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Services

Primary responsibility

- Small number of patients who have extreme problems near the end of life. Our inpatients.
- Aid to so many other health professionals who are generalist or specialists in other fields whose patients die. General practitioners are key in this. Education, support, liaison consultation is the major role for whole team

Emphasis

- Clinical Team, part of the oncology group. Hence basis towards cancer and its problems. Its so symptomatic!
- Palliative care doctors began as symptom control specialists.
- Service evolved into assistance with QOL helping patients “live” in this phase of life. [Within confines of disease]

Who are we?

- 3 SMO's all fellows of the Chapter of palliative medicine 1 is a Pain Specialist as well
- 2 Registrars both should be in training to become specialist's. Currently vacant positions
- 5 Nurse specialists plus 1 co-ordinator
- Clerical 0.9 receipt and 1 typist

Services Supplied

- Normal Specialist services to those who can't be managed elsewhere. Our inpatients.
- A supportive service to primary palliative care. Education/liaison consultation/OP appts/LCP support to CCFs and home visiting.
- A service dept for patients in Waikato hospital under other specialist teams who require palliative care
- Contract with Lakes DHB for 24 telephone support

What you should expect?

- Our team will offer the best available “treatment” for any given palliative care problem.
- Therefore charged with:
 - finding the evidence
 - appraising the evidence
 - ? Making the evidence
 - using the evidence

WHAT
DYING
PEOPLE
WANT

PRACTICAL
WISDOM *for the*
END OF LIFE



DAVID KUHL, M.D.

"An all-encompassing guide for people with a terminal illness and those who know someone who is dying." —*The New York Times*

Intervene

- To come in as something extraneous
- To come between
- To interfere so as to prevent or modify result

How easily do these words sit?



Divine Interventions

Out from the shadows, into the light...

Problems

- Should we shy away from doing high-quality trials just because it is difficult?
- We do acknowledge that the methodology is not adequate to design quality studies of the ways we deliver care
- But we do know how to perform relatively simple trials and reviews

Problems:

- For example, cancer pain is one of the basic symptoms that we address.

It sounds simple, cancer putting pressure on organs or nerves gives pain. Therefore pain proportional to amount of cancer.

Right?

Wrong pain is best regarded as an output from the brain not an input related to something noxious.

So measurement is the core of science


- What are we measuring.

- Research and audit in our dept:

Bowel obstruction guideline of management introduced 2007 measurement tool introduced July 09

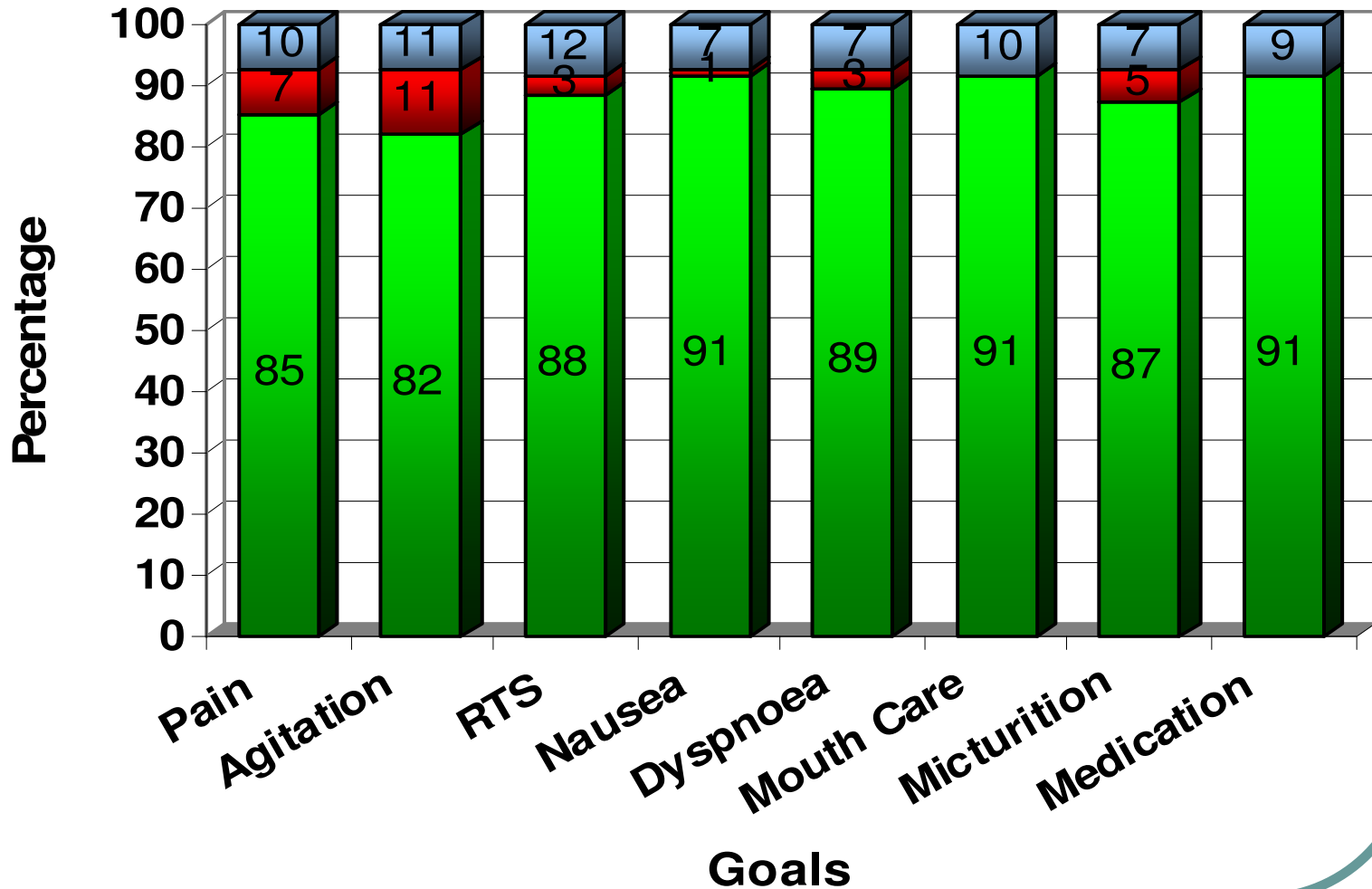
Pain: hospital agreed to common measurement tool. July 09. The 5th clinical sign!

LCP ?????



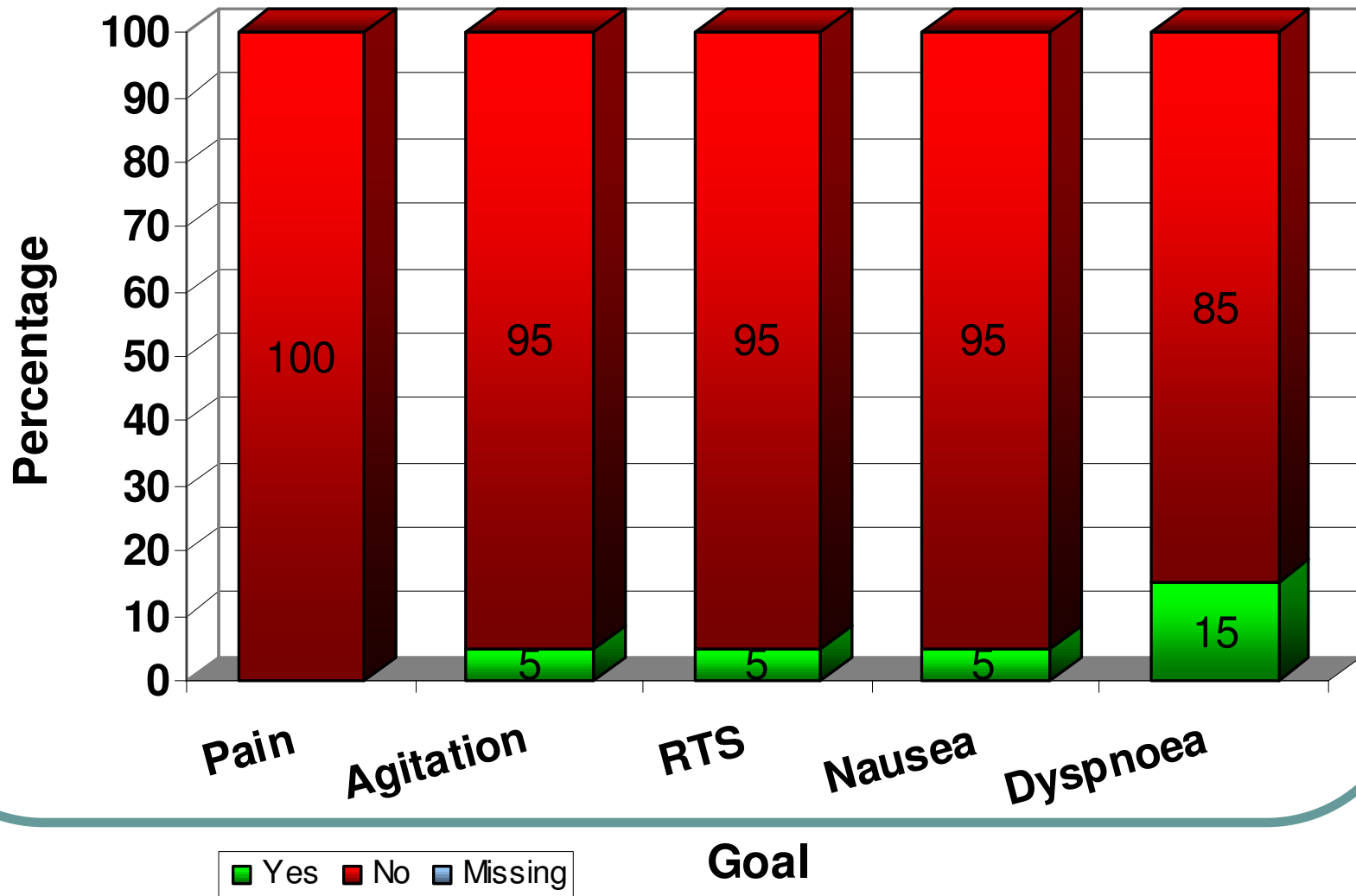
**A snapshot
of Waikato hospital's
pre- and post-LCP
implementation audits...**

Assessment of documentation of ongoing care in the last 48hrs of life: *after LCP implemented*



■ Achieved ■ Variance ■ Missing

Assessment of documentation of ongoing care in the last 48hrs of life: *before LCP implemented*



Hence we intervene in many ways

- **Caution.**
- **Consequences** for many.
- Who are we doing this for?
- Have we the support to do this well?
- Family discussion, team discussion, openness, non possessive care.

Art and Science

- Clearly we need to be practitioners of compassionate care
- Equally clearly we need to incorporate moderate science into our many interventions



Palliative
Medicine
needs
science but
will remain
an art