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Integrated Palliative Care

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Definition

* Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

WHO Definition

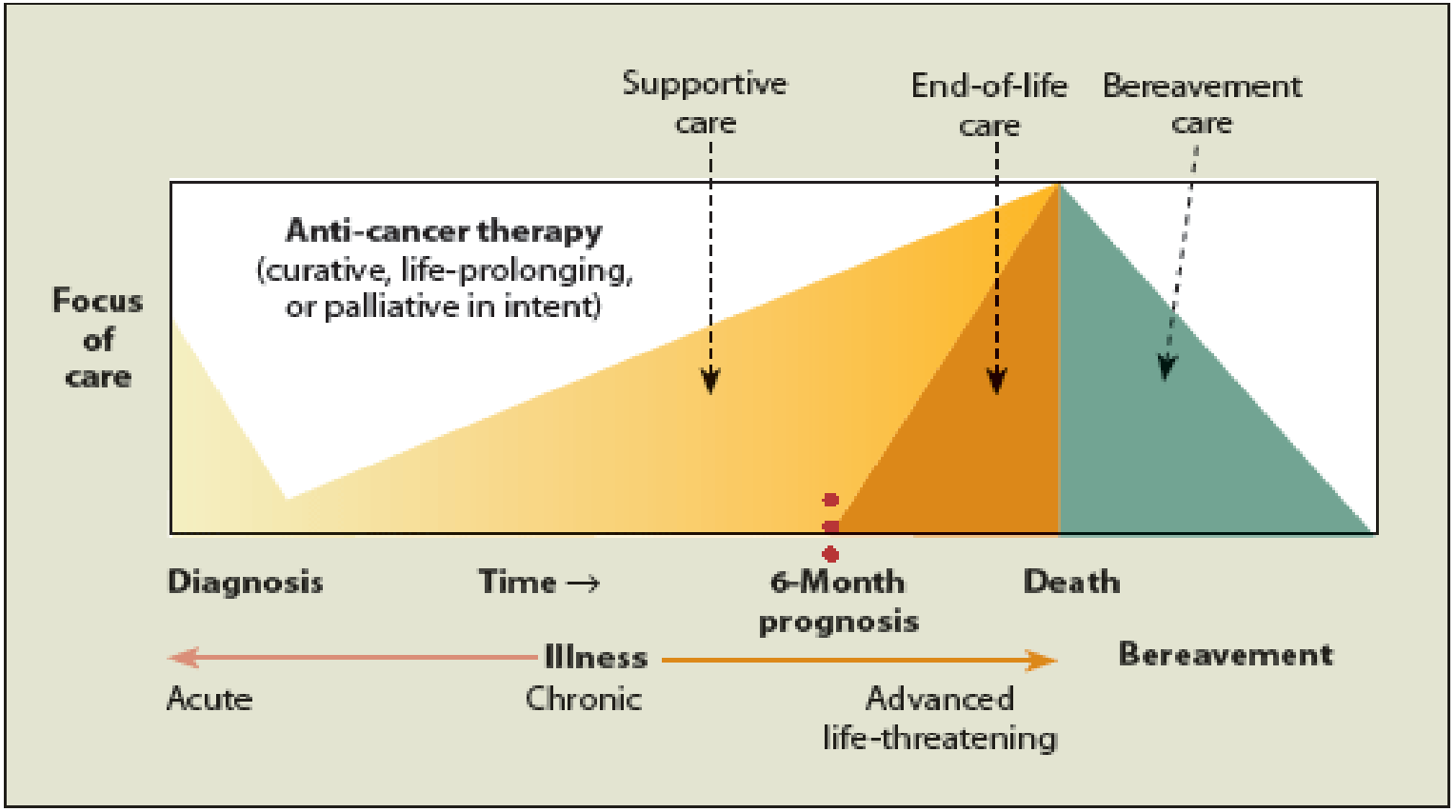
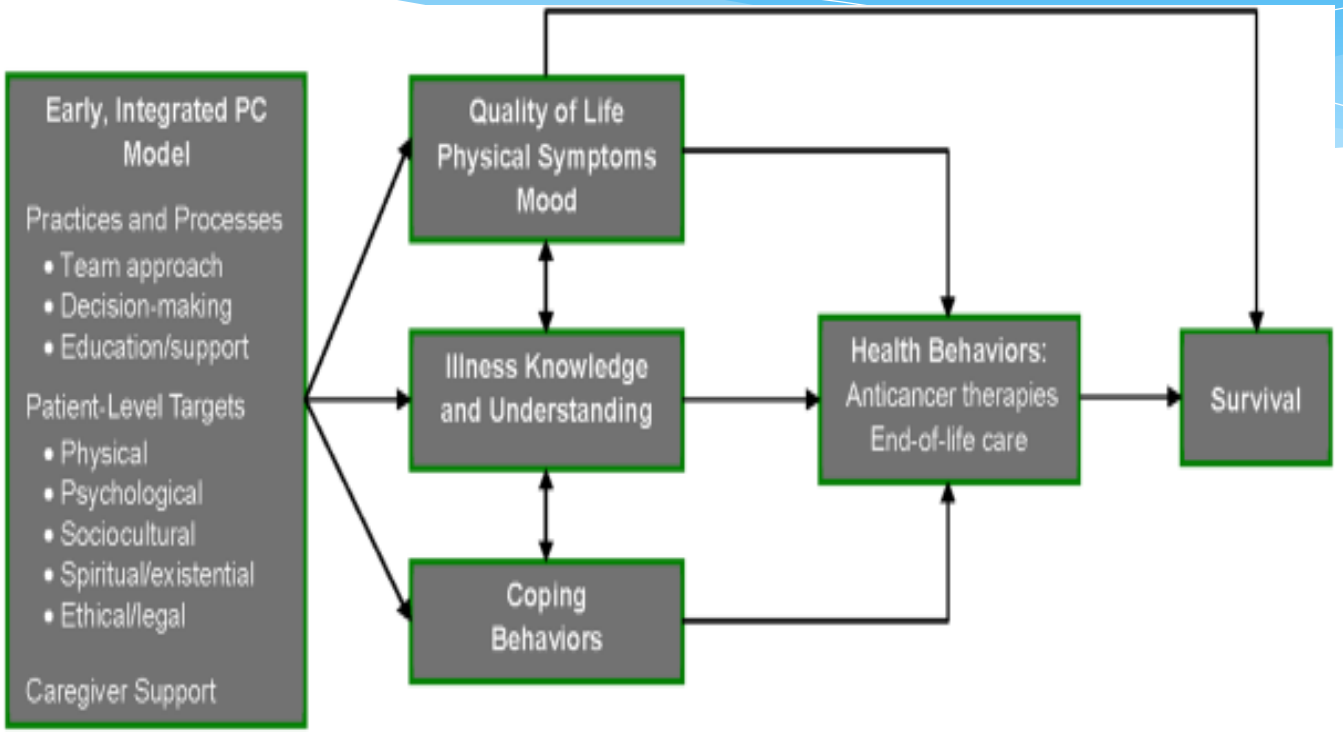


Figure 1: The balance between anti-tumor therapy and palliative care across the continuum of cancer care.

Early integration of palliative care services with standard oncology care for patients with advanced cancer



CA: A Cancer Journal for Clinicians
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http://onlinelibrary.wiley.com/doi/10.3322/caac.21192/full#caac21192-fig-0001

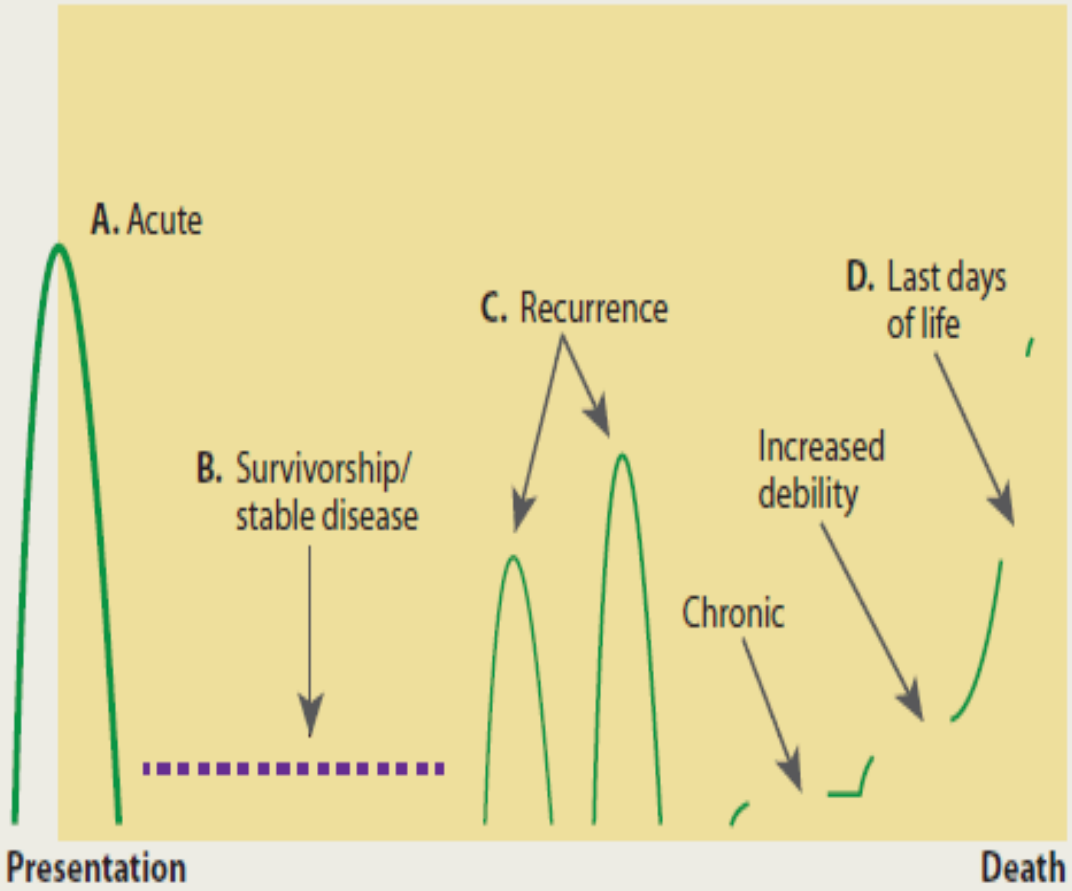


Figure 4: Palliative Care Across the Continuum of Cancer Care—

(A) At diagnosis: a period of increased physical, psycho-social, family, and financial distress

(B) Survivorship/stable disease: decreased palliative care needs; concerns may include new role identification (ie, "cancer survivor"), sequelae of treatment

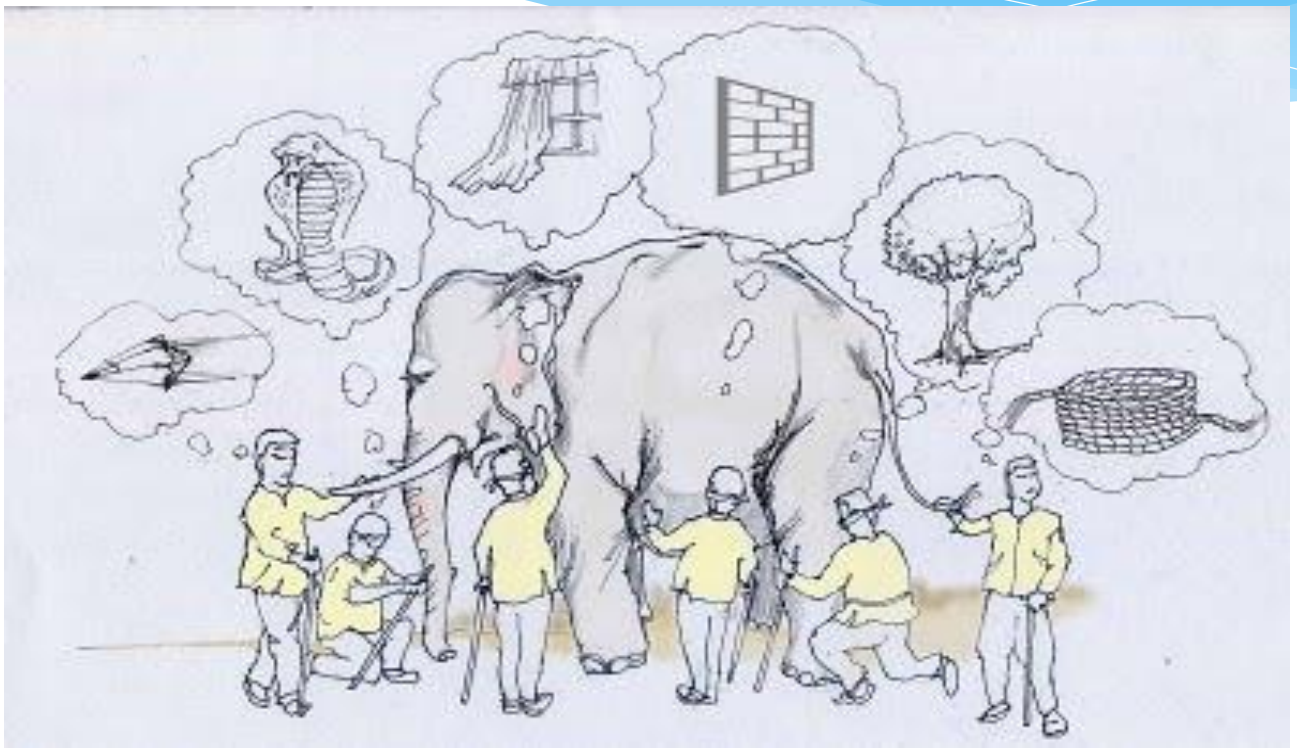
(C) Recurrence: palliative care needs increase; disease may recur, with increased symptom burden as well as overall distress

(D) Last days of life: disease may progress, with increased debility leading to increased palliative care needs, with eventual transition to hospice care

The concept of Best Supportive Care

* "Supportive care for cancer patients is the multi professional attention to the individual's overall physical, psychosocial, spiritual and cultural needs, and should be available at all stages of the illness, for patients of all ages, and regardless of the current intention of any anti-cancer treatment".
* EORTC - Ahmed et al 2004

The Holisitic approach



Philosophy

* Evidence-based medicine or…
* Preference-based medicine
* Guidelines or…
* Pathways
* Opinion leader or…
* Team spirit

Philosophy

* But…
  * Theoretic and normative end of life
  * Death Psychologisation
  * Ideologic conflict
  * Moral dilemma?

Ethics

* Therapeutic de-escalation
* Therapy or therapeutic abstention
* End of life
* Passive Euthanasia
* Active Euthanasia

Ethics

* Medical assisted suicide
* Prolonging life
* Communication
* Secret
* Etc.

In the fields of palliative care

* Pain
* Psychiatry
* Dyspnea
* Fatigue
* GI Trouble
* Psycho social problems
* Bereavement
* …

Purposes

* Family support
* Formation
* Education
* Research

Reflections

* “Health is life in the silence of organs”.
* On the other hand, pain should not longer be considered as a collateral damage but as a “monstrous individual phenomenon and not a law of the species. (It is) a fact of disease”. *Leriche, France, 20th century*
* Pain should not be considered as the expression of “normal activity” even in pathological states and should not be reduced as a simple stimulus /effect relationship
* Pain is a disease and not a collateral damage .

Pain and cancer

* More than 7 millions of cancer cases diagnosed each year
* Over 50 % occuring in patients aged 70 years or more
* « Almost » 100% of patients with advanced cancer have at least one pain syndrome
* « Pain, discomfort and suffering must not be equated with the process of normal ageing »

Differences ?

Non cancer pain	Cancer pain
Slow evolution	Fast evolution
No vital lesion	Vital lesion frequent
Indolent treatment	Agressive treatment
Few nerve lesions	Frequent nerve lesions
Mono syndrome	Multiple syndrome
Mediators ?	Mediators
Central sensitization ?	Central sensitization

Neuropathic pain and cancer

Syndrome	Direct effect	Iatrogenic	Paraneoplastic	Infection
Polyneuropathy	+	+++	+	-
Mononeuritis	+++	+	-	++
Plexopathy	+++	++	-	-
Cranial nerves	+++	+/-	-	++
Radicular lesions	+++	+	-	+
Medullar lesions	+	+/- +	+/-	-
CNS lesions	+++	++	-	+

End of life care

* Historical controversy and opposition between palliative care and euthanasia
* Sedation vs Euthanasia?
* Sedation is not a “natural death”
* Autonomy
* Conscience clause: individual or institutional?
* A Belgian model?

Les paradigmes dans les soins (in french…)

Paradigme maternant	Paradigme religieux	Paradigme scientifique	Paradigme libéral	Paradigme humaniste
-Affectivité -Discrétion -Générosité -Disponibilité -Douceur -Partage -Abnégation Registre relationnel	-Assistance Bienfaisance -Charité -Respect de la vie -Obéissance -Humilité -Vocation Registre religieux	-Objectivité -Méthode Fonction-nalité -Efficacité -Expertise -Rigueur -Technicité Registre technique	-rentabilité -Productivité Performance Concurrence -Prestige Rationalisa-tion Spécialisa-Tion Registre fonctionnel	-Autonomie -souffrance Développe-ment personnel -Tolérance -Empathie Responsabi-lité personnelle Registre humaniste

Conclusions

* Integrated palliative care : a new concept
* To share experiences from both curative and palliative care
* Importance of communication
* Ethics
* Quality of end of life: sedation, euthanasia, a question of choice

* Bedankt!
* Merci!
* Danke Schön!
* Thank you!
* Děkuji!

Liberté,
j'écris ton nom

En notre âme et conscience

Fin de vie et éthique médicale

Dominique Lossignol

La Belgique s'est dotée en 2002 d'une loi qui dépénalise sous conditions la pratique de l'euthanasie. Ce sujet soulève et soulèvera encore de nombreuses questions qui relèvent autant de l'éthique que de l'idéologie. Face à une opposition toujours active et parfois hostile, il est nécessaire de recentrer le débat et surtout d'apporter les éléments de réflexion qui permettent d'aborder la question de manière pragmatique et non partisane, et certainement pas moralisatrice.
La question de la clause de conscience, et de son éventuelle extension à l'échelle institutionnelle (il conviendrait de dire politique institutionnelle) est ici abordée, au même titre que le concept de dilemme moral, sous l'angle de la pratique médicale. Par la démonstration de leur inconsistance, l'auteur déconstruit les arguments avancés par les opposants au cadre légal ou à la pratique même de l'euthanasie.

Dominique Lossignol est docteur en médecine, spécialiste en médecine interne, soins palliatifs et traitement de la douleur. Chef de clinique à l'Institut Jules Bordet à Bruxelles (ULB) où il dirige l'unité des soins «supportifs» et palliatifs, il est également responsable de la Clinique de la douleur et de la consultation médico-éthique. Il est titulaire d'un master en éthique et coordinateur du Forum EOL (End of Life). Il est l'auteur de nombreuses publications.

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[En notre âme et conscience] Dominique Lossignol

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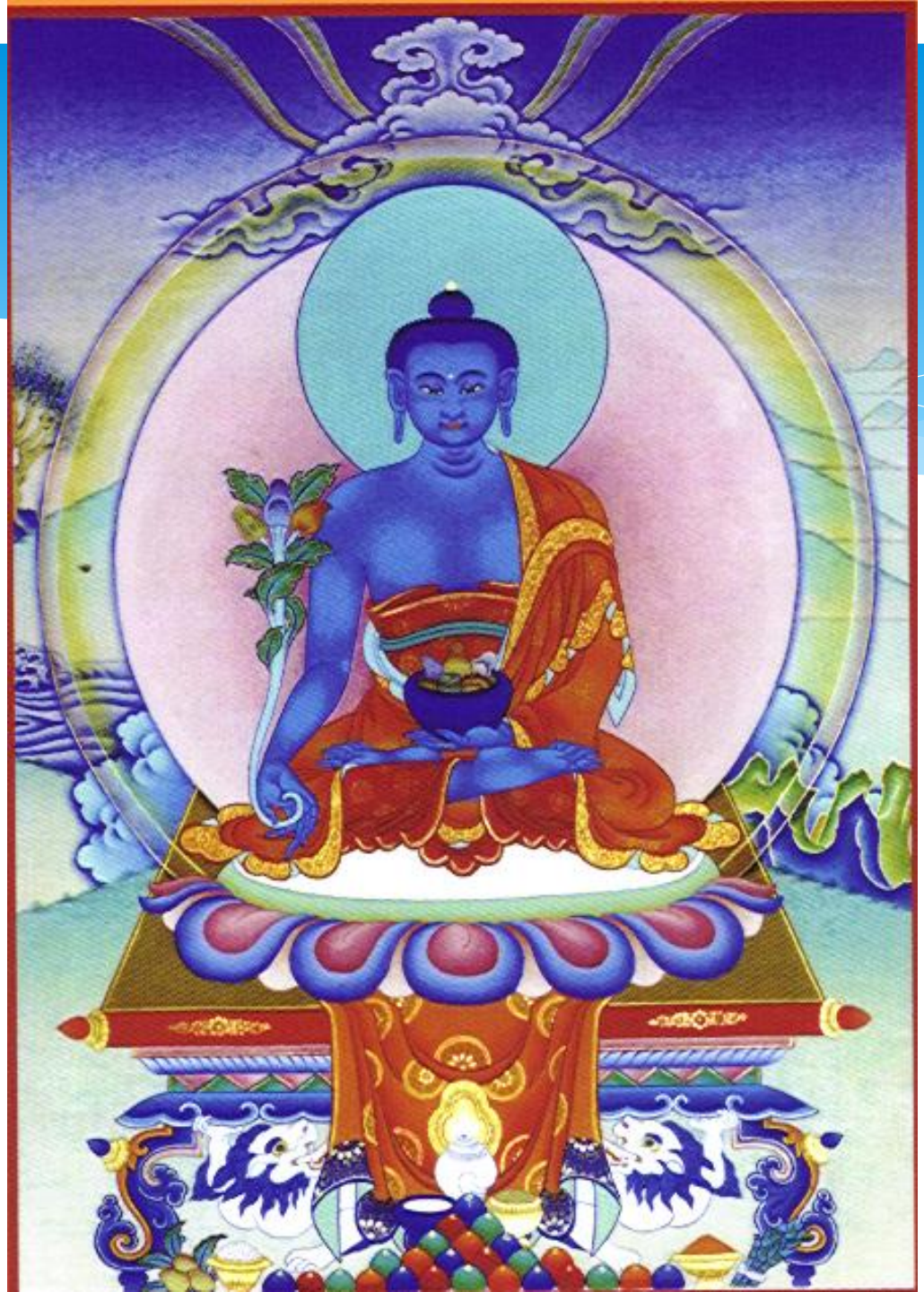

Questions

* Choose the correct answer.
* Note there is only one correct answer.

Question 1

* Palliative care is:

1. Commercial medicine that takes money from the dying.
2. An approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness.
3. “Sub-medicine”.
4. Restricted to end-of-life situations.
5. Only related to psychology.

Correct: 2

Question 2

* Historically, palliative care is:

1. In opposition with euthanasia
2. The only option for pain management
3. The best answer to curative care
4. A non confessional specialty
5. Away from psychology

Correct:1

Question 3

* Death psychologisation is

1. Normative
2. Useful
3. The only way to help dying patients
4. Better than no psychology
5. Interesting because it fits to all patients regardless their origin

Correct: 1

Question 4

* Euthanasia (in Belgium)

1. Is part of the medical process but have to be strictly controlled
2. Must be forbidden at any time
3. Have nothing to do with palliative care
4. Opens the door to the so-called “slippery slope”.
5. Leads to substantial economy

Correct: 1

Question 5

* Sedation

1. Is natural death
2. Must be justified in all case, to alleviate intolerable suffering
3. Is the best response to euthanasia
4. Relies only on the use of opioids
5. Does not require informed consent

Correct:2