**Dr Steve Brinksman calls for kindness and compassion in palliative care.**

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Most of us don't like to think about dying and we are probably even worse at talking about it. Yet as the average age of those in opioid treatment is increasing alongside co-morbid physical health problems, I am seeing more and more people who are at the end of their life. It has often been said that people who use drugs regularly – and this applies to alcohol and cigarettes as well – are physiologically ten to 15 years older than their chronological age. So the likely cause of death for those in treatment has moved from overdose to chronic illness, with chronic obstructive pulmonary disease (COPD), cancers and end-stage liver disease from hepatitis C now commonly listed on death certificates.

I am as keen as anyone to promote recovery in the form of long-term abstinence, but also feel we need to have a pragmatic and kind response to those for whom prognosis is poor.

Danny had been using heroin for 30 years. Having started in the early 80s he had a history of injecting and had been diagnosed as hepatitis C positive in prison, but never really felt he was stable enough to think about treating it. As he got older he engaged with treatment, stabilising on 80ml of methadone and stopping illicit use. After a couple of years he was thinking of stopping methadone and we talked about his hepatitis C and the significant improvement in treatment. He agreed to a referral to the liver team.

Two weeks before this appointment he attended surgery with weight loss and nausea, noticing that his urine had become dark. I was concerned about his liver function and encouraged him to keep his hepatology appointment. His ultrasound scan and fibroscan showed minimal fibrosis but unfortunately a mass in his pancreas and a subsequent CT scan revealed an inoperable pancreatic cancer.

As his condition worsened we were initially able to control his pain by increasing his methadone dose and switching it to three times daily. The local hospice team were involved and he was admitted for three days while being switched to long-acting morphine. On discharge he was able to manage with oral medication for a few more weeks, although his doses were significantly higher than for many patients because of his opioid tolerance.

Danny lived alone and had not seen his family for years. When we had talked about his preferred place to die he had asked to be back in the hospice. The team there dealt with him without stigma and he passed away peacefully five days after being admitted.

The way that we deal with end of life scenarios for people who use drugs and alcohol defines how caring we are as a treatment system and a society – and yet this

remains an area that commissioned services rarely address. Perhaps it’s time that they did.

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