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1829th Conference



July 2018 | Volume 8 | ISSN: 2165-7386
Journal of Palliative Care & Medicine

Proceedings of
5th World Congress on

HOSPICE AND PALLIATIVE CARE

July 18-19, 2018 Melbourne, Australia

CONFERENCE SERIES LLC LTD

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5th World Congress on

Hospice and Palliative Care

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Keynote Forum

Day 1

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Trisha Dunning

Deakin University, Australia

Developing guidelines to manage diabetes during palliative and end of life care: A collaborative iterative approach

Statement of the Problem: Diabetes is an underlying cause of death in over 60% of deaths due to diabetes complications and other comorbidities. People with diabetes have a shorter life expectancy than the population. Quality diabetes palliative and end of life care requires a personalized approach and should be a proactive collaborative endeavor. Clinicians are reluctant to discuss these issues with people with diabetes and there is limited guidance to support their decision-making.

Aim: The aim is to develop and formatively evaluate guidelines for managing diabetes at the end of life that were evidenced-based, clinically relevant, holistic and usable.

Method: The standard guideline development procedures are used. In addition, palliative care clinicians used several successive iterations of the draft guidelines to deliver care. Thus, the guidelines were tested before they were released into the public domain. The interview was done for the people with diabetes receiving palliate care and families about their experiences and the care issues they believed needed to be included in the guidelines.

Findings: The literature review identified only five relevant papers, three of which provided advice based the initial paper, none advocated a holistic approach. People with diabetes wanted blood glucose testing and diabetes medicines continued until 'the end' as part of symptom control and comfort. Families were concerned about assuming diabetes self-care when their relative was too ill to continue do so. Important aspects of diabetes palliative/end of life care were included in the final guideline that was not mentioned in the literature review. Collaborating with key end users enhanced the likelihood they would be used.

Conclusion: The guidelines are clinically relevant and encompass issues relevant to people with diabetes and clinicians. They were developed collaboratively with end users and care recipients, which enhanced their relevance.

Biography

Trisha Dunning is the inaugural Chair in Nursing and a Member of the Centre for Quality and Patient Safety Research in the Barwon Health Deakin University Partnership. Her research and care focus are on older people with diabetes and end of life care. She serves on many Professional Committees and Advisory Boards, including Diabetes Victoria, College of Nursing Australia and the International Diabetes Federation. She was made a Member of the Order of Australia in 2004 for her work in nursing and diabetes.

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Irudaya Rajan S

Centre for Development Studies, India

Palliative care for the elderly in India

India's elderly population stands at 123 million in 2018. According to the 2014 round of the National sample survey, two million elderly persons in India are bed ridden and another seven million are confined within their households. Who will take care of them during their sunset years? The issue of caring for the elderly and ensuring their dignity at death should thus receive immediate public attention. In this context, this paper is an attempt to understand the steps taken by government and other agencies in India to cater to the care needs of the elderly. It further looks at the flaws in these mechanisms and offers some suggestions to improve the present situation. We shall use government reports, organizations working in the field of palliative care and Kerala Aging Survey data. Palliative care for elderly in India is still in the early stage of development. Many elders are not aware of the existing policies on palliative care. Awareness programs, care training centers, etc. are need of the hour. Though we have multiple mechanisms in palliative care for the elderly, there are many loopholes here which must be addressed.

Biography

Irudaya Rajan S has completed his PhD from International Institute for Population Sciences, Bombay. He is the Professor at Centre for Development Studies, Kerala, India. He has published extensively in national and international journals on social, economic, health and demographic facets of aging since the last three decades. He conducted the first longitudinal Aging Survey in Kerala in 2004, which is repeated every three years and entered its fifth wave in 2016. He has been involved in several projects on aging funded by the United Nations, South Asian Network of Economic Institutes, Indo-Dutch Program on Alternatives in Development, Shastri Indo-Canadian Institute, International Development Research Centre, World Bank and Help Age International.

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Michaela Bercovitch

Tel Aviv University, Israel

Hospice: The right to choose

Since ancient times, the obligation of the physician was to relieve suffering. Despite this fact, little attention was given to the problem of suffering and dying in medical education, research or practice. In the 21st century life expectancy is increasing, more people live with serious effects of chronic illnesses and they must deal with many complex issues, relief of symptoms, effect of the illness on roles and relationships, restoring or maintaining quality of life. Each of these issues creates expectations, needs, hopes and fears, which must be addressed in order for the ill person to adapt and continue living and presents a set of public health challenges requiring the attention of policy makers. Traditionally end of life care in the form of palliative care has been offered mostly to cancer patients. For some years this kind of care has been offered for a wider range of serious illnesses and was integrated more broadly across care services. Hospice was created as a coordinated program providing palliative care to terminally ill patients and supportive services to patients, families, 24 hours a day seven day a week. Services are comprehensive, case managed based on physical, social, spiritual and emotional needs during the dying process by medically directed interdisciplinary team consisting of patients, families, health care professionals and volunteers (WHO). Hospice treatment is the most personalized way to care, by recognizing a patient not only like a body part, but as a unique being, with soul and psyche. Each patient means a new book to be read and understood by the team. Accordingly, hospice care is flexible and aggressive palliative interventions have to answer some questions: What is the goal of intervention? Does the intervention have a chance of high efficacy? What is the impact on the patient (side effects, complications, discomfort)? What is the life expectancy? And what does the patient want? Hospice program is limited for those patients diagnosed with terminal illness with a limited life span and it is not a must in health care system. Hospice is a choice and any individual have the right, in conformity with the law, to decide how to be treated when facing a terminal illness. Those patients refusing to accept the imminence of death and want to continue to fight they are not eligible for hospice. Those prefer to concentrate on living as comfortably as they can until their last day prefer the hospice care.

Biography

Michaela Bercovitch is the Director of the Oncological Hospice in Sheba Medical Center, Israel and a Lecturer at Tel Aviv University, Sackler School of Medicine. She was born in Romania, Bucharest, where she graduated from Medical School as MD in Pediatrics. In 1987 she emigrated to Israel and after two years training in Internal Medicine and Geriatrics she continued her medical practice in the Oncological Hospice. She is involved in the education of medical students, nurses and doctors across Israel.

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Notes:



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Pushparanee Somasundram

Sengkang General Hospital, Singapore

Diverse and unique end of life practices in a Buddhist patient in Singapore

Mr C had terminal cancer of the colon. He was keen to have Tibetan Buddhist rituals and prayers prior to and after his death so he can have a good rebirth. This entailed was no touching of the body for 8 hours after the last breath leaves his body for the soul to leave peacefully. Tibetan Buddhists believe the soul is still around in the body until 8 hours after death. The dilemma for the health care worker was how to pronounce time of death of the patient. A win compromise was achieved after health care workers discussed and analyzed the inputs from the family and the monks. The ECG monitor was set up before the 8 hours period. This allowed the health care worker and the monks to know when death (asystole) occurred. Just before his demise, Monks performed rituals and holy chants. Relatives refrained from crying as it may hinder a happy rebirth. They also placed holy garments on the patient before death, placing Buddhist pictures and their meditation beads in his hands. The healthcare worker could still do the monitoring and pronounce the time of death. The monks could do the prayers for the departing soul. The family is happy the loved ones managed to have a peaceful death. Clinical importance of understanding the cultural and psychosocial aspects of patient care ensures there are no glitches in bereavement process for the grief-stricken family.

Biography

Pushparanee Somasundram is the Senior Staff Registrar in the Department of Family Medicine in Sengkang General Hospital, Singapore. Her research and care focus are on older people and end of life care. She serves on many professional committees and advisory boards.

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