

PRACTICAL Palliative Care Today

A Professional Newsletter of San Diego Hospice and Palliative Home Healthcare

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The WHO Step-Ladder: Steps Two & Three

In the last issue of Practical Palliative Care Today, we discussed the first step on the WHO step-ladder, the administration of non-opioid analgesics and non-steroidal, anti-inflammatory drugs (NSAIDs) to manage pain. In this issue, we present steps 2 and 3 of the ladder and discuss when and how to administer an opioid when non-opioid interventions do not sufficiently relieve pain.

Step Two: Weak Opioids

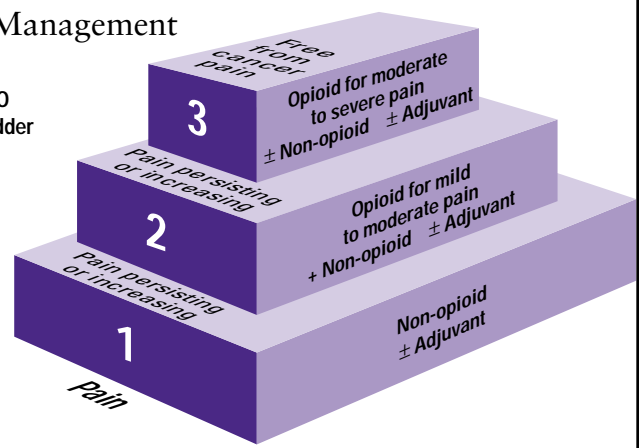
Weak opioids by definition are those that are less potent than strong opioids. However, there is confusion about relative potencies of different opioids due to single dose versus chronic administration studies. Resources disagree. Some rate both oxycodone and hydrocodone weaker than morphine while others rate them both as equianalgesic to morphine. It is highly confusing.

To make matters worse, these opioids are frequently combined with the co-analgesic acetaminophen in fixed combination tablets. Often, it is the approach of acetaminophen toxicity that limits the prescription rather than a true ceiling effect for the opioid.

Codeine, however, is definitely a weak opioid. It cannot cross the blood-brain barrier until it is metabolized to morphine in the liver. The enzymatic conversion in the liver is the limiting factor and prescribing more than 120mg of codeine (two tylenol #4 tablets every four hours) will only result in more codeine binding to gut receptors causing worsening constipation with no concomitant improvement in pain relief.

Pain Management

The WHO Step-Ladder



Propoxyphene has been found to be no better than placebo in many trials. Prescribing Darvon or Darvocet-N-100 for pain is ineffective, except for the acetaminophen in the latter formulation. Patients do like propoxyphene however for its limbic system stimulation and the resulting euphoric effects.

The problems with step two of the WHO step-ladder can be summarized as follows:

- There is often a ceiling effect for analgesia whether direct or indirect due to being in fixed combination with acetaminophen.
- Often when the patient is advanced to a strong opioid, they are advised to

take the weak “leftover” medication to relieve breakthrough pain that is incompletely relieved by the new strong opioid. This is completely irrational!

- Confusion regarding fixed combination agents and their relative potencies.

The solution is relatively simple. Delete step two. Do not prescribe weak opioids or fixed combinations of opioids and acetaminophen. Instead start with lower doses of stronger opioids. There is no difference in prescribing 5mg oxycodone (Percocet) or 5mg oral morphine. Starting the stronger opioid in lower dosage eliminates the temptation to prescribe weak opioids for

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On Bereavement

Nothing can fill the gap
when we are away from
those we love and it
would be wrong to try
and find anything.

We must simply hold
out and win through.

That sounds very hard at
first, but at the same time
it is a great consolation,
since leaving the
gap unfilled preserves
the bond between us.

It is nonsense to say that
God fills the gap; he does
not fill it, but keeps it
empty so that communion
with one another may
be kept alive, even at the
cost of pain.

Dietrich Bonhoeffer

Writing from a Nazi Prison

From the desk of the editor ...

As we stated in the last issue of this newsletter, pain remains one of the most distressing symptoms and most common complaints of our patients at San Diego Hospice. It can and must be controlled so that our significantly ill patients may complete their lives and meet their psychosocial, emotional, and spiritual needs. In fact, we believe that state-of-the-art pain control should become the standard of care for all patients, including those with non-life-threatening illnesses.

This issue of *Practical Palliative Care Today* continues the discussion of pain management started in our last newsletter. It forms the second part of a multiple part monograph on pain management. My colleagues and I hope you will keep all of these issues as a reference.

In this issue, we will discuss the rational prescription of opioids, differentiating between weak and strong opioids, with advantages and disadvantages openly revealed about specific drugs.

We will briefly review opiate pharmacology and the physiology of opiate receptors in order to better understand the effects modulated by these medications. This leads to a discussion of

opioid side-effects and the opioid myths of addiction and tolerance.

The concept of opioid rotation and general principles of opioid administration are defined and listed. Each of several specific strong opioids is then discussed in depth.

The section titled *Integrative Palliative Care* provides a discussion of Energy Therapies by Patti Mittendorf, San Diego Hospice Nurse Practitioner and Energy Practitioner. A case misinterpreted as pain responds to Healing Touch.

In *Meet the Staff*, it gives me a great deal of pleasure to introduce our two most recent additions. I'm sure you will be impressed with the academic credentials and international leadership in palliative medicine provided by Drs. Charles von Gunten and Frank D. Ferris.

As editor, again I invite your comments and contributions. I hope you enjoy this newsletter.



Michael E. Frederich, M.D., Editor

Meet the Staff

Two physicians with impeccable academic credentials joined San Diego Hospice Corporation on August 1, 1999. The addition of Drs. Charles von Gunten and Frank Ferris brings our total of full-time palliative medicine boarded physicians to eight. Our San Diego Hospice medical staff has more such physicians than any other program in the United States.

Charles F. von Gunten, M.D., Ph.D., is the Medical Director of the Center for Palliative Studies at San Diego Hospice and has a teaching appointment at the University of California at San Diego, School of Medicine. Charles currently serves as a consultant to the Ethics Standards Division of the American Medical Association and the National Board of Medical Examiners in the area of end-of-life care. He also currently serves as vice chairman of the board of the American Board of Hospice and Palliative Medicine and as a member

of the board of directors of the American Academy of Hospice and Palliative Medicine.

Charles received the Bachelor of Arts Degree with honors from Brown University in 1978. He then earned a Ph.D. in Biochemistry and an M.D. degree with honors from the University of Colorado Health Sciences Center. He subsequently pursued and completed residency training in internal medicine and subspecialty training in hematology and oncology at the McGaw Medical Center of Northwestern University.

Prior to joining San Diego Hospice Corporation in August, Charles was an assistant professor of medicine at Northwestern University where he directed programs in hospice and palliative care, education, and research. He continues to hold the academic rank of Associate Professor of Medicine, Northwestern University Medical School.

Charles' main task with San Diego

Hospice Corporation consists of oversight of education and research. Organizing and fine-tuning our current medical student and resident rotations is only one part of his responsibility. Charles has received grant funding for one of the Roxane Visiting Scholars in Hospice and Palliative Medicine Programs in the past and is hoping to continue a similar program in San Diego. The program consists of physicians practicing palliative care who wish to improve their skills and involves the development of flexible individualized programs to meet the individual needs and time constraints of busy practitioners.

To say that Charles von Gunten M.D., Ph.D. is a leader among academic hospice and palliative care physicians in the U.S. is an understatement. More accurately, he is the leader, and we at San Diego Hospice feel very fortunate to have his guidance and leadership in the areas of education and research. *Continued on page 4*

pain unrelieved by strong opioids.

Step Three: Strong Opioids

Before beginning the discussion of the pharmacology of specific strong opioid analgesics, it is necessary to discuss briefly opioid physiology including receptors. For the purpose of this discussion we will focus only on the mu-1 and mu-2 receptor with morphine as our prototypical medication.

Mu-1 opioid receptors are unique in neuropharmacology because all opioids including morphine will bind to mu-1 sites with greater potency and affinity than to their respective selective sites. Morphine binds better to the non-specific mu-1 receptors than to its specific mu-2 receptors.

This is very important and may be understood from the following table of effects:

Effects of Mu Receptor Activation

Mu-1	Mu-2
Analgesia	No Analgesia
No Apnea	Apnea
Indifference	Sedation
Miosis	Myoclonus
Nausea & Vomiting	(rhythmic total body jerks)
Constipation	

Every time a patient is given a therapeutic dose of an opioid, all the medication is bound at mu-1 sites and the patient experiences analgesia or pain relief. Nausea and vomiting are usually a transient problem and constipation continues. There is no respiratory depression as a mu-1 effect.

It is only when the dose of opioid is too high and saturates mu-1 receptors that the opioid begins binding with mu-2 receptors. This may lead to apnea and sedation and death. However, there is a wide therapeutic window or range based on the number of individual mu-1 receptors an individual patient possesses.

One can also monitor a physical parameter to ensure the patient is not

bordering on mu-1 oversaturation. If the pupils are not constricted, there is no danger of mu-1 oversaturation. Checking the patient's pupils, therefore, is a reasonable safety check before increasing opioids.

With chronic administration of opioids, a phenomenon known as plasticity develops with increasing or decreasing numbers of opioid receptors. Sometimes related to advancing disease or poor nutritional status, this plasticity requires that opioid dosing be repeatedly changed to meet the needs of the patient.

Managing Opioid Side Effects

Opioid side effects can be very distressful to patients. Because these potential problems are predictable with prescribing opioids, they should be managed prospectively and prophylactically whenever possible. Common side-effects include constipation, nausea and vomiting, sedation and confusion, pruritis, respiratory depression, and myoclonus.

Constipation occurs with every opioid. There is no objective evidence that one opioid is less constipating than others. Constipation is caused by opioid receptors in the gut that slow peristalsis. Unfortunately there is no tolerance to this problem and dietary interventions alone are not sufficient to relieve it. The problem is compounded in the elderly and terminally ill because of decreased fluid intake and decreased mobility. Treatment usually includes softener/stimulant combinations dosed routinely with more aggressive interventions (eg. enemas) if bowel evacuation does not occur at least every third day.

Nausea and vomiting is often transient at initiation of opioids and is a result of vestibular instability. Tolerance to this mechanism usually develops after a few days, but nausea and vomiting may persist due to slowed gastrointestinal peristalsis. Because the early mechanism is movement induced, the patient should be advised to move slowly, and should be given meclizine (Antivert) or scopolamine (TransdermScop) before initiating the first dose of opioid. Later in the disease process when

nausea and vomiting becomes multifactorial, rational combinations of anti-emetics are more effective. Haloperidol and Diphenhydramine or Metoclopramide and Promethazine are effective combinations.

Sedation at initiation of opioids is often a very transient effect. The patient sleeps because he or she is able now that the pain is relieved. If the sedation continues to be problematic, stimulants such as dexedrine or methylphenidate may be helpful.

Pruritis is usually a result of direct histamine release by morphine, not an allergic phenomenon. Opioid rotation and treatment with an anti-histamine are usually indicated.

Respiratory depression and myoclonus are both mu-2 effects that are readily avoided by careful titration of the opioid.

Principles of Opioid Administration

Giving medication routinely by the clock assures that opioid receptors will remain saturated and that pain relief will be continuous. It makes no rational sense to prescribe a medication that is effective for four hours every six hours or one that is effective for twelve hours every two hours. Do not prescribe prn dosing unless it is for incident or breakthrough pain as a rescue dose.

Remember: PRN means Pain Relief Not!

Frequent re-titration of dosage is indicated in unstable disease. If the disease is progressive, increasing the dosage is likely. If the patient is anorexic and has a poor nutritional state, the dose may need to be reduced. There is no maximal dose of opioid. There is no end-organ damage from opioids. The correct dose is one that relieves pain and provides comfort with minimal side-effects.

Opioid Rotation

Many strong opioids exist. These include morphine, hydromorphone, oxycodone, methadone, levorphanol, fentanyl and meperidine. Each has its own positive and negative attributes. But one concept is universal. If one is not working to control pain or if the patient is experiencing too many side-effects, the opioid should be rotated to another. Having all these strong opioids is a blessing and gives a great deal of flexibility.

Knowledge of opioid equianalgesic dosing is critical to rotation of opioids, however. Using the following table should facilitate accurate titration to some extent:

Opioid Agonist		Equianalgesic Dose	
		Oral	Parenteral
Morphine	Q4h	30mg	10mg
Hydromorphone	Q4h	7.5mg	1.5mg
Oxycodone	Q4h	30mg	NA
Methadone	Q8h	30mg	10mg
Levorphanol	Q8h	4mg	2mg

The existence of incomplete cross-tolerance in rotating opioids is also somewhat problematic. If the patient is being rotated because of intolerable side-effects and the pain is controlled, it is necessary to reduce the starting dose to 75% of the direct conversion dose to avoid toxicity. Providing additional strong opioid dosing is mandatory, however, so the patient may rescue themselves for pain incompletely relieved by this calculation.

Mixed opioid agonist-antagonist combination agents are not indicated for use in chronic pain management. Initially constructed to have an analgesic ceiling in order to prevent addiction and tolerance, their variable effects at opioid receptor sites prohibit their use. In fact, prescribing a mixed combination agent may precipitate withdrawal in a patient taking a pure-opioid agonist for pain. Therefore medications like pentazocine (Talwin), butorphanol (Stadol), Nalbuphine (Nubain) and Dezocine (Dalgan) should be avoided.

Fentanyl: The Patch

Fentanyl is the shortest acting strong opioid available. For years it has been given immediately post-operatively in surgery by the anesthesiologist to relieve pain caused by the post-operative transfer to recovery.

The most common form of fentanyl prescribed for chronic pain management is in the form of the Duragesic Patch. The patch consists of a unique transdermal delivery system that supplies fentanyl to the patient's subcutaneous tissue reservoir. The duration of action in the average patient is 72 hours given the usual passive absorption across the skin and the rate of uptake by the subcutaneous capillaries. High output states such as fever may increase the rate of uptake in the capillary bed, accelerating the rate of absorption across the cutaneous barrier. Observation is necessary to determine the "rapid uptake" patients and make appropriate dose adjustments (usually changing the patch every 48 hours instead of every 72 hours).

Because transdermal fentanyl is a long-acting delivery system with over twenty-four hours required to reach steady state, patients who require rapid titration of opioids should be treated with different delivery systems. It is an excellent delivery system, however, in patients with stable pain or in those who have difficulty swallowing. Transdermal fentanyl is available in dosage strengths of 25, 50, 75, and 100µg/hr. The twenty-five ug patch is approximately equivalent to 50mg of morphine per 24 hours.

While the fentanyl patch is not recommended for very young children, oral transmucosal fentanyl (Oralet) is effective for brief pain relief for children during procedures like bone marrow aspiration. Another version of oral transmucosal fentanyl (Actiq) is available for rapid onset, short acting, breakthrough medication. Because fentanyl is highly lipophilic, (absorbed between cells) it reaches blood and CSF levels much quicker than other hydrophilic opioids (absorbed through cells.)

The accepted indications for transdermal fentanyl are:

1. Patients who cannot swallow
2. Patients with compliance issues (especially if unable to remember to take pills)
3. Occasionally in long-term care settings where limited medication administration time would otherwise result in omission errors.

Meet the Staff

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Frank D. Ferris, M.D., is the Medical Director for Palliative Care Standards and Outcome Measures at San Diego Hospice. Frank currently serves as Senior Consultant, writer and editor for the Education for Physicians in End-of-Life Care (EPEC) Project of the American Medical Association and as Chairman of the Standards Committee of the Canadian Palliative Care Association. He is therefore active in setting and defining standards of practice in palliative medicine throughout North America.

A graduate of McMaster Medical School in

Hamilton, Ontario, Frank received postgraduate training in Internal Medicine and Radiation Oncology through the University of Toronto. He completed a Fellowship in Pain and Symptom Management at the Toronto-Sunnybrook Regional Cancer Centre in 1991.

Frank chairs both the education and development committees of the American Academy of Hospice and Palliative Medicine. He is a Faculty Scholar in the Project on Death in America (New York) and a Research Consultant for the HPC Net

Project at the Temmy Latner Centre for Palliative Care in Toronto.

Frank's main task with San Diego Hospice will be to develop standards in palliative care and to organize, promote, complete, and publish outcomes measurement research in the field of hospice and palliative medicine. Through the accomplishment of this task, we will be able to prove that the high quality end-of-life care delivered by San Diego Hospice truly does improve the quality of living and dying experienced by patients and families cared for by this program.

Morphine: The Gold Standard

Morphine remains the gold standard of strong opioids at least in part because it is the only opioid that may be administered by all possible routes. Multiple dosage forms exist including oral controlled or sustained release tablets and capsules, immediate-release tablets, capsules, and liquid, and parenteral forms. Morphine may be administered orally, sublingually, rectally, subcutaneously, intravenously, or intrathecally.

One disadvantage of morphine is the stigma of the name and the fear it generates. This alone may be extremely difficult to overcome and necessitate opioid rotation.

In starting morphine in an opioid-naïve patient, low doses are required, particularly in elderly individuals or in those with compromised renal function. Morphine may not be the drug of choice for these individuals because of a potent metabolite, Morphine-6-Glucuronide, which is manufactured in the liver and excreted in the kidney. A suggested starting dosage of 5mg every four hours for these patients is indicated for this reason.

In healthier, less fragile, patients a loading dose of immediate release oral morphine may be helpful to begin building a therapeutic level and mu-1 receptor saturation more quickly. It definitely will provide significant immediate relief to a suffering patient. Morphine 30mg PO STAT is usually a sufficient dosage.

Using an opioid conversion table, calculate a reasonable starting dose for the patient. For a patient with significant unrelieved pain it is not unusual to start at a routine dose of morphine 10-20 mg orally every four hours. To allow easy titration, prescribe morphine liquid concentrate 20mg/cc. Also allow the patient a breakthrough or rescue dose to take prn. Usually this is one-half of the routine dose every hour prn. This truly provides patient controlled analgesia (PCA by Mouth.)

When initiating therapy with morphine, especially if the patient has been sleep deprived due to pain, an HS dose of controlled or sustained release morphine is helpful. By prescribing an agent that will be effective for up to twelve hours, there is no need to wake the patient during the night to take medication.

The initial morphine regimen is summarized:

Oral Morphine Immediate Release (20mg/cc)

Loading dose: 30mg
Routine dose: 10-20mg Q 4hr
Breakthrough: 5-10mg Q 1hr prn

Controlled Release Morphine

HS dose: 30-60mg 10pm

After a few days, the total morphine dose per day required for comfort is calculated. It is divided by two resulting in the twelve hour dose for the controlled or sustained release morphine. The liquid concentrate oral morphine is continued for breakthrough pain and the dose is adjusted to one-third the twelve hour dose and made available to the patient every hour as needed.

For example, a patient whose initial twenty-four hour dose requirement was morphine 120mg would be converted as follows:

Controlled Release Morphine

Routine dose: 60mg Q12hrs

Oral Morphine Immediate Release (20mg/cc)

Breakthrough dose: 20mg Q1hr prn

Morphine Titration

When it is noted that the patient requires three or more breakthrough doses in a twenty-four hour period, it is time to titrate the dose of controlled or sustained release morphine upward. If the patient requires three breakthrough doses to remain comfortable, add the controlled or sustained release daily dose of 120mg to three times the breakthrough dose of 20mg (60mg) for a total of 180mg of morphine

required daily for pain relief.

Dividing morphine 180mg by two gives the new dose of controlled or sustained relief morphine 90mg Q12hrs. Don't forget to increase the breakthrough dose similarly by dividing the new Q12hr dose by three. The new breakthrough dose is thus morphine 30mg Q1hr prn.

By using this technique and system, morphine can be prescribed accurately with no guessing involved in titration. Best of all, this system does not rely on the patient taking the intermediate and often difficult step of rating his or her pain with a number.

New Morphine Releases

A twenty-four hour controlled release form of morphine is now available, Kadian. It is a capsule containing pellets which may be opened and sprinkled. Each individual morphine pellet has sustained release properties and therefore efficacy for twenty-four hours. This formulation is particularly useful in patients with swallowing difficulties and may be administered via gastrointestinal tubes with calibers greater than 16fr.

A new agent combining morphine and dextromethorphan may be available soon enhancing analgesia through a combined effect at the mu and NMDA receptor. This combination may have twice the efficacy and twice the effective interval of immediate release morphine.

Oxycodone: Morphine Without the Stigma

Oxycodone is a potent strong opioid analgesic without the stigma of the word morphine attached. It has a relatively high oral bioavailability of 60-87%, a short elimination half-life, no ceiling effect for analgesia, and both a controlled release and immediate release form available. Unfortunately, it is not currently available in parenteral form.

In its controlled release form it is either one and one-half *Continued on page 6*

Opioid Myths

There are many myths about prescribing strong opioids that sometimes inhibit physicians from prescribing and patients accepting these medications. The JUST SAY NO TO DRUGS campaign has been misinterpreted by many pain patients to mean themselves. Many physicians are very concerned with abuse potential, recreational use and diversion of these controlled substances. For the most part, these issues are irrelevant for chronic pain patients.

Addiction

Addiction is defined as psychologic dependence: aberrant behavior causing an overwhelming involvement in the use or acquisition of a drug for euphoria. Usage is generally out of control. The patient is obsessed with obtaining a supply. Use causes personal and legal difficulties and continues despite these problems. The user denies taking the substance and most importantly, quality of life is not improved.

Patients taking opioids for pain management exhibit none of these behaviors. Large clinical trials have documented that the incidence of drug-dependent behavior in chronic pain patients is less than one per thousand.

In 1994, Russell Portenoy, M.D., in *Progress in Pain Research and Management Volume 1*, divided normal drug-related pain, not addiction behaviors from aberrant

drug-related behaviors. Hopefully the following table will be useful in identifying the variation.

Normal (pain, not addiction)	Aberrant (drug-related)
Complain aggressively for more drug	Stealing prescription drugs
Hoard medications	Buying or selling prescriptions
Request specific drugs	Forging prescriptions
Seek drugs from many physicians	Altering drugs
Vary dose on their own	Repeated unauthorized escalations in dose
Resist changes	
Experience anxiety	Deteriorating quality of life

Tolerance

Tolerance is another concern and another opioid myth. Both physicians and patients frequently fear that early dosing with these medications “before the pain gets really bad” will lead to opioid ineffectiveness when it is needed most. This effect does not happen with opioids administered for chronic pain. Usually the need for escalating dose is based on advancing disease and increasing numbers of mu-1 opioid receptors. In many patients despite advancing disease, the same low dose of oral opioid is effective for months.

Neither fear of addiction or tolerance should impair our ability to prescribe opioids for persons with chronic pain. They are definitely opioid myths.

Morphine, The Gold Standard *continued from page 5*

or twice as strong as morphine. In its immediate release form, it is most often considered to be as strong as morphine.

The combination of these two forms may be prescribed as follows (similar to the morphine system just reviewed.)

Oxycodone Immediate Release (20mg/cc)

Loading dose: 20mg
Routine dose: 10-20mg Q4hr
Breakthrough: 5-10mg Q1hr prn

Oxycodone Controlled Release

HS dose: 20-40mg 10pm

If the total amount of oxycodone taken in twenty-four hours was 120mg, the conversion would be as follows:

Oxycodone Controlled Release

Routine dose: 60mg Q12hr

Oxycodone Immediate Release (20mg/cc)

Breakthrough: 20mg Q1hr prn

Hydromorphone

Currently hydromorphone is available

as immediate release tablets. It is very potent: seven times stronger than morphine parenterally and five times stronger than morphine orally. Unfortunately, there is no available sustained or controlled release form of the medication available in the United States yet, but it is being developed. When this becomes available, three opioids will work within the controlled release, immediate release system outlined: morphine, oxycodone, and hydromorphone.

Because of its relative potency, hydromorphone is a good alternative to morphine when prescribed in subcutaneous infusions where volume is limited.

Methadone

Methadone, like all opioids, has advantages and disadvantages. It costs less than other strong opioids and this may be a factor. However, it has a long half-life and accumulates particularly in the elderly. It is difficult to titrate quickly and the time to reach a steady state may be longer than a week. Initially it

requires dosing a shorter intervals than its chronic interval of eight hours.

In general, methadone is a good alternative in experienced hands. If it is being prescribed as part of an abuse prevention maintenance program, it is best to prescribe another opioid for pain management so as not to confuse the two issues.

Levorphanol

Like methadone, levorphanol has a long half-life and is difficult to titrate. It is not inexpensive and therefore lacks methadone's advantage. Practically speaking this opioid is not useful.

Meperidine

Meperidine (Demerol) is not indicated for the management of chronic pain. The AHCPA guideline states this directly. Due to a toxic metabolite, normeperidine, which accumulates in chronic administration and which has caused restlessness, hallucinations, seizures and death, this medication should be removed from hospital formularies.

Integrative Palliative Care

The San Diego Hospice Integrative Palliative Care Team continues to organize and draw together individuals within San Diego Hospice and in the community to further learn about and apply integrative medicine techniques to the care of our terminally ill patients. The word *integrative-versus complementary or alternative* was specifically chosen because these therapies are integrated into the plan of care to complement traditional modern American palliative medicine. They do not stand alone. In this issue, energy therapies are discussed.

Energy Therapies

In 1996, San Diego Hospice addressed the need to reverse trends which distanced patients from their caregivers by incorporating certain touch therapies known as energy therapies into our palliative treatment regimens. Healing Touch, Reiki, and Therapeutic Touch are provided by energy-trained staff members and volunteer energy practitioners from the San Diego community. Results have ranged from the general (an increased sense of well being, deep relaxation and release from fear) to the specific (easier breathing and less pain). Some individuals have noted insight into personal and family problems while others have received the energy to release and let go.

All three types of energy therapies utilized at San Diego Hospice have common roots in the traditions of India. All three types of therapies work in the dimensions of body, mind, and spirit. Each, however, consists of different techniques.

Healing Touch consists of various techniques built on a philosophy of caring for the whole person based on the theory of the human energy field. It is used to influence changes in the human energy field affecting physical, emotional, mental and spiritual health.

Reiki, which originated in Japan, means “universal life energy.” Used

within the context of the Usui System of Natural Healing, it accelerates the body’s ability to heal physical ailments and opens the mind and spirit to the causes of disease and pain. Reiki provides persons with the means of maintaining balance in their own and others’ health and it requires simply the hands in order to provide

Energy therapies arise from diverse healing traditions that are based on a philosophy which considers a person as consisting of intertwined mental, emotional, spiritual, and physical components, some of which extend beyond the physical body.

the treatment.

Therapeutic Touch is a consciously directed process of energy exchange during which the practitioner provides the intention to relieve the patient and uses his or her hands as a focus for facilitating healing.

Energy therapies arise from diverse healing traditions that are based on a philosophy which considers a person

as consisting of intertwined mental, emotional, spiritual, and physical components, some of which extend beyond the physical body. Non-invasive touch therapies are performed by the use of the practitioner’s hands either directly on or over the body to facilitate a sense of peace, harmony, and balance within the human energy system.

According to Janet Mentgen, the founder of Healing Touch:

“The human energy system is the name given to the combination of energy tracts (meridians), energy centers (chakras), and energy field (aura). These components act interdependently and influence physical, emotional, mental, and spiritual life.

The human energy field appears to be affected by human touch. The North American Nursing Diagnosis Association defines an energy field disturbance as ‘a disruption of the flow of energy surrounding a person’s being which results in a disharmony of the body, mind and/or spirit.’

Energy therapies use human touch to restore a harmonious flow of energy within and around the patient.”

Case Study

A 92-year-old former schoolteacher lay in her bed at a skilled nursing facility wishing only to be left alone. She once stood like a piper in front of thirty children, but now her heart was so weak

Continued on page 8

that a movement as trivial as turning her head to look out her window left her breathless.

When the aides would come to attend to her, she would hit and pinch like an angry two-year-old. These combative episodes would invariably leave her fragile skin with fresh tears. The hospice team thought she might be in pain. Scheduled morphine was ordered but there was no change in her behavior. The nursing home and hospice team had tried everything short of sedating her.

Wondering what effect energy therapy might have, the hospice nurse contacted the administrator of the facility and received permission to try it. Healing touch was started. No other changes were made in her plan of care.

The morning following the first treatment the staff noted that the patient was very cooperative and relaxed. This dramatic change in her behavior lasted for approximately four days after each treatment. She became violent again at five days post-treatment and the treatments were increased to twice a week. The last three weeks of her life, she lived the same quiet, dignified existence she had experienced earlier.

Touch is Essential

“No one wants to touch me anymore,” is a common complaint among hospice patients. Family members sometimes fear catching the illness (cancer, AIDS) and may have diffi-

culty coping with the sight of the physical deterioration of their loved one.

Deeply personal and tough emotional issues may arise within the family and increase the patient’s sense of isolation. These issues of separation occur within a medical culture that de-emphasizes physical contact with patients. This distancing has been multiplied by our increasing reliance upon technology. In addition, more frequent charges of sexual misconduct resulting in litigation have made individuals wary and reluctant to touch.

For all people, the need to be touched and to experience the presence of another is an essential component of human comfort. In fact, the need of dying patients to be touched is rivaled only by that of infants and children. As basic as touch seems to be to human experience, we have little understanding of it as a therapeutic option.

The appearance of the stylized touch of energy therapies is deceptive in their simplicity. The quiet hand motions of the energy practitioner appeared to restore calm and dignity to the aged schoolteacher. But there really seems to be more going on than a collection of unusual hand motions or hand placements. A profound peace replaced the combative behavior of the elderly schoolteacher. Touch is and can be a great gift of healing the wounds of body, mind, and spirit.



San Diego Hospice

4311 Third Avenue
San Diego, CA 92103

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