Contemporary Themes

Care of the terminally ill in a district general hospital

W A MORRIS

In past years the care of the dying has been neglected in general hospitals as efforts have been concentrated on providing better technical care for patients. This hiatus has gradually been filled by the hospice movement—religious and medical foundations caring for patients facing death. Around 40 hospices are now open in Britain; but Ford¹ argued that a team of staff with the necessary skill and experience can achieve many of the objectives of hospice care within a district hospital.

Furthermore, while there is a "demand" for hospice accommodation, many district general hospitals have up to 30% of their acute beds empty.² Would it not be sensible to make full use of these facilities to provide the dying patient with an adequate and caring service within the confines of an existing hospital rather than using capital on more bricks and mortar?

In November 1978 a post at nursing-officer grade was created within North Tees General Hospital to care for the needs of dying patients. This subject has interested me for some years, especially after my experience as a ward sister nursing a girl of 18 for some four months before she died. During these four months I spent many hours with her and her parents and close links were forged between us. In retrospect, however, as a ward sister I was wrong to neglect the other 24 patients in my care. After my patient's death I recognised the need for a person or persons to devote skill, energy, and—most important—time to caring for the dying patient, and I accepted the post of nursing officer (special care).

The post was the first of its type so there were very few guidelines. Because I have worked in this health district since 1960 as a ward sister and nursing officer (surgery) I am well known by most consultants, ward staff, and general practitioners. At first I spent time with these people discussing my new work and trying to convince them that the main thing that I could offer which they could not was *time*.

The Anglican, Roman Catholic, and Free Church chaplains were brought in at the outset. While the chaplains' task is to care for the spiritual well-being of the dying, mine is to deal with the physical and emotional health of these patients and their families. Particularly when giving emotional support to relatives of dying patients the work of the nurse and chaplain may overlap, and between them they must decide how this support can best be given and by whom.

Practical aspects

Patients are referred to me by the consultant and ward sister. In theory referral is on a nurse-to-nurse basis, but I find the support of the consultant medical staff very necessary. Since November 1978, 240 patients have been referred to the special care nursing service, and of these, 37 have been seen at home

after their discharge from hospital; nine have been referred by general practitioners before their admission.

When a patient is referred (usually by telephone) I go along and introduce myself by saying that I am a nursing officer with more time to spare than most nurses, to talk, listen, and answer questions if I can. At this first visit I make a practice of staying only 10-15 minutes, and on leaving I tell the patient that I will visit again the next day—unless they need to talk before. Though officially my working hours are from 8.30-5.00 pm, unofficially I operate an on-call service that covers the needs of the terminally ill patients for 24 hours a day.

After my first visit to the patient I make an appointment to see the relatives because I think that part of my work is to provide a supportive service. I very rarely need to say more than that I can offer time and perhaps some answers to questions. Usually I need only to listen. Friction between relatives, financial strain, fear of whether they will be able to support the patient, and the very real fear of whether they will be able to go on living after the patient has died all slowly unveil themselves and may need to be discussed.

One of the most important aspects of patient care is control of pain, which can be achieved only with the full co-operation of all the nursing and medical ward staff in hospital and district nurses and general practitioners in the community. The drug prescribed may require to be changed or the dose adjusted to remove pain from conscious thought. Time spent with the patient unhurriedly communicating, not necessarily by speech, but all the time observing is the best way to discover whether the analgesic prescribed is adequate for the prescribed time. Often a patient will not admit to pain if a nurse can spare only a few minutes and appears busy. Not all terminally ill patients have pain, but other symptoms such as vomiting or constipation may be more distressing and should be treated when possible.

Patients who become confused during terminal illness are difficult to treat, and the drugs being given should be reviewed in order to exclude them as the cause of confusion. Anxiety is inevitable in dying patients, and again it can best be alleviated by giving time to the patient to express, however haltingly, his thoughts and fears if required to do so. Often questions will be asked that require no answer. In this way the relationship of trust may be formed. Even though the patient is dying it is of paramount importance to him to go on hoping.

It would be impossible to carry out my job alone, and during the months that I have been in post this has become more and more clear. I have been given co-operation, guidance, and support from staff in almost all disciplines. Catering staff have taken trouble to satisfy the whims of my patients by producing special diets on request—on one occasion tripe and onions. Staff in the supplies department have ordered special pillows, back rests, and sheets. As if by magic, laundry staff produce sheepskin rugs, etc. Social workers have helped in providing equipment at home, and obtaining attendance allowances—without this help we could not have made patients at home so comfortable and relaxed during the final weeks of life. The local branch of the Cancer Relief Organisation gave ready help to those patients in financial need.

North Tees General Hospital, Stockton-on-Tees, Cleveland TS19 8PE

W A MORRIS, SRN, ONC, nursing officer (special care)

Home visiting

Patients who are discharged from hospital are always asked if they would like me to visit them at home; if so the general practitioner will be contacted by the consultant and his permission sought for a home visit. In turn, I discuss the patient, his treatment, and care with the community nurse. When and if the patient is discharged and later readmitted my service is mainly one of counselling and liaison between home and hospital; and by having time to offer, I can provide special nursing care within a district general hospital. Patients may prefer their own china cup and saucer, their own pillow, and even their own sheets. This is a novel idea in a general hospital—but it is not wrong to help a patient to die in comfort and dignity. In past years hospital staff have not had the time to think about such policies because they have put all their energies into the care of patients who will live.

Need for honesty

Dying patients require a confidant. Quite often they are unwilling or unable to communicate with their loved ones. I find that it is totally futile to be dishonest at this time. Though

I always accede to the wishes of the individual doctor if questioned about diagnosis or prognosis, I also try to be honest, for to tell lies destroys any trust between the patient and myself. The patient soon realises that his body is getting weaker and his pain or vomiting more prolonged; if he has been told anything other than the truth in answer to his question "Am I going to die?" he has no one in whom to trust or confide and must face the reality and fear of death in total isolation.

There is no more rewarding phrase than to hear a patient or relative say, "We feel safe as long as we know that you are around and we can get you." The emotional cost is high to the special care nurse; the counsellor must herself be able to be counselled when necessary. I am fortunate that my senior nursing staff are as enthusiastic and interested in the special care service as I am. Without their support I could not even start to provide this type of service.

References

- ¹ Ford GR, Pincherle G. Arrangements for terminal care in the NHS (especially those for cancer patients). *Health Trends* 1978;10:76.
- ² Yates J. *Hospital beds—an acute problem?* London: Heinemann (in press).

(Accepted 14 November 1980)

Today's Treatment

Clinical pharmacology

Adverse drug interactions

JEFFREY K ARONSON, DAVID G GRAHAME-SMITH

In this article we shall discuss the incidence and mechanisms of adverse drug interactions, give examples of clinically important interactions, and mention other sources of information. We shall not discuss beneficial interactions.

In considering the incidence of adverse interactions one must distinguish between potential interactions—that is, the concurrent prescription of two drugs known to interact—and interactions that result in clinically obvious adverse effects. In one study¹ of 2422 patients studied prospectively during two months 113 (4.7%) were taking drugs with the potential for interaction but in only seven cases was there any clinical evidence of interaction (0.3% of all the patients; 6.2% of those potentially affected). With certain combinations of drugs, however, clinically important effects may occur more often. For example, in one survey of 1554 prescriptions for potassium chloride and 245 for spironolactone² 104 prescriptions were issued for the combination of those two (6.1%), and in a sample of 25 patients taking

such a combination three developed hyperkalaemia (0.7% of all patients; 12% of those taking the combination). In a study of the use of oral anticoagulants³ in 277 patients 94 were receiving other drugs that might have interacted (33.9%) and clinically significant interactions were thought to have occurred in six (2.2% of all patients; 6.4% of those taking combinations).

Unfortunately there are problems in collecting incidence figures of this type. For example, it may often be difficult to determine whether an adverse effect of a drug occurs as a result of a drug interaction rather than as a result of, say, misuse of the drug or of an interaction between the drug and some peculiarity of the patient, such as renal or hepatic dysfunction. What is certain, however, is that the chance of an adverse drug interaction increases with the number of drugs the patient is taking.⁴

Most drug interactions concern only two drugs, although there are published examples of interactions among more than two drugs. In general, when two drugs interact one *precipitates* the interaction by one or more of several different mechanisms (see below) while the other is the *object* of the interaction, and its effects are either increased or reduced. We propose, therefore, for ease of discussion, that the drug that precipitates the interaction be called the *precipitant* drug while that whose effect is altered be called the *object* drug. Occasionally, two drugs may each alter the effects of the other (as in the complex interaction of

MRC Unit and University Department of Clinical Pharmacology, Radcliffe Infirmary, Oxford OX2 6HE

JEFFREY K ARONSON, DPHIL, MRCP, Wellcome lecturer
DAVID G GRAHAME-SMITH, PHD, FRCP, Rhodes professor