

CANCER AND END OF LIFE CARE – WHERE DOES IT HAPPEN?

The diagnosis and management of cancer has a significant impact on the lives of more than 114,000 Australians who develop cancer every year and their families. Cancer is the leading cause of death in Australia with more than 43,000 people estimated to have died from cancer in 2010. Cancer costs account for 7.2% of health expenditure (www.cancer.org.au). Evidence suggests the further from a metropolitan centre a cancer patient lives; the more likely they are to die within five years of diagnosis. Geographic isolation, shortage of health care providers and a higher proportion of disadvantaged groups are acknowledged factors to the problem of diagnosing, treating cancer and providing end of life care (EoLC) in regional Australia (Australian Institute of Health and Welfare and Australian Association of Cancer Registries, 2003, p.1).

Although Australia has some of the best palliative care services in the world, the reality is that almost two thirds of those that die in Australia, die in an acute hospital (Bloemer, Moss & Cross, 2011). According to Hillman (2009) 70% of people who died in hospital received active treatment right up until the moment of death rather than end of life care. Acute care focuses on treatment and cure, increasing survival rates and reducing mortality. The challenge then is ensuring that the dying patient and their family receive optimal care (Aleksandric and Hanson 2010).

There have been many changes in the experience of dying and in the delivery of care to people at the end of life in Australia over the past three decades. More people are dying of chronic and complex conditions, with longer periods between diagnosis and death. Patients and families with these conditions have become better informed about the availability of services to provide care and support during this period and are seeking access to services (Sharry, 2009).

The importance of evaluating the effectiveness of palliative care has been recognised for at least 20 years. It is important not to assume, that because palliative care is part of a growing and successful speciality, that there is no need to provide vigorous evidence of the benefits of palliative care (Addington-Hall, Callaghan, 2009). There is substantial value in conducting research into patient and family satisfaction with the care they receive because it gives us a clearer understanding of the needs of our consumers. It informs us of the way they look for information, seek advice, and communicate with the service provider and it gives us alternatives to providing care. (Adams, 2005).

Families have an important role in end of life care and decision making. The experience of the family must be heard in order to improve delivery of end of life care. Retrospective interviews with the bereaved family are used to evaluate the quality of the care provided. In palliative care the family and the patient are seen as one unit and therefore the family member's views have validity. The loss of a family member can have associated physical and mental health consequences and can have an increase in the mortality rate of the bereaved person (Ellershaw, Wilkinson, 2011). We need to consider both the family and the patient's perspective of what constitutes good end of life care. The definition of quality care changes for each person. As a person dies what was once important may change, and what once was ignored may become significant.

At end of life it is the patient's comfort that is the key to all decisions about care and treatment and goals of care are adjusted as death approaches. The aim of any intervention will be symptom control and the relinquishing of futile interventions. It is essential that health care professionals in all settings are equipped to provide the highest possible standard of care at the end of life. Palliative care and end of life care is not the domain of only specialist staff, but should be able to be provided across all health care settings (Heide, Veerbeek, Swart, Rijt, Maas, Zuylen, 2010). It is the memory of how someone dies that will live on with those who are bereaved (Teno, Casey, Welch, Edgman-Levitan, pg. 739, 2001).

PALLIATIVE AND END OF LIFE CARE FOR CHILDREN AND YOUNG PEOPLE: HOME, HOSPICE AND HOSPITAL

This book includes a strong emphasis on the needs of teenagers and young adults. Find out more by reading a review of this new book by Anne Grinyer at <http://bit.ly/new-book-children-palliative-care>

PASTORAL CARE VIDEO

Nourishing the spirit involves being relational, present and authentic. Hear more in this excellent video in which Kate Hewett talks about different ways of genuinely meeting the spiritual needs of people living in residential aged care: <http://bit.ly/pastoral-care-aged-care>

WORLD HOSPICE AND PALLIATIVE CARE DAY - 13 OCTOBER 2012

World Hospice and Palliative Care Day is a unified day of action to celebrate and support hospice and palliative care around the world. The theme for World Hospice and Palliative Care Day 2012 is 'Living to the end - palliative care for an ageing population'.

In almost every country, the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. From 2000 until 2050, the world's population aged 60 and over will more than triple from 600 million to 2 billion. Most of this increase is occurring in less developed countries, where the number of older people will rise from 400 million in 2000 to 1.7 billion by 2050.

The specific palliative care needs of older people are increasingly being recognised due to the burden of non-communicable diseases on older people as well as those ageing with HIV in the era of anti-retroviral therapy. The palliative care needs of older people are complex and often neglected. The issue is globally applicable and incorporates older people living with life limiting diseases as well as the issue of older people as carers of people with life limiting illness, particularly HIV and AIDS, in developing countries.

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