ESMO Palliative Care Fellowship

(Nov 2015 – Dec 2015)

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FINAL REPORT

Home Institute: Murni Teguh Memorial Hospital
Host Institute: Parkway Cancer Center Singapore

Introduction

Palliative and hospice care nowadays are integral part of healthcare services for cancer patients. As cancer is fast becoming the leading cause of public health morbidities and mortalities worldwide, the burdens become significant in almost every part of the world. In the past, palliative intent is only considered for terminally-ill patients, who have no means of cure anymore. In many cases in developing countries -such as Indonesia, due to ignorance and delay in starting treatments, cure becomes unachievable since patients came with very advanced diseases. Patients were then left with limited or even none efforts to be taken care of during their remaining days of life, living with pain and other physical symptoms; psychological, social and spiritual concerns, which were escalating as the patient's illness progressed. This viewpoint is later challenged by modern clinicians who share their different perspective in treating these suffering patients. Many symptoms related to their progressive diseases are emerging as a manageable task for the palliative care clinicians in terms of improving quality of life. Patients and caregivers are now actively involved in providing palliative care with a more comprehensive approach. Communication has a major impact on the diagnosis and therapeutic efforts. Ethnical - cultural - religious or spirituality background should also be taken into account in order to bridge a good understanding between the healthcare providers and their patients and families. There are many studies to confirm the role of religion or spirituality in terms of better quality of life by accepting that life and death is a natural phenomenon that happens to any living being in this world. Palliative care is also proven to be suitable for patients in their early stage of their advanced disease to promote better quality of life, and avoid unnecessary burdens & sufferings in the future. Palliative care clinicians today are challenged to evaluate, communicate and guide their multi-disciplinary team to work with the patients and their caregivers towards realistic achievable goals, and to address expectation of the patients or their family. The new goal-setting of palliative care empowers the home-caregivers that mostly are their family members. This approach is now important in providing home-care to the patient, which means less dependent on the medics (doctors, nurses, paramedics).

Goals or aims

Pre-visit identifications

During the period of two weeks before the visit to host institute, identification of all means of palliative care provided in recipient's center was carried out by the palliative team. The manpower, facilities, infrastructures, and funding, etc., are all taken into account. These identifications were later brought under intensive discussion with the mentor at the host center of Parkway Cancer Center, Singapore.

The points of discussion are summarized into:

a. Manpower (skill and knowledge) that should include GPs and nurses dedicated to provide Palliative Care
b. Patient's flow and management
c. Therapeutic efforts that could be offered in correlation with the availability of facilities
d. Funding; in correlation with Indonesian National Insurance Coverage and/or private insurance and/or self-funding measurement
e. Networking:
    1. Promotion campaigns to raise awareness and alertness among common people
    2. Education for
        i. Internal or external fellow colleagues, nurses and paramedics
        ii. patients' relatives or home-caregivers
        iii. community, social workers, volunteers
    3. Spirituality or religious approach
f. Future developments:
    1. Continuous education
    2. Evaluation and audits
    3. Improvement plans

Description of the time spent at host institute

ESMO has provided an opportunity to many clinicians worldwide to explore more about palliative care with the fellowship program. By participating in this program, clinicians could have a good experience with comprehensive efforts and guidelines that could be implemented in many centers. I was attached to the Parkway Cancer Centre, Singapore, which is the largest private-run oncology center in Singapore, based in three private hospitals. I had the opportunity to see how palliative care was integrated with oncological care during my four-week attachment.

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b. On-site comparisons

Although Indonesia and Singapore share the similar cultural backgrounds of ASEAN countries; due to the differences in their economic status (GDP),health policies, facilities and infrastructures, level of education, etc.; a big discrepancy in palliative cares being provided in both countries is significantly noted.
In Parkway Cancer Center (PCC) Singapore, palliative care is organized by Dr. Joshua Kok, whom is well-trained and dedicated to provide care for inpatients, outpatients, home-care and hospice care. As Dr. Joshua Kok's team is working in a hospital-based setting, most of the patients come from PCC clinics.

Activities

I started my fellowship on November 16th 2015, and from the very first day I was integrated into the daily routine of Dr. Joshua Kok and his Palliative Care Team. Mostly we started the day with a clinical round at the hospital ward and saw all patients whom Dr. Joshua Kok co-managed with the primary oncologists. Though Dr. Joshua Kok is mostly based in Gleneagles Hospital, he also covers two other private hospitals which Parkway Cancer Center operates in - Mount Elizabeth Orchard Hospital and Mount Elizabeth Novena Hospital. Dr. Joshua Kok's team has three skillful nurse practitioners. The team is supported by the cancer center's dieticians and a team of trained counselors who provide psychosocial support. The team works closely with the primary medical oncologists. I have learned a lot about palliative care symptoms assessment and management. In particular, I appreciated the excellent skills in pain assessment which Dr. Joshua Kok and his team demonstrated. Proper pain assessment led to appropriate pain

management and pain relief for the patients. Patients also have the privilege to get advice about nutrition and counseling as a comprehensive care. We also went for home visit for patients who wished to be taken care at home in their last days. Home-care setting is very different from the hospital-care setting, as family members would be expected to provide most of the care with advice from the team. I also had the opportunity to join Dr. Joshua Kok in his Visiting Consultant's session at the community-based Dover Park Hospice in teaching specialist trainees and junior residents. I also sat in one of his teaching session with medical students. Nurse Yang Juan was showing how to set up a PCA opioid infusion device, for pain-control.

During my 4-week observation program, I was exposed to good experience and knowledge in palliative care in the context of :

• Symptoms assessment, e.g. respiratory problems, gastro-intestinal (GI)problems, consciousness and mental status.

• Symptoms management, e.g. pain (most common complaints),nausea-vomiting, constipation, breathlessness, anxiety, depression, delirium and bleeding

• Communication skills to deliver any information to the patients, family members and caregivers, especially the way to deal with sensitive issues such as Do Not Resuscitate (DNR), care planning, etc.

• Communication skills to liaise with primary oncology doctors to provide best treatment/management strategies for the patients.

Compared to my workplace, there are a lot of differences in the model of care and treatment of these advanced stage patients. I was trained as a Radiation Oncologist in Indonesia, and at present, I am working in the Department of Oncology and Radiotherapy of a private hospital in Medan - the third largest city in Indonesia, and the capital of North Sumatra province, with approximately 13 million populations. However, due to limited facilities in my surrounding provinces, our hospital actually accepts patients from neighboring provinces that could be sum up to more than 24 million populations. Indonesian people are covered by National Healthcare Coverage that covers hospitalization and limited preventive care, but not for home-care settings. This is a big challenge for patients who could not afford to pay to get an adequate care at home. We are considering to involve third parties such as Non-governmental organizations (NGO), private or public companies' corporate social responsibility funding (CSR), social workers and other sort of charity/donation acts to support palliative and home-care in Medan.

Conclusion

The ESMO Palliative Care Observation Fellowship is an excellent experience I have since my professional practice as an oncologist. Although I was trained as a Radiation Oncologist, that doesn't mean to limit the possibility to giving comprehensive care for cancer patients at any stage of disease. I benefited a lot in terms of integrating the oncology basis I had, with new horizon of palliative and hospice care.

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References

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