

Recently announced guidelines to boost care for dying patients are a good step forward, but more needs to be done.

Getting from C to A in palliative care



EYE ON SINGAPORE

By JANICE TAI

BACK in 2008, then Health Minister Khaw Boon Wan said Singapore might score an A-minus for acute care services but was probably “below C” when it came to palliative care.

It has come a long way since. The World Health Organisation and Worldwide Palliative Care Alliance this year ranked Singapore among the top 20 countries in the world for its palliative care.

Palliative care is an approach to care that improves the quality of life of patients with life-threatening illness, through minimising suffering by treating pain and other physical, emotional and spiritual problems.

Close to one in three of about 19,000 people who died here last year received such care at home or in a hospice or nursing home.

Demand for palliative care is rising as the population ages and the incidence of cancer and chronic diseases – which tend to affect older people – increases. By 2020, more than 10,000 people a year here would need palliative care.

In 2011, the Ministry of Health (MOH) commissioned the Lien Centre for Palliative Care to draw up a national strategy for palliative care, which looked at how to deliver such care in a more coordinated manner.

This was followed by an industry task force led by associate professors Pang Weng Sun and Cynthia Goh to draw up national guidelines over the past year. Last

month, the guidelines were among the plans which MOH announced to enhance the quality of palliative care, expand services and ensure their affordability.

Right now, palliative care is offered at hospices like Dover Park Hospice or Assisi Hospice. Other organisations such as HCA Hospice Care tend to dying patients at home.

All restructured hospitals such as Tan Tock Seng Hospital (TTSH) and the Singapore General Hospital have their own palliative care teams and established programmes for patients. But many community hospitals and nursing homes still call in palliative care doctors on an ad hoc basis.

The guidelines spell out what hospices, hospitals and other providers are required to do in 13 different areas, from coordinating care to bereavement support for family members and the use of pain-relieving drugs.

Industry experts said the guidelines are helpful but are concerned about whether they will really make for improved palliative care on the ground.

The guidelines will make palliative care more consistent. For example, one proposed guideline requires health-care providers to have a system in place to identify people who are likely to die within the next 12 months.

Once identified, the doctor or medical team has to determine the care needed for the patient: in a community hospital or nursing home, or discharged back home, with home care nurses and palliative care doctors on standby. A care coordinator is then appointed. The patient must be told who the care coordinator is, and advised on how to reach the care provider 24/7. This is crucial because every minute counts for dying patients when they are being re-

ferred to different places to receive palliative care.

At Dover Park Hospice, 21 per cent of patients referred to it and put on wait lists died before admission, according to its 2013 annual report. About 15 per cent of the patients getting home care from HCA Hospice died within a week or less while being tended to at home.

But guidelines, no matter how rigorously developed, will not improve the quality of patient care if they are not implemented well.

“The point of every set of guidelines is professionals actually using them while on the go so as to improve patient care,” said Dr Mervyn Koh, head of palliative medicine at TTSH.

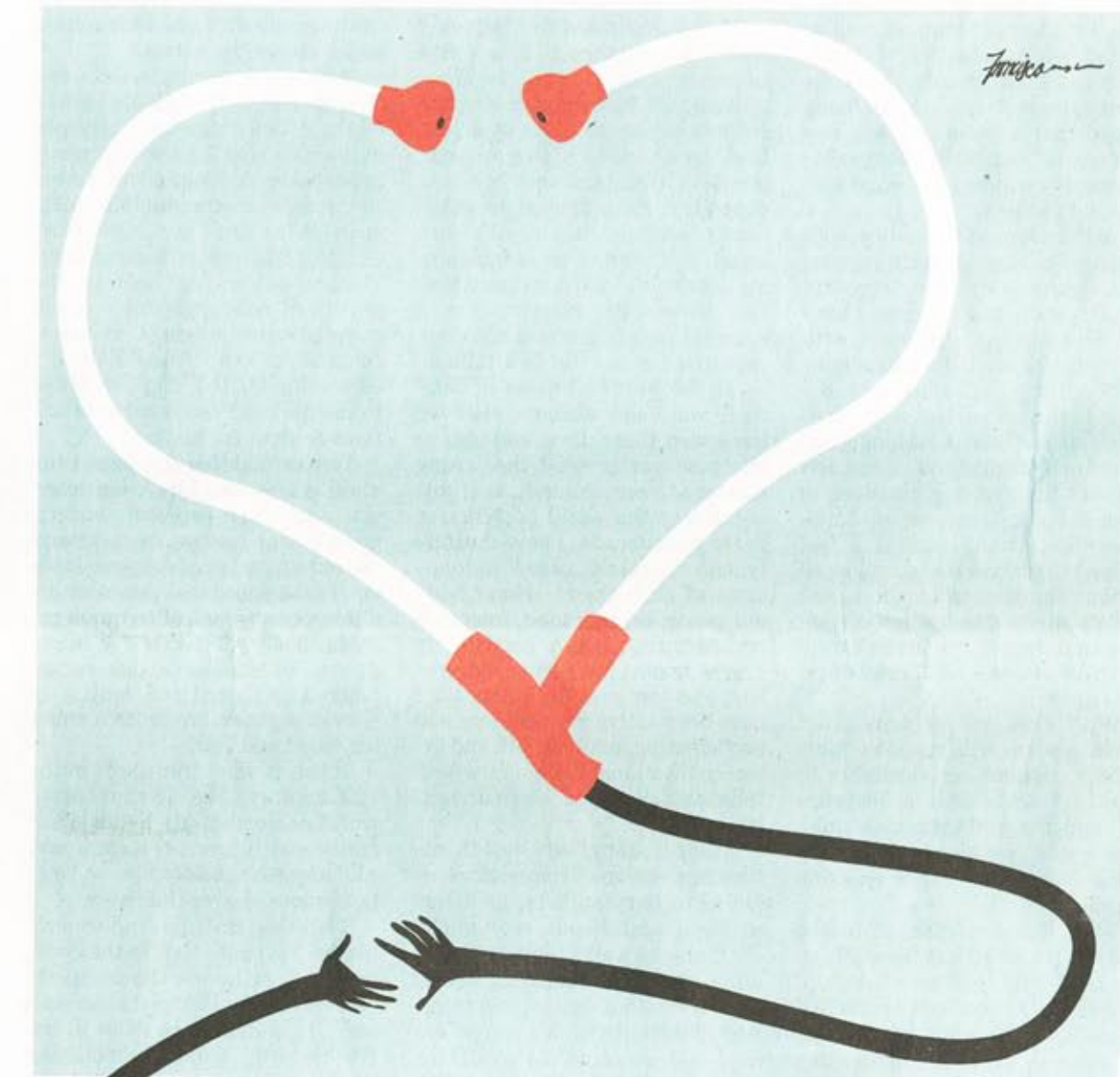
Industry experts cite three possible roadblocks to the establishment of seamless palliative care.

The first is lack of trained health-care professionals.

In a recent survey by Lien Foundation of 200 doctors and 425 nurses, about six in 10 doctors and four in 10 nurses said that their basic training did not prepare them to handle patients with life-threatening diseases. “The survey gives an assessment of the critical weaknesses in our health-care system, especially in the area of professional training,” said Mr Lee Poh Wah, chief executive of Lien Foundation.

Two, there is no impetus for these professionals to follow the guidelines which are not enforceable. The Ministry of Health told The Straits Times that it has no plans to tie the guidelines to licensing at the moment, though it intends to use them as a basis for training and other initiatives to raise quality of care.

“Licensing could be an option but I hope it will not be punitive,



so one way in which more people can be encouraged to follow the guidelines is giving incentives such as providing more funding if people comply,” said Dr Wu Huei Yaw, medical director of Dover Park Hospice.

Three, even if the health-care workers are motivated to follow guidelines conscientiously, the many sets of guidelines out there make patient care a daunting and potentially confusing task.

Take, for example, a doctor in a nursing home who is caring for a diabetic patient on palliative care. The doctor has to try to meet the patient’s complex needs by grappling not only with the guidelines on palliative care, but also those for nursing homes and diabetes

care as well. To be fair to MOH, it has begun to look at these issues. For instance, there will be a new graduate diploma course to train more doctors in palliative care. But more can be done.

Students should get more basic training in palliative care. The National University of Singapore’s Yong Loo Lin School of Medicine devotes only four days of its entire medical course for students to spend time in a hospice to learn more about palliative care.

Basic training is important because it is harder to later get general practitioners to attend short courses on their own time.

Ms Vanessa Yung, secretary-general of the Singapore Hospice Council, noted: “The only three-day course offered current-

ly to familiarise doctors with the basics in palliative care has received such poor response that its last few scheduled sessions did not run, except for one session in August last year.”

The guidelines should also be given more weight by awarding palliative care licences only to those who comply with them. Or the guidelines can be used as a basis for quality audits.

Singapore may be two decades behind Australia in having local standards in palliative care, but it is ahead of Canada and Scotland. The guidelines announced last month are a good step forward. However, it takes a lot more than guidelines to get Singapore from a “below C” to an A in palliative care.

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