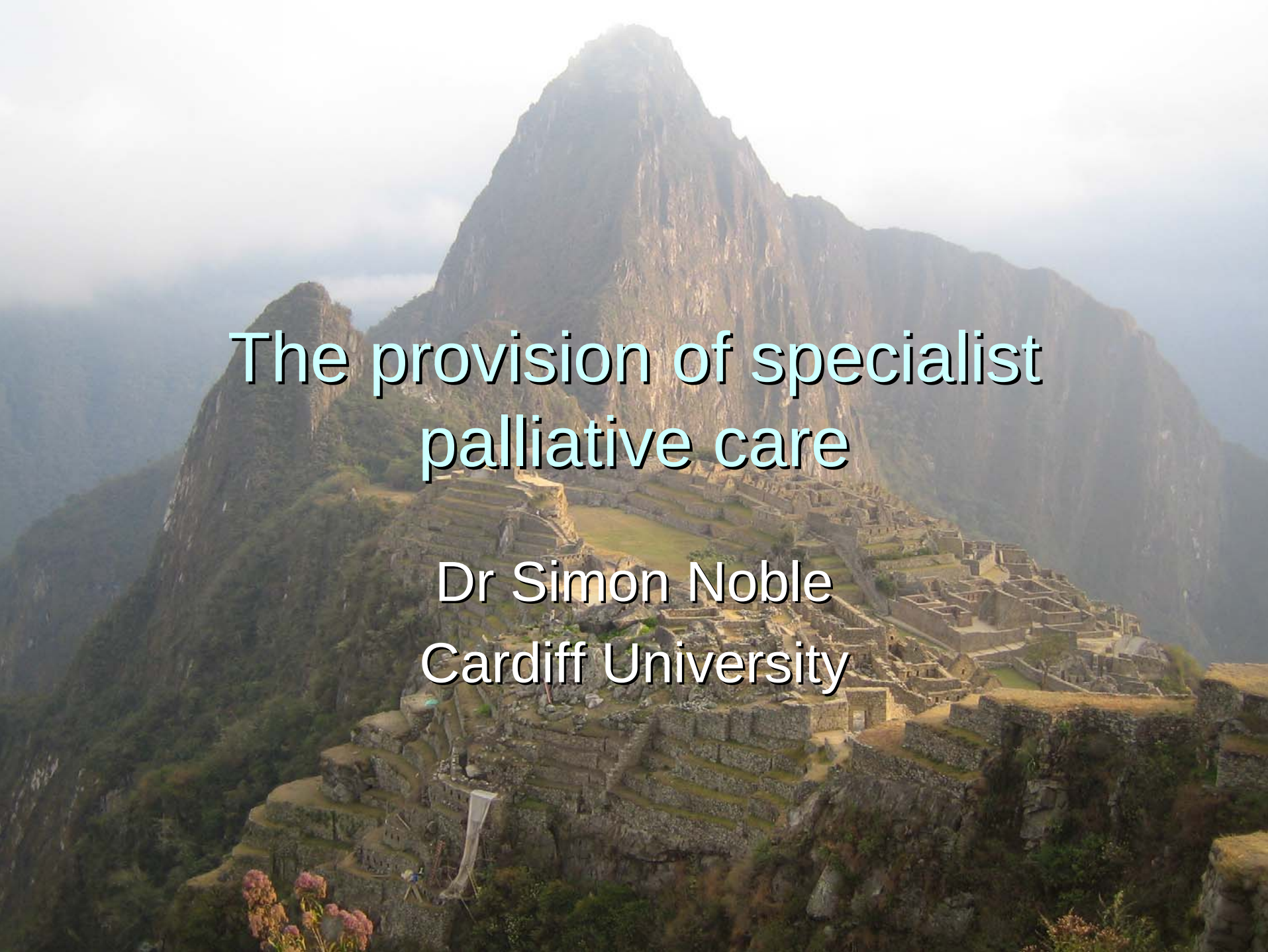
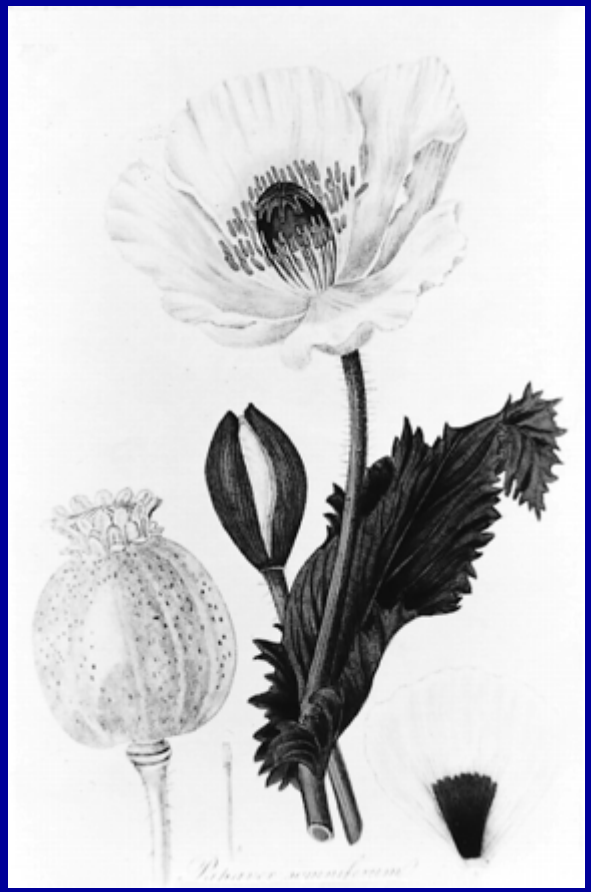


The provision of specialist palliative care

Dr Simon Noble
Cardiff University

Palliative care is not



- Death and dying
- Solely end of life care
- Giving morphine
- Hastening death

Palliative care

"The **active total care** of patients whose disease is not responsive to curative treatment

where **control of pain, of other symptoms** and of **psychological, social and spiritual** problems is paramount

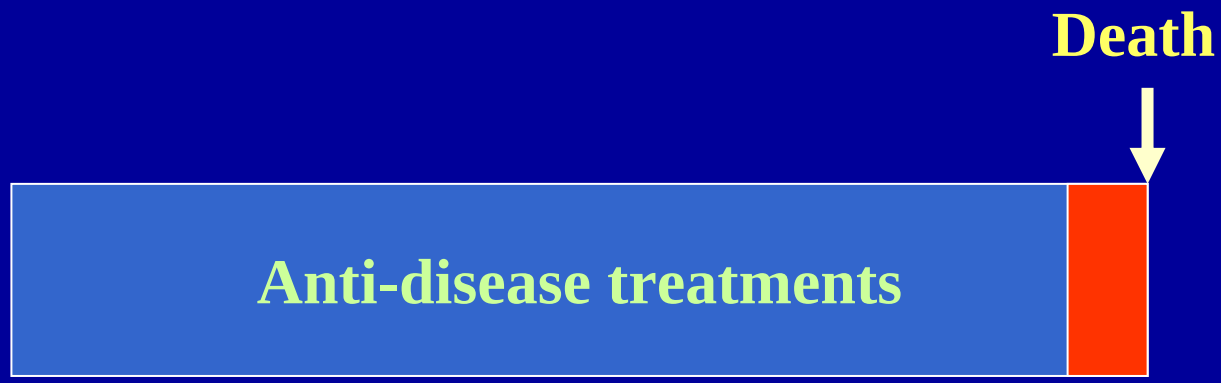
with the achievement of the best possible **quality of life** for patients and their families as the goal."


SAINT
FABIOLA

History

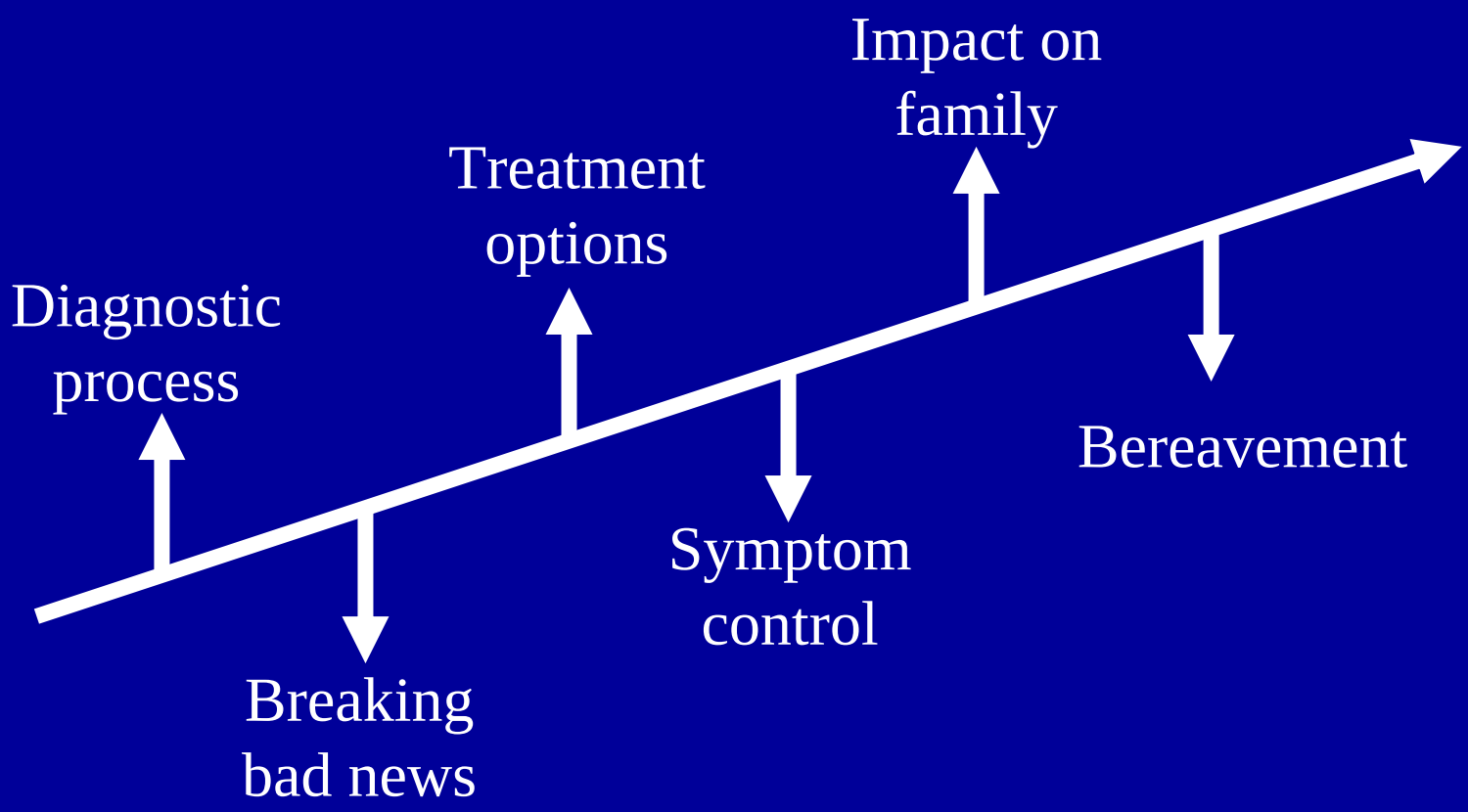
- 1842 Mme. Jeanne Garnier, Lyons
- 1885 St Columba’s, Edinburgh
- 1891 Hostel of God: Trinity, Clapham
- 1892 Dr Barrett: West London Mission
- 1905 Cardinal Vaughan: St Josephs
- 1911 Douglas MacMillan
- 1948 Squadron Leader Bernard Robinson

Model of Palliative Care

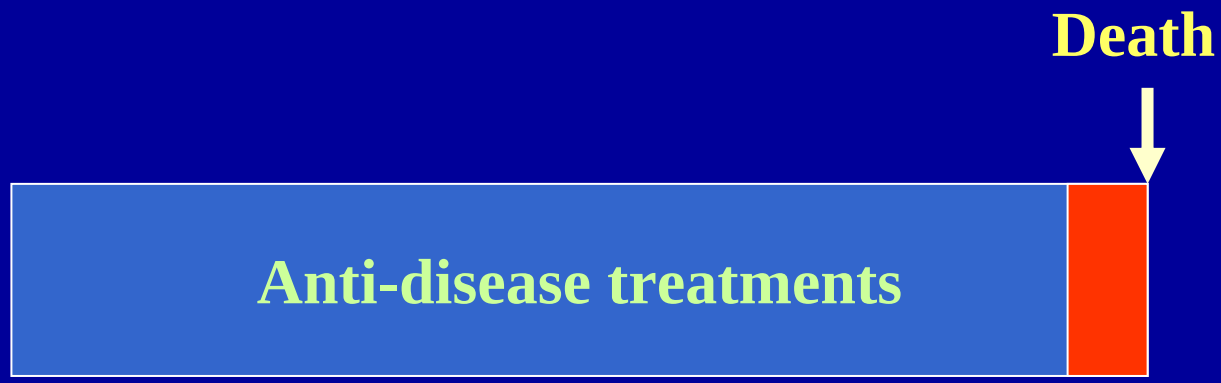



There is
nothing more
I can do

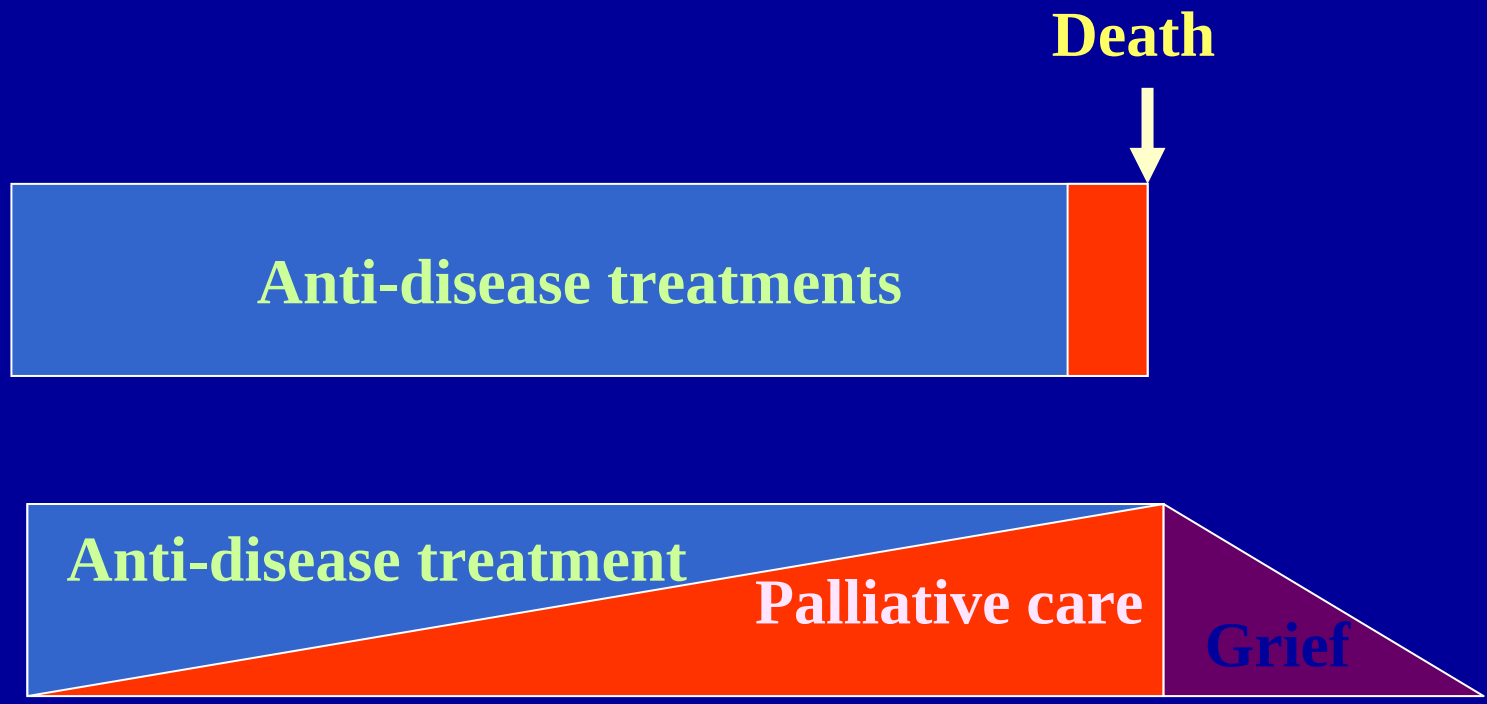
Patient's journey



Model of Palliative Care



Model of Palliative Care



Provision of palliative care

- Expertise centred around hospice
- Majority of deaths occurred in hospital
- Majority of patients express wish to die at home.

Changes after St Christophers

- Philosophy of palliative care
- Model applicable to all care settings
- Specialist palliative care teams in hospitals
- Community based services
- Enhanced General Practitioner skills

Generalist vs Specialist

- Level 1: Recognition of basic palliative needs as part of assessment
- Level 2: Provide interventions that are more specialist but predictable
- Level 3: Interventions that require knowledge and experience of life limiting disease processes.
- Level 4: Highly specialist interventions: complex unpredictable needs

Outreach of palliative care

Role on Modern Practice

- Recognised as a specialty in 1987
- Specialist training posts
- Integral to modern clinical practice
- Once based within the hospice, now integrated to hospital and community care

Catalysts for change

- Attitudinal change
- Research
- Patient expectation
- Natural history of diseases

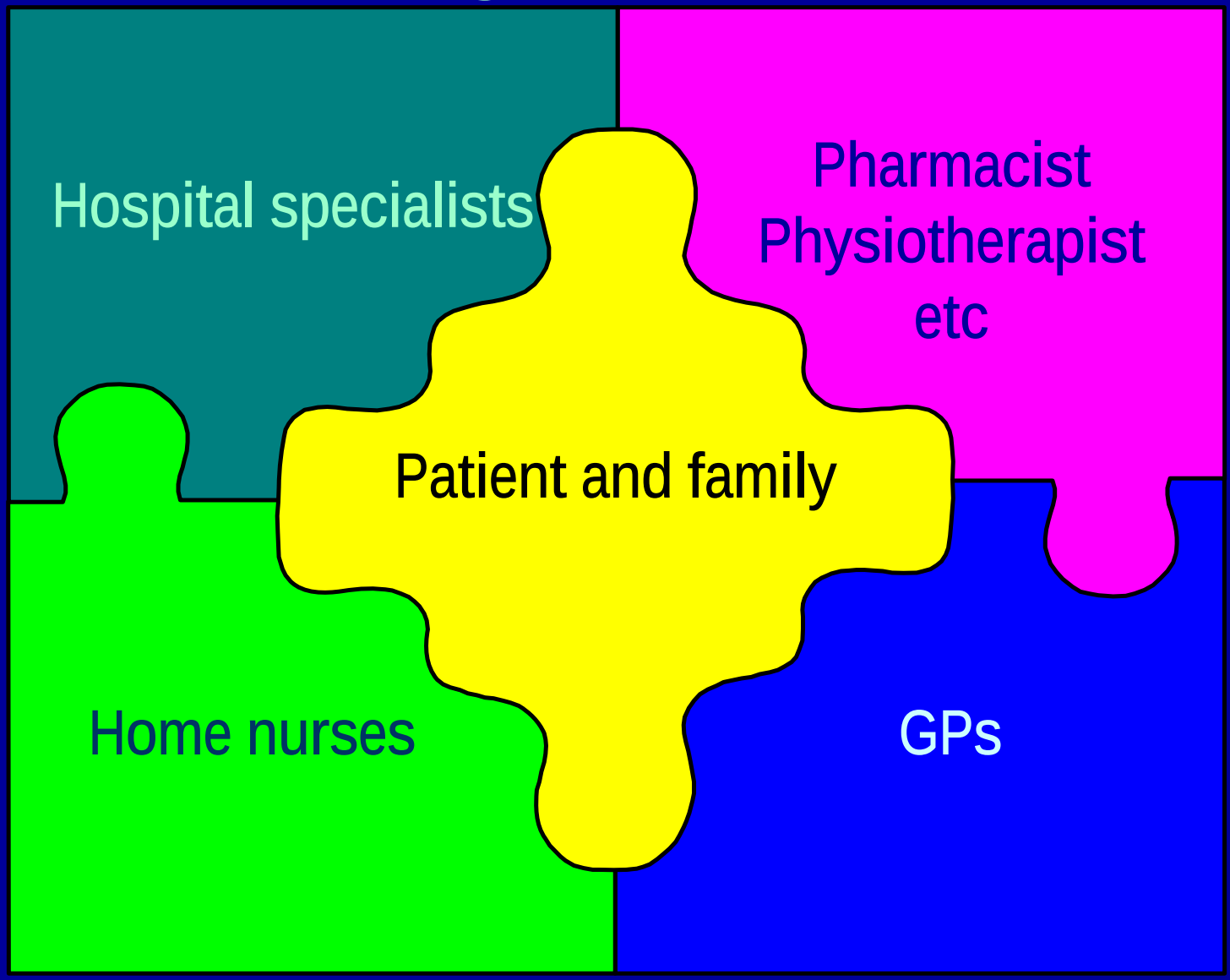
Modern practice

- All cancer patients access to palliative care
- Provision of palliative care integral to management of non malignant disease
- Provision of support and education to providers of generic palliative care

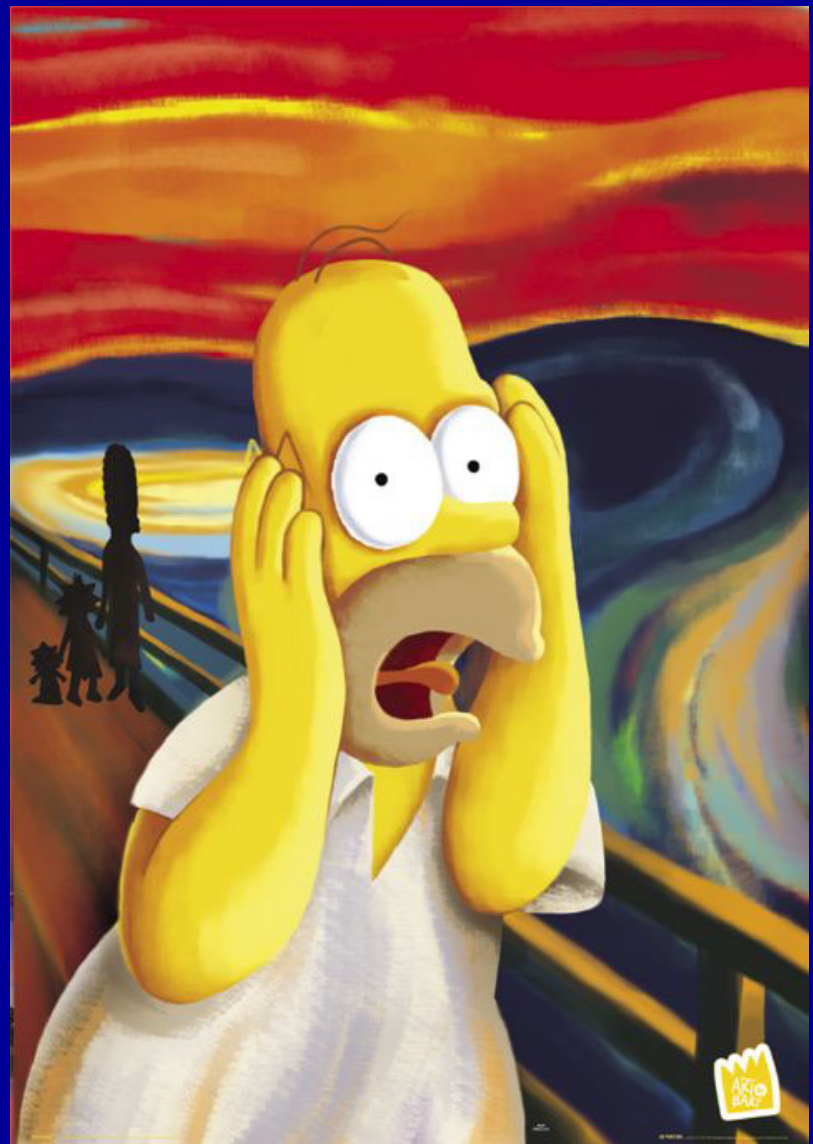
Changes required to provide specialist palliative care

- Resources
  - Staff
  - Training
  - Evidence based practice
- Attitudinal shift
- Recognition from commissioners
- Adaptability

Integrated care



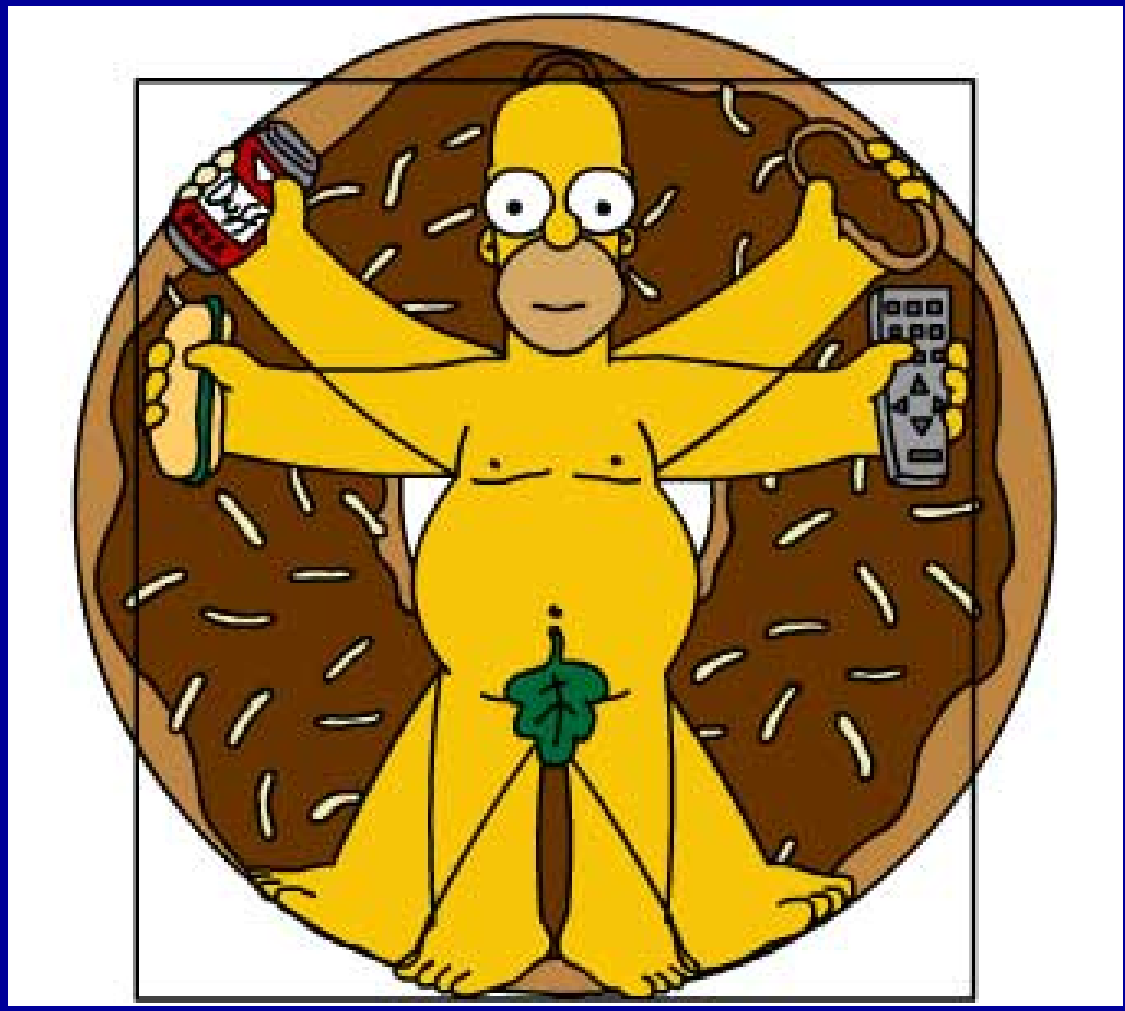
Psychosocial



Spirituality

What allows you to make sense of the world around you

Spirituality



Can UK models be applied to Hong Kong?

- 11 inpatient units and home hospice services
- Recognised as medical specialty 1998
- Over 30 accredited specialists
- Part of medical training
- Cardiff University Diploma MSc quotable qualification

Need adaptable models of care

- Less people wish to die at home
- Sometimes logistically difficult
- Attitudinal change to role of palliative care
- “Doctor to dead horse as if it were still alive never gives it up for lost”

Models that work

- Parallel clinics / integrated working
- End of life care pathway
- Specialist practicing physicians

Components of Professional Practice

The challenges

- Truly integrated working
- Non malignant disease
- Measuring outcome
- Value for money


THANK YOU