Diversity in palliative care between the UK and Germany

An increasing number of doctors from Germany come to the UK to learn about palliative care. However, using that experience once they return home is not always easy, as **Eva Katharina Herrmann** and **Claudia Bausewein** know only too well

To gain experience in palliative care, more and more German doctors are working for a while in the UK, where it originated, so that they can then help to implement it in the German healthcare system. However, transferring what they have learned in a British hospice or palliative care unit to a German hospital can be a major challenge.

This is certainly the experience of the authors of this article. The first author recently worked in a palliative care unit in London and is now involved in setting up a similar unit in a haematology and oncology department in Berlin. The second did a placement in a UK hospice in the early 1990s and then went on to set up two palliative care units in Munich.

Key points

- For a foreign doctor, learning palliative care in the UK, where it originated, can be a rewarding experience and a fertile ground for mutual learning.
- In palliative care, there are significant differences between the UK and Germany regarding implementation of services, availability of drugs, routes of administration, habits, attitudes and expectations.
- Differences in the respective healthcare systems make it difficult to transfer palliative care practices directly from one country to the other.
- Working in another healthcare system stimulates a process of questioning one's own practice. The art is to decide which practices can and should be transferred and in what way they need to be adapted to local circumstances.
- Working in a different country raises awareness of a crucial question: how should common standards be formulated in an international context?

Two different healthcare systems

Where is the challenge? First, the two healthcare systems have a completely different structure with regard to financing, general practitioners, access to specialist care, home care and the implementation of palliative care. Second, drugs that are routinely used in palliative care in Germany are not available in the UK and, likewise, drugs that are regularly used in the UK are unknown to German doctors. Third, drug administration in the UK differs from that in Germany. Finally, different 'cultures of care', values and expectations lead to different decisions about initiating, withholding or withdrawing treatment. At first, these varying ways of thinking and acting appear to conflict and seem difficult to reconcile.

In this article, the authors share some of their experiences of working in the UK and of transferring British palliative care practices to the German health system.

What are the differences?

Availability and use of medication

For the sake of brevity, only some differences regarding analgesics will be discussed, although the availability of certain anti-emetics, laxatives and antimuscarinics differs, too. Looking at the various drugs available for pain management according to the WHO pain ladder,[1] there are several differences between the two countries that have a significant impact on the prescription of analgesics.

Non-opioids: metamizol/dipyrone

Regarding the use of non-opioids, one of the deepest differences is the absence, in the UK, of metamizol – or dipyrone as it is called in the English literature. This is a highly potent non-opioid analgesic with antipyretic and

spasmolytic effects, and fewer gastrointestinal adverse effects than non-steroidal anti-inflammatory drugs (NSAIDs). It has been withdrawn from the market in some countries, including the UK, because of the adverse effect of agranulocytosis. In a Swedish trial, the reported incidence of agranulocytosis associated with metamizol was estimated to be at least 1:1,439 prescriptions.[2] In a large trial in several European countries, the estimated excess risk for any exposure to metamizol was 1.1 per million.[3] In Germany, it is universally used for cancer pain, alone or in combination with opioids.[4] In the UK, paracetamol seems to be the drug used in its place.

Weak opioids

Whereas in the UK, co-codamol seems to be the most frequently prescribed medication for step two on the WHO ladder, this fixed combination of codeine and paracetamol is hardly used in cancer pain management in Germany. Instead, the two weak opioids tramadol and tilidin are regularly used, often in combination with metamizol.[5] Tramadol, which is also used in some British palliative care units, has the advantage of possible subcutaneous administration, which makes it a good drug for pain management before strong opioids are introduced.

Strong opioids

In general, the same strong opioids (except diamorphine) exist in both countries. However, there are differences in the availability and the use of their different forms. Liquid morphine is available in Germany, but its use is not well established. Instead, immediate-release morphine tablets are preferred in many German hospitals, despite the fact that the lowest dose in tablets is 10 mg, whereas the liquid form can be prescribed at much lower doses.

The use of immediate-release opioids for breakthrough pain in a dose adjusted to the regular analgesics is not well established in many German hospitals. Patients either do not receive *prn* opioids at all, or they are given them in a dose unrelated to their daily regimen or in slow-release form. In Germany, outside palliative care, immediate-release opioids are rarely prescribed for titration purposes. The morphine dose is often titrated using regular slow-release morphine in combination with *prn* immediate-release morphine. Consequently, some healthcare professionals in Germany are unfamiliar with, and therefore initially suspicious about, dose titration by four-hourly application of immediate-release morphine. In addition, the usual drug charts are not adequately designed for prescription of four-hourly opioids at specified times.

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Opioid rotation is still an unfamiliar concept in many German hospitals and is complicated by the fact that immediate-release oxycodone is only just coming on to the market in Germany. This means that, until now, titration of oxycodone has only been possible using its modified-release form or oxycodone for injection. Presumably, this is one of the reasons why oxycodone seems to be used less frequently in Germany than in the UK. On the other hand, hydromorphone and fentanyl – especially as a transdermal patch – are prescribed more often in Germany than in the UK.

Routes of administration

Subcutaneous administration of medication, often as continuous subcutaneous infusion via a syringe driver, is universally accepted in the UK and has been for many years.[6,7] In Germany, subcutaneous administration is not much in use, especially not for continuous infusions. It is considered old-fashioned and thought to be uncomfortable for the patient.

The majority of cancer patients in Germany have constant intravenous devices (portocaths), and nurses in the community are well trained in handling portocaths and intravenous infusions,

often more so than in handling continuous subcutaneous infusions. Therefore, it might be more sensible to use an existing portocath for a continuous intravenous infusion rather than apply a separate subcutaneous line. The wide availability of portocaths also means that everyone is used to intravenous application as a standard for continuous infusions as well as parenteral bolus application.

Implanting a portocath for parenteral access is relatively common in Germany. Suggesting medication via a subcutaneous route is likely to elicit reactions such as, 'Subcutaneous? That's what we used to use 30 years ago …' or 'Wouldn't it be better to implant a portocath? Then the patient could get parenteral nutrition, too …' This is particularly true in the inpatient oncology sector, where there is no affiliation to palliative care. However, in outpatient care as well as in palliative care units, acceptance of the subcutaneous route has risen significantly over the past few years.

In Germany, patients and relatives tend to expect that a patient will automatically be given intravenous hydration or nutrition if they are not eating or drinking 'enough'

Habit certainly plays an important role with regard to these attitudes and preferences. Whereas in the UK, the subcutaneous route has been used for a long time and seems to be well accepted and well tolerated by patients,[7] an Italian survey concluded that patients and their carers preferred the intravenous route, at least for hydration.[8] In Germany, patients who are used to being given medication and fluids intravenously might prefer it to the unfamiliar subcutaneous route.

A change in attitude would enable patients and their families, aided by their professional carers, to make an informed choice, but this can only be brought about by altering current practice to make subcutaneous infusion an option on hospital wards, as well as by informing and educating the public.

There are also differences regarding the mode of drug delivery. Continuous infusion of drug mixtures is only slowly being accepted in Germany. It is mainly implemented by those who have worked in the UK and have included it in their teaching to other doctors. Many palliative care units still prefer bolus doses every four hours rather than continuous infusions.

Whereas, in the UK, most palliative care units use the same or very similar types of syringe drivers for continuous infusions, a remarkably large range of devices are used in Germany. In addition to syringe drivers such as the Graseby MS26, there are pumps with easily adjustable rates measured in ml/h, with or without bolus function, and several types of computer tools for patient-controlled analgesia. Many professionals favour computer-based systems, believing they are safer. But they involve more incidental costs and many home care providers do not know how to handle them.

Values and expectations

In the UK, palliative care team members are just as often confronted with the question of whether intravenous medication or hydration still make sense – especially when the patient is transferred from haematology or oncology to palliative care – as they are with the plea, 'He/she is not drinking/eating enough, can't he/she have some intravenous fluids/calories?' In Germany, patients and relatives tend to expect that a patient will automatically be given intravenous hydration or nutrition if they are not eating or drinking 'enough'.

Equally, total parenteral nutrition is often prescribed by doctors and nurses without questioning whether or not it is indicated, even near the end of life. In part, this automatic prescribing is brought about by the readily available intravenous access: the portocath. While in the UK palliative care unit, the norm is not to give parenteral nutrition to a patient near the end of life and to evaluate carefully the indication for hydration, in Germany, the norm, at least on non-specialised hospital wards, involves hydration until death and, in many cases, nutrition until a very late stage as well.

Again, there probably is a reciprocal causality between these factors: as long as most patients are given fluids and often also parenteral nutrition near the end of life, relatives and professional carers will expect this practice to continue. In turn, these expectations will contribute to perpetuating the practice. It will be the task of palliative care services and future research to provide standards and guidelines regarding assessment for, and decisions about, hydration and nutrition in order to apply them more rationally.

The art of connecting diversity

These are some of the differences that the authors experienced when working in palliative care in the UK. It is not for us to judge which ways are better. Every practice has to be seen in its specific context and various aspects have to be considered. The intention of this article is to make people aware, first, that what they learn in

one country is not necessarily easy to transfer to another country; alternative ways of management, including different drugs, may have to be considered, and creativity and flexibility will help implement new ideas. Second, that working in another healthcare system can help you question your own practice as well as the unspoken practice of colleagues. The art is to find a balance between appreciating the pre-existing, ‘grown’ practice with its own tradition and challenging it by considering the British way. To achieve that balance, one has to decide which aspects of the British practice can and should be transferred into the German system and in what way they need to be adapted to local circumstances. Ideally, this process should ensure optimal functioning of the team and the whole system within its unique context.

These observations relate to two European countries with similar standards. This gives us an idea of the problems people from other parts of the world might face when they are confronted with far deeper differences between their country and the UK. It raises the questions of how common standards should be formulated in an international context and how they should to be adapted to local circumstances.

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