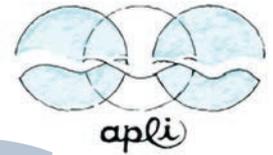


# nAPLI news



Volume 16;  
Issue 1 April 2012

## Editor's Note President report

### Hamrahi experiences Theme: Health care in India

Over the past 5 months, there has been a flurry of activity in Project Hamrahi. Four volunteer visits have taken place to various centres in the northern states of India. Two of these have been newly established links, one to Cachar Cancer Centre in Silchar, Assam, and the second to a centre in Orissa. Each Indian centre has its unique challenges, but common to all, is the vast amount of human suffering encountered, the sparseness of resources, and the relative isolation of the palliative care providers in each site. At some sites, opioid availability has improved, but sadly, this is not the case in all. One centre, a major 700 bed teaching hospital, still has no opioid available other than weak opioids of tramadol and codeine.

If you stop for a moment and let that fact really take hold of you, it is impossible to do nothing about it.

Many actions are possible. Writing to the Chief Minister of Bihar or other states to which Project Hamrahi has connected, to advocate for changes in health policy that result in better opioid availability, writing to DFAT highlighting this injustice, donating to IAHPC, Pallium India,

APHN or other advocacy organisations to assist them in their work, raising your own awareness of this issue and the awareness of those in your workplace, buying a copy of the Life before Death film which was launched on World Cancer Day, 2012, and hosting a viewing of this in your workplace or in a local community setting (consider Rotary or Lions clubs).

APLI has sent a letter to the Chief Minister of Bihar and the Health Minister, and has included it in this edition.

Some excellent outcomes have already emerged from Project Hamrahi. One group of volunteers donated funds for the training of 2 nurses in Trivandrum, Kerala, at the Pallium India course. Strong collegial links have been established between volunteers and palliative care providers. Improved confidence and perseverance have been reported by Indian colleagues. Reduction in isolation, Skype links, facebook and email contacts, sharing of literature resources, exchanges about patient care, all strengthen the impact of this project.

We continue to seek funds for continuing the financial support for volunteers.  
Thanks to Sarah for taking up the mantle of newsletter editor, and for doing a such a great job.

*Dr Odette Spruyt*  
President, APLI

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acknowledges the  
support of MUNDIPHARMA



## Updates on Indian mentor sites



*Odette Spruyt, Sarah Rose and Anne Adams*

2012 has seen the continuation and growth of Hamrahi site visits. Wendy Scott and Dr Anil Tandon have had a second visit to Jamshedpur where previous relationships were fostered and new teaching introduced. Dr David Brumley, Dr Oliver Haisken and Sarah Corfe visited the Cachar Cancer Hospital in Assam. Hosted by Dr Iqbal Bahir the team worked with the medical staff and nurses to develop relationships. Their time in Assam was short but much was achieved in this time, the team conducted exams for the nurses, participated in home visits, ward

rounds and also had interaction with the local media. The Indira Gandhi Institute of Medical Sciences was visited again by Dr Odette Spruyt along with nurse Sarah Rose and hospital project manager Anne Adams. This team championed for change of the opioid practice in the IGMS hospital where opioid supply was intermittent. Dr Meera Agar will be visiting Dr Niharika Panda, Behrampur, Orissa in the last weeks of March 2012.

## **Advocacy for Indian patients and the clinicians caring for them is an integral part of APLI.**

**Below is an open letter to the Chief Minister of Bihar Re: Uninterrupted supply of oral morphine for moderate to severe pain in patients with cancer and other severe illnesses.**

22.3.2012

Attention:

Mr Honourable Chief Minister of Bihar

Dear Mr Honourable Ministers

Re: Uninterrupted supply of oral morphine for moderate to severe pain in patients with cancer and other severe illnesses.

On behalf of Australasian Palliative Link International (APLI) and Pallium India, we are writing to draw your attention to the issue of providing opioids for pain relief for patients with cancer or other severe, painful illnesses. There is international agreement that morphine or similar opioids are necessary for the control of moderate to severe pain associated with cancer and other severe, painful illnesses. It is now advocated that access to pain relief is a human right and that the failure to ensure that patients have such access is akin to a kind of torture.

We advocate for morphine because it is cost effective, compared to other drugs and it can relieve pain where other medications have failed. We have observed that patients suffer in the absence of morphine.

Pallium India and APLI have established a mentoring project, Project Hamrahi, to support new palliative care providers here in India through mentorship from Australian and other experienced practitioners. We are linked to the IGIMS here in Patna and are visiting for the second time.

It is a great concern to us that an institution of the stature and academic excellence of IGIMS is unable to ensure an uninterrupted supply of oral morphine for its patients, for reasons of excessive complexity of processes of procurement and supply. One problem appears to be the required tendering process which adds unnecessary delay to placement of orders. Another is the small number of tablets ordered at any one time. There are over 3,600 patients seen per month at IGIMS, of whom at least 3,000 will have advanced disease. Currently, through the intervention of the Director, only 2,000 tablets are ordered at a time. This naturally runs out rapidly and the complex ordering process must be repeated. It is distressing to meet patients who return in severe pain after running out of morphine, only to find that the hospital has no further supply to give them. It is even more concerning to know that this situation is not limited to IGIMS, but is to be found in most major centres across Bihar.

Given that at least 70% patients with advanced disease suffer severe pain, there is a need for large amounts of morphine in this institution alone. This situation would be greatly relieved by amending the existing rule governing opioid procurement in the state of Bihar. Other states in India have amended their rules which has resulted in much better supply of morphine and improved pain management for patients.

If the rule was amended and the process was simplified we believe the supply would be more consistently maintained.

We implore the Honourable Ministers to take this matter to heart and to i) intervene so that the regulatory processes can be simplified and standardised ii) hold the Directors of each institution accountable for ensuring an uninterrupted supply of morphine and iii) ensure practitioners are supported to develop expertise in prescribing morphine for patients in need.

We will be in Patna until the 25th March 2012 and would welcome an opportunity to discuss this further. We can be reached on +61405515296.

Yours sincerely

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# Reflections on Palliative Care in Assam

Never did I consider that a career in palliative care would have me in an ambulance driving at top speed through the countryside of Northeastern India. This was the final few minutes of my most enjoyable mentorship program, on our drive to make it onto our flight back from Silchar to Calcutta. As we travelled quickly past the multitude of tea and rice plantations, my project colleagues Dr David Brumley and Dr Oliver Haisken – two Australian palliative care specialists that I was travelling with, agreed that it had been an inspiring and beneficial trip.

Through Project Hamrahi, David, Oliver and myself visited Silchar in India's region of Assam for one week in early February and provided mentorship for the palliative care staff in delivering a high quality palliative care service. Project Hamrahi (meaning 'fellow-traveller') is run through the Australasian Palliative Link International and the focus for this trip was to mentor Dr Iqbal Bahir and the nursing team of the palliative care unit at the Cachar Cancer Hospital. They are a busy service, with a 12-bed unit already at capacity, a busy outpatient clinic and a budding home service. It was apparent early in the visit that the palliative care services already offered were thoughtful, caring and creative, and were provided with good use of their existing resources.

Mentorship activities that were conducted during our visit included nurse training using ward based and relevant clinical assessment, and then the supervision of nursing examinations for their in-house six-week short course in palliative care foundations. It was impressive that all 12 nurses achieved very good results in their examination as this was despite some interesting language barriers.

At times during the visit, I felt that I could only offer support and reassurance that the problems encountered in clinical practice were similar to those experienced in Australia. For example, together we observed a patient displaying high levels of symptom burden, psychological distress and who also had poor social supports. The staff were finding this patient complex in his ongoing needs, and I assured them that his needs would also be a challenge for us also, even in a western hospital.

The medical mentorship involved ward based rounds, and grand rounds to the wider medical staff of the hospital. Some home visits and involvement in the daily outpatient clinics also exposed us to a variety of patients and their differing needs. Seeing the dedication and perseverance of Dr Bahir was inspiring and it was also good to see how well integrated palliative care medicine was within the whole hospital – other specialists there, including the surgeons, saw the service as important in holistic patient care. I felt myself wishing that this level of support were the same back home!

A very important aspect of our visit was local community engagement - improving the general understanding of 'What is Palliative Care?', how does it help the community to know about it and promotion of the excellent services being offered by the hospital. This was done through media interviews and engagement in a public seminar on our last evening to community members and NGOs of the region.

It was a big positive to see that the staff at the hospital felt that our visit was beneficial for them and the future development of palliative care in their area. It is also pleasing that



*Sarah Corfe and nurses during exams*

*Sarah Corfe with Dr Iqbal and Dr Haisken*



mentorship will continue through regular phone calls between Australia and Silchar. I would like to extend my appreciation to the generous hospitality of all the hospital staff and volunteers who offered their time, food and accommodation during our weeks stay, and I am looking forward to my second mentorship visit.

**Sarah Corfe**  
*RN, Palliative Care Nurse Specialist*

## Analgesic Prescribing in Jamshedpur, India

### **Dr Anil Tandon**

As part of Project Hamrahi, I have conducted two mentoring visits to India. Both of these visits have been with a colleague also from Perth, Wendy Scott, a Clinical Nurse Consultant. We were allocated to support the team at Meherbai Tata Memorial Hospital (MTMH), a 70 bed specialist cancer hospital in the city of Jamshedpur, approximately four hours train journey west of Kolkata. The Palliative Care Service at MTMH is ably led by Dr Urmila Patel, who travelled to Trivandrum in 2009 to receive initial training in palliative care from Dr Rajagopal and his team.

Having now spent two weeks at MTMH, I feel that I have a reasonable understanding of the process of prescribing and dispensing medications, particularly analgesics, in MTMH. As much as possible, we tried to be mindful of what medications were practical and feasible to recommend based on local experience, availability and cost but at the same to balance this with what was felt to offer the best chance of optimal symptom control based on our Australian clinical experience and the current available evidence. It is important to remember that India is a very large

*Dr Anil Tandon*



country with a large degree of variation in governmental regulations and health care professional training so what is written below is not necessarily relevant or applicable elsewhere.

## Analgesic Prescribing in Jamshedpur, India *continued*

The World Health Organisation three step analgesic ladder seems to be generally well understood. Paracetamol and NSAIDs are frequently prescribed, although it seems that they are often used together as a combination preparation of paracetamol 500mg and diclofenac 50mg in the one tablet. In addition, the frequency of administration is often three times a day - the result being a subtherapeutic dose of the paracetamol.

Tramadol is very frequently used in both oral and intravenous formulations. In large part this is related to ongoing reluctance to prescribe morphine, even though the latter is available for use. The most common formulation of oral tramadol that is used is the 50mg immediate release preparation, with the result being similar to the above experience with paracetamol, there is a tendency to prescribe low doses: often in the order of only 50mg or only occasionally 100mg twice a day. Because Jamshedpur and the surrounding countryside is an area of widespread poverty and the cost of medications needs to be borne by the patients and their families, higher cost formulations such as slow release tramadol were not prescribed. For certain patients, intravenous tramadol at a dose of 100mg either as required or a regular dose up to three times a day is prescribed. This formulation is in 100ml of normal saline and would be administered over half an hour.

In Jamshedpur, the only way to prescribe oral morphine is for a patient to be admitted as an inpatient to MTMH. For patients seen as an outpatient in the daily Palliative Care clinic, this would mean a day case admission even if they did not require admission for any other reason. Once the patient had been admitted, the morphine would be prescribed and then dispensed following which the patient would be discharged - all of which created several hours of work tying up scarce human resources and significant inconvenience for the patient. Unfortunately, a combination of hospital and governmental regulations has prevented a more efficient system of outpatient prescriptions from being implemented.

The only preparation of oral morphine that is available is a 10mg immediate release tablet. Although inconvenient by Australian standards, patients were generally able to adjust to the need to take this on a frequent basis - sometimes four or more times per day - without too many problems. Obviously, with such a frequent dosing regime there is a real risk that compliance drops off. Unfortunately, this probably occurs most often in those very patients in whom we are most keen to ensure constant plasma levels of morphine: the patients with severe and uncontrolled pain. Following our first visit to Jamshedpur, we concluded that obtaining oral slow release morphine should be a priority for the future. Further advice from our Indian colleagues led us to conclude that although this would be the ideal situation, the cost implications for the patient would end up outweighing any of the advantages.

Parenteral morphine was effectively not available during our first visit to Jamshedpur, other than in the Intensive Care Unit of the adjacent tertiary hospital. Fortunately, our second visit coincided with this formulation becoming available for inpatient use in MTMH. This comes as a 15mg ampoule and on discussion with both the doctors and nurses in the hospital it was decided that this would be best to administer intravenously. During our first visit to Jamshedpur, we had tried to show the staff how to give subcutaneous injections but soon realised that this was outside of their normal experience and was unlikely to be widely adopted - particularly as the general ward nurses at MTMH were very proficient in intravenous cannulation.

It was therefore a momentous occasion for all concerned when final approval was obtained to use the parenteral morphine and we were able to open the box of morphine. The particular patient who was the first recipient was in the midst of a pain crisis, so we agreed with Dr Patel to follow the Indian practice of a 'morphine trial' ie. injecting small aliquots of morphine at intervals of several minutes until the patient is either comfortable or drowsy. Once the morphine was given

we were then left with two new problems. Firstly, how to store the remaining unopened morphine ampoules in a safe and secure manner that would enable staff to access them after hours - up until that day there was no locked box on the ward - and secondly how to store the used morphine ampoules so that if government officials came to audit the hospital's use of morphine then staff would be able to reconcile the broken ampoules with the patients' medication charts. A workable solution was found but it will be interesting to see if these barriers to use have proven to be so great that staff conclude that injectable morphine is too much trouble and so return to using injectable tramadol.

With respect to adjuvant analgesics for the treatment of neuropathic pain, even though gabapentin and pregabalin are available for purchase in community pharmacies, their high cost prohibits general use. For patients with neuropathic pain, if these 'gabanoids' were beyond the means of the patient then amitriptyline and carbamazepine were the first line choice. Neuropathic pain was clearly a significant problem in the patients we treated in Jamshedpur. Having said that, training local staff in the recognition and treatment of neuropathic pain was forced to take a lower priority because we felt that hesitancy to prescribe adequate doses of morphine was an area of greater educational need.

To conclude, there are many barriers to prescribe morphine - inadequate assessment of the pain, morphine is a dangerous drug to use, it carries a high risk of bringing forward the death of the patient, the pain is not severe enough to commence morphine, there are too many drug addicts in India - but yet we have observed a genuine desire to learn and to improve the quality of pain management in Jamshedpur. Although there remains much more work to be done, there are still many reasons to be encouraged by what can be achieved through Project Hamrahi.

***Come and get involved, you won't regret it!***

Dr Anil Tandon

# 19th International Conference of Indian Association of Palliative Care

**The 19th International Conference of Indian Association of Palliative Care** was held in Kolkata February 2012. Over 400 delegates attended the conference. Dr Vishnu Dutta Paudel from Nepal was the successful candidate of the Inaugural Cancer Aid Society Award for Excellence and Leadership. Dr Dutta Paudel is an Associate Professor and Acting Head of Department of Oncology and

Radiotherapy at The Manmoham Memorial Hospital Thamil, Katmandu, Nepal. The award was given for evidence of leadership in palliative care in Nepal and recognising and meeting the challenge of opioid availability in Nepal. One of the highlights of the conference was the attendance of Robert Twycross. The conference was attended by both nurses and doctors.

## Palliative Care Perspectives

**Dr Parvathy Madhavan**

Below is a copy of the winning speech given by Dr. Parvathy Madhavan given during a debate, "Palliative care should be delivered by any health care professional": at the IAPC conference, Kolkata 2012.

We are living in an era where the number of specializations are increasing, health professionals are narrowing their focus to their respective specialties. A neurologist most often will not pay attention to complaints of hematuria unless you have something like an associated incontinence. A nephrologist will be least interested your headache unless you have something like polycystic kidney disease. In the present situation, palliative medicine is the part of medicine that broadens your focus to not only whole body care and treatment of physical complaints but also psychosocial and spiritual care. It overlaps with all specialties. Can we really afford to restrict palliative care into yet another specialty hence making all other specialists selectively deaf to symptoms which require palliation?

We all know the principles of palliative medicine – beneficence, non maleficence, autonomy and justice. But by restricting palliative care delivery to only palliative health care professionals are we doing justice to our resources? The doctor patient ratio in India is around 1:1700, the population needing palliative care is also vast: it is, if not impossible, at least difficult to reach all that population even if all the present doctors give palliative care and unthinkable if given only by a few trained specialists.

In a few decades, India and China will be the countries with the maximum number of elderly people. A large segment of the population who need palliative care is from the geriatric age group who are very often ignored. Even if it is the bread winner who suffers, most of the families in India do not have the resources for treatment in specialist care hospitals. Hence, the needs of such groups will be addressed only if they can be managed by the local doctor. The disease burden is yet again increased by those with chronic life threatening diseases like cardiac failure and motor neuron disease and also the need for simultaneous care along with curative therapy in diseases like cancer.

We have already been delivering palliative care for centuries through our many systems of alternative medicine. Even before the time of Emperor Ashoka who built many institutions which are very similar to the modern day hospice. Kerala, a tiny state with only 3% of India's population provides two-thirds of India's palliative care services. The reason of the success of palliative care in Kerala is the volunteer and the community support from people who are not even health care professionals. We can say for argument sake that if palliative medicine is practiced by health care professionals who have not specialized in palliative care there might be "overtreatment" of the terminal patient and "undertreatment" of the patients who require long term palliative care. Terminal patients may be hooked up to tubes in ICU's and patients with chronic diseases may not be given adequate symptom relief. However, by increasing the importance of palliative care during the undergraduate years, we can expect that health professionals of the next generation will give more attention to quality of life than quantity of life. And, after all, every person involved in giving health care in any field should know the meaning of a good death.

The exposure to palliative medicine in the formative years of any health professional will not only help in addressing the needs of palliative care patients better but also rekindle the principles of good medical practice in the coming generation and give us better doctors. This I am also saying from my personal experience, as I think after exposure to palliative care, my approach towards the importance of addressing emotional issues of the patient and the family members/carers, communication with the patient, has changed tremendously and I believe that if I had this experience during my undergraduate training, I might have been a better doctor during my house surgeoncy.

Let us consider the issues we have to deal with while delivering palliative care. Often the needs



*Dr Parvathy Madhavan*

are simple issues like pain, nausea, anxiety, constipation, anorexia, wound care etc. Most of these symptoms which make the patient's life miserable are simple issues involving symptom relief and emotional support, the treating of which are essential skills for any doctor and ideally should be dealt with easily by any competent and compassionate physician. Only a small number of patients with difficult physical and psychological symptoms require hospice and specialist palliative care.

In India we follow a tertiary referral health care system. Here we don't expect obstetricians to take all deliveries or pediatricians to treat all pneumonia in children in the rural area. Only complex issues which cannot be managed by health professionals in the periphery are referred to secondary or tertiary level to be managed by the respective specialists. Even in patients who need palliative care, those who need specialist attention form only the tip of the pyramid, all these patients can be easily managed by forming a proper referral system as we do in all other specialties.

The need is, not to just train a few health professionals in palliative care specifically to give perfect attention to the affordable few, achieve academic excellence and technical glory, but also to increase the competency of all health professionals in palliative care principles and increase its focus in undergraduate training and set up a tertiary referral system to provide maximum relief to the maximum number.

# Palliative Care Nursing in Jamshedpur: Is it too soon?

It was the third day of our second visit to Jamshedpur and I found myself standing in front of a class of fourth year students at the School of Nursing of Tata Main Hospital (TMH), to commence the first of four sessions that day. I felt like I was in a time warp. I had been standing in same spot just over a year ago, on our first mentorship visit to Jamshedpur, but it was more than that.

I had to quickly re-establish the etiquette that I had learned the previous year, by remembering that I, as 'Madam', needed to grant permission for the students to enter the room to avoid a clutter of young women in the hall way, resplendent in starched white. While writing on the blackboard, I broke the chalk, it fell to the ground and someone had retrieved and returned it to my hand, before I could be nostalgic for my laser pointer and whiteboard. Everyone was very polite. There was no evidence of 'technology' in the classroom, the only computer I saw was in the staff room, and the books in the library were old editions.

I remembered many of their faces from the previous year, and they said they remembered mine. They appeared happy to see me again. Did they remember what I spoke about the previous year? I asked, they didn't. They were unable to articulate any understanding of palliative care, good communication skills or the concept of 'caring'. Not to worry. Maybe I spoke too fast? I was speaking a foreign language, presenting in English, but maybe I was speaking a foreign language? I was talking about something, a new model of care, which appears to be very far removed from their current day to day, including their position in the health care hierarchy, and something very 'different' from their normal curriculum. In addition, it was possibly something that they were unable to 'champion' and push as change, as they appeared to be very 'institutionalised' or 'managed' in regards to the way they had to behave and the roles they were allowed to perform. The routines and etiquette of standing up first before they answered a question, waiting for me to give them permission to sit down, making coffee for all the lecturers after the session was at the time, something I thought was very sweet, but it put me in a great position of power. How in their future nursing careers will they be empowered enough to work as equal partners in a multidisciplinary team, to utilise learned assessment skills, confidently share knowledge and review and deliver new plans of care? It seemed comparable to my Mother's experience during her training at Royal Perth Hospital in the 1950's. How could I expect them to embrace, understand and deliver something that was commenced in the 1970's and has only been really established as a speciality of health care in the last 20 years?

The School of Nursing at Tata Main Hospital is onsite and currently has 4 'intakes' totalling approximately 110 students (all girls). This includes a PTS

(pre training school) of 7 weeks in the class room, before hitting the wards and then a further 3 years of study and rotational ward work. Accommodation was also onsite, attached to the 'school' and the students lived there. The 'apprenticeship system'. I remember one of my (Australian) university lecturers saying (over 20 years ago) that nurses used to be 'trained' but now we were being 'educated' to enhance the professionalism of the role.

The staff and the students were again very welcoming and enthusiastic about the visit. I remember the previous year they had made me feel like a very special guest. This year I was even asked for my autograph which was fun but, to me, again highlighted the 'divide' and the differences in our reality. The staff felt that my presentations were beneficial to their learning, but I was not so sure it would change their practice in the short term, but I considered that it would potentially aid opportunities for change in the future. At the very least it would enable them to recognise that things could be different.

Despite being one of my goals, I had very little opportunity to work alongside, learn and mentor the nurses. Unfortunately the two palliative care nurses who I met during the first visit, one who had completed the course at TIPS in 2009, who I had planned to spend a lot of time with during the week, were both on leave (one on maternity leave). It also appeared that the opportunities for palliative care delivery, had greatly reduced over the year, and at the small cancer hospital MTMH (where I spent most of my time) there was disappointingly now no nominated nurse.

At TMH, despite Sister Jessenlha being very capable, caring and enthusiastic, both herself and the Doctor (who also completed the course), were providing less on request palliative care consultations due to increased work load demands of their 'core businesses.' Sister Jessenlha was completing pain management, and 'trials of IV morphine' after her work shift had ended, in her own time. Pain assessment was the theme our week, after we had identified the previous year that the gaps were great and that many patients were suffering. The nursing staff did not appear to assess or treat pain well, despite the student nurses in the classroom, giving me a text book definition. I believe there may be many reasons for this and it will take some time and coordinated effort to resolve.

Documentation is not utilised like we are used to. The nursing staff (next door to TMH) at MTMH (The Cancer Hospital) did not write in progress notes and the only documentation at the bedside was a vital signs form. This was completed daily. There are no medication charts, but a 'daily diary' book of medications written out every day which was ticked off when given, and the times of any prn injections added. Any oral medications are given by the packet to the patients to put in their bedside lockers for them to self manage as directed. The palliative care Doctor had designed a small pain chart for patients to score their pain which was not utilised by other staff, and it was the only pain assessment chart I saw. There is hence not an opportunity to assess, document, evaluate or report the analgesia recipe or its benefits. I did not witness if the patients are supervised and 'checked on' to see if the oral medications have been taken, nevertheless reviewed. The practice appeared to be resorting to counting the number of tablets left in the packet to work out if the patient had been 'compliant' or had utilised prn doses. At TMH there were medication charts.



Wendy Scott and Jamshedpur nurses

## Palliative Care Nursing in Jamshedpur: Is it too soon? *continued*

The nursing role was very task orientated, as they have a lot to achieve. They appeared busy and did not have the time to engage effectively with us during our rounds. The main core business is the administration of IV chemotherapy, IV antibiotics, and IV antiemetics and cannulation. There was at least a ratio of one nurse to at least 10 patients. The patient turnover was high as they were caring for both inpatients and chemotherapy day patients (of all ages).

When reporting a patients pain, there appeared to be too much emphasis on the 'emotional' aspect of what the patient was feeling and reporting, and sometimes 'not believing' the patient or thinking the pain is related to the family. Many staff believed it was okay to give placebos and they were useful.

Many of the cancer patients had advanced disease and had severe cancer pain, with opiates being the most effective solution. During the delivery of the Essential Pain Management workshop during the week, which was attended by many nurses, the pre workshop questionnaires identified that, all expressed apprehension about the use of opiates. Due to the lack of access, with parental morphine being used for the first time during our visit, there is a lack of 'exposure' and experience. Even after the workshop, not all respondents to the post workshop questionnaire, felt confident.

Despite my previous perception that the hurdles to achieving access to basic palliative care appeared insurmountable, I was heartened by the enthusiasm of the nursing staff to learn and

their high attendance at the education sessions during the week. A journey of a thousand miles begins with but a single step, and I do believe that with enhanced management and support by key senior staff, there are great opportunities for change. The nursing staff in Jamshedpur are a valuable asset and with good leadership and continued mentorship, palliative care services could be developed and improved. It's not soon enough.

Wendy Scott

## Websites of interest

Human Rights Watch website for Access to Pain relief to become a Human Right.

<http://www.stoptortureinhealthcare.org>

## Looking for a different Christmas present idea?

**Make a donation to APLI on behalf of a loved one.**

The funds will contribute to strengthening projects such as Hamrahi that are working towards bettering Palliative care in India.

**DIRECT DEBIT TO:**  
Name: Australian Palliative  
Link International  
BSB: 063806  
Account: 10160981