers of people live with complex conditions in their later years.

There is still a shortage of academic leaders for capacity building, and research remains challenging for a number of reasons, including ethical considerations, difficulty of predicting time to dying, frailty of patients, and the subjectivity of measuring factors such as quality of life. The Cicely Saunders Institute, opened in 2010 in London, strives to address all of these challenges in a multidisciplinary organization that reflects the origins of the specialty in nursing, social work, and medicine, but despite efforts here and elsewhere, much remains to be done.

The Development of Hospice and Palliative Care

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Speaking personally, I feel that Cicely would be pleased at how far we've come but also frustrated at how far we still have to go. As anyone who met her would know, she would also be rolling up her sleeves alongside us and encouraging us to get on with it.

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Somatic Symptoms, Symptom Clusters, and Symptom Burden

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Other Respiratory Symptoms (Cough, Hiccup, and Secretions)

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Dehydration and Rehydration

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