

National Guidelines for Palliative Care



Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Confederation

Federal Department of Home Affairs FDHA
Federal Office of Public Health FOPH



GDK Schweizerische Konferenz der kantonalen Gesundheitsdirektorinnen und -direktoren
CDS Conférence suisse des directrices et directeurs cantonaux de la santé
CDS Conferenza svizzera delle direttrici e dei direttori cantonali della sanità

Contents

Introduction	3
Objective and purpose of the “National Guidelines for Palliative Care”	6
1 st guideline: Definition of the term “palliative care”	8
2 nd guideline: Basic values in palliative care	9
3 rd guideline: Principles for the delivery of palliative care	11
4 th guideline: Target groups	15
5 th guideline: Treatment and care settings	19
6 th guideline: Palliative care providers	21
7 th guideline: Intercantonal and international collaboration	23
Glossary	24
Literature	28

Introduction

“National Guidelines for Palliative Care” as a central measure of the “National Strategy for Palliative Care 2010–2012”

Within the scope of the “National Health Policy” platform, the federal government and the cantons have decided to promote palliative care in Switzerland in co-operation with the most important actors in the spheres of healthcare, social, training and research. To this end, they developed and have officially adopted the “National Strategy for Palliative Care 2010-2012” in October 2009.

In preparation, about 80 experts under the auspices of the Federal Office of Public Health (FOPH) and the Swiss Conference of the Cantonal Ministers of Public Health (CMH) assessed the need for action in the field of palliative care in Switzerland, because access to palliative care for terminally ill and dying patients in Switzerland is far from comprehensive. Moreover, a representative population survey concerning palliative care commissioned by the FOPH in 2009 revealed that nearly 75 percent of people in Switzerland would like to die at home. However, the reality paints a different picture: most people die in a home for the elderly, a nursing home or in hospital.

With the “National Strategy for Palliative Care 2010–2012”, the federal government and the cantons are defining objectives aimed at closing the identified gaps relating to care, financing, information, education and research. For instance, the field of action “care” aims to provide a sufficient number of palliative care services. Ensuring access to palliative care services for all patients, irrespective of their socio-economic status, is the goal of the field of action “financing”. The goal of the field of action “training, further education and continuous education” is to ensure that specialists and volunteers working in palliative care possess the necessary and appropriate level of expertise in palliative care. The field of action “research” is geared towards establishing palliative care research to deliver high-quality research results and to make significant contributions relating to social end-of-life issues.

The measures to achieve these goals will be realised in co-operation with all partners, and the resources will be used efficiently. The “National Strategy for Palliative Care 2010–2012” is focused on intensified co-ordination and better utilisation of synergies on the national and cantonal levels. The “National Guidelines for Palliative Care” presented herein were developed as a first and central measure. Promoting palliative care is crucial in view of the demographic development in Switzerland and the associated societal, socio-political and health care policy-related challenges: the Swiss population is ageing, and the incidence of incurable, chronically progressive illnesses is greater in old age. Multimorbidity, i.e. the concomitant presence of several illnesses in one person, is an increasingly prevalent characteristic phenomenon in the ageing population. As a result, medical treatment and care during the last phase of a person’s life become significantly more complex. However, younger, seriously ill patients with cancer, neurological disorders or chronic illnesses often require comprehensive treatment and care over extended periods as well.¹

The mortality of adolescents, children, infants and neonates in Switzerland is relatively low. However, the majority of all deaths in this age group occur after the decision to forgo life-sustaining measures and a more or less extensive phase of palliative treatment and care. Depending on the age of the patient, this phase consists of different yet usually extremely complex problems and can lead to severe stress in the affected children, adolescents and their families. Nevertheless, paediatric palliative care is still in its infancy. But the demographic development in Switzerland is also a challenge because the number of annual deaths in Switzerland is expected to rise in the coming years and decades. At present, the annual death

¹ The term “treatment”, as used in these guidelines, refers to medical and nursing care of an ill person, whereas the term “care” comprises the psychological, social or spiritual care.

rate in Switzerland is of the order of 60,000 people of all ages. The Federal Statistical Office (FSO) projects that the number will rise to 90,000 by the year 2050.

Not all of these people will require palliative care at the end of their lives. But palliative care should be available for anyone who requires qualified treatment and care at the end of their life. It is therefore the objective of the “National Strategy for Palliative Care 2010–2012” to establish palliative care in health care and social services as well as in education and research. For this purpose, a common understanding of palliative care among all stakeholders in Switzerland is required first.

Objective and purpose of the “National Guidelines for Palliative Care”

A number of divergent definitions for palliative care exist in Switzerland. For example, the different disciplines (e.g. medicine, nursing, social work, psychology, theology and ethics) and regions each have a distinct understanding of palliative care. The “National Guidelines for Palliative Care” aim to create a nationwide consensus among the actors with respect to the definition as well as the basic values, principles, target groups and providers of palliative care. Their goal is to improve the acceptance of palliative care in Switzerland and to promote its establishment in different areas of society. A common understanding of palliative care is one of the key prerequisites for the successful implementation of the “National Strategy for Palliative Care 2010–2012”.

The presented “National Guidelines” are to be considered a signpost for the development of palliative care in Switzerland. Their purpose is not to define quality criteria of palliative care or to discuss financing models for palliative care services. These and other measures are addressed within the scope of the implementation of the “National Strategy for Palliative Care 2010–2012”.² Nor are the “National Guidelines” intended to create any incentives for claiming non-indicated services by patients in the final stage of their life.

To ensure that the guidelines are accepted as widely as possible in Switzerland, a large circle of stakeholders were included in their development. The first draft, with the working title “National Principles for Palliative Care”, was compiled by a national interdisciplinary group of palliative care experts under the auspices of the Federal Office of Public Health (FOPH). It was based on international and national technical literature.

2 Cf. implementation plan for the “National Strategy for Palliative Care 2010–2012” on the FOPH website: www.bag.admin.ch/palliativecare.

The draft was discussed by selected stakeholders on 13 April 2010 within the scope of a “sounding board”. The numerous comments, notes and corrections were subsequently integrated into the document by the FOPH, taking into account the objectives of the “National Strategy for Palliative 2010–2012”. The revised version – renamed at that point by the FOPH and CMH to “National Guidelines for Palliative Care” – was subject to a broad-based commenting procedure. More than 100 oral (within the scope of a hearing) and written comments concerning the guidelines were received between mid-May and the end of June 2010. They were subsequently evaluated and integrated into the seven national Guidelines for Palliative Care presented here. The “National Guidelines for Palliative Care” were adopted by the Dialogue for National Health Care Policy on 21 October 2010.

1st guideline: Definition of the term “palliative care”

Palliative care³ comprises the care and treatment of patients with incurable, life-threatening and/or chronically progressive diseases. It is proactively taken into account, but its focus is on the time when the cure of the disease is no longer considered possible and no longer represents a primary objective. Patients are guaranteed an optimal quality of life depending on their situation until they pass away, and attachment figures receive adequate support. Palliative care prevents suffering and complications. It includes medical treatments, nursing interventions as well as psychological, social and spiritual support.

Palliative care is designed to address the patients’ needs in a comprehensive manner. Symptoms and discomfort are anticipated and relieved as much as possible. Qualitatively adequate palliative care services are dependent on the specialists’ professional skills. To the extent possible,⁴ palliative care is delivered in a location requested by the sick or dying patient. Networked health care structures enable the continuity of treatment and care. It is important that the possibilities of palliative care be included proactively and in a timely manner, i.e. in addition to curative and rehabilitative measures. At the same time, the focus of palliative care is on the time when the cure of the disease is no longer considered possible and no longer represents a primary objective.

3 “Palliative” is derived from the Latin verb “palliare” (to cloak) and “pallium” (the mantle). “Care” is an English word and means protection, guardianship and safekeeping. The term “palliative care” refers to “palliative medicine, care and support”.

4 Cf. 2nd guideline “Basic values”, paragraph “Self-determination”.

2nd guideline: Basic values in palliative care

Self-determination, dignity and the acceptance of illness, dying and death as components of life are the basic values extensively considered in the delivery of palliative care, similar to any nursing or medical activities.

Self-determination

The focus of palliative care is the person in his or her personal life-world. Palliative care recognises and respects every person as a unique individual. Palliative care is delivered only if the patient and/or his or her attachment figure – with a focus on adhering to the patient’s right to self-determination – are requesting it. Patients’ ability to make a decision is strengthened in order to allow them to make their own decision about the place of treatment, the treatment, care and support.⁵

It is important to note that complete self-determination may not be possible in every case. Especially because the focus is on the person in his or her personal lifeworld, system and resource-related factors also play a role (e.g. the patient’s financial resources, time-related resources and resilience of the attachment figures, available services). On the other hand, there are people who are unable to make their own decisions (any more) because of their age (e.g. children), dementia, disability or very advanced illness.

If a person no longer has the capacity to consent, the patient’s will, outlined in the patient’s advance health care directive (if applicable), will apply.⁶ Furthermore, the health care directive can designate a person (authorised representative) who will decide about the medical treatment if the patient is no longer able to do so him- or herself. If no written health care directive is available, the patient’s authentic most

5 The patient may change his or her mind as the illness progresses. These changes must be possible at any time and must be respected by attachment figures and the clinicians treating the patient.

6 Cf. SAMW guideline “Patients’ advance health care directives”.

likely will must be determined. For patients who never had the capacity to consent, the decision will have to be based on the patient's well-understood interest.

Dignity

Palliative care is delivered in a respectful manner by taking into account patients' personal, cultural and religious values and ideals. Human dignity as an indivisible basic value applicable to any phase of life is fully respected.⁷

Acceptance of disease, dying and death as components of life

Palliative care accepts the finite nature of human life by comprehending dying and death as components of life. What is feasible is weighed up against what is reasonable. Health care professionals accept the limits of available options and of human life.

⁷ Cf. Federal Constitution of the Swiss Confederation, art. 7: "Human dignity must be respected and protected."

3rd guideline: Principles for the delivery of palliative care

The following principles should be considered for the delivery of palliative care:

- **Equal treatment of all**
- **Interprofessional networking and continuity**
- **Open and reasonable communication**
- **Assistance with decision-making processes**
- **Inclusion of the personal environment**
- **Multi-dimensionality**

Equal treatment of all

Palliative care should be available to patients with incurable, life-threatening and/or chronically progressive diseases irrespective of their gender, age, socio-economic status, place of residence or cultural/religious background as well as to their attachment figures. It takes into account the special needs of women and men, migrants, premature babies and neonates, children and adolescents as well as their parents, the elderly, people with psychiatric disorders and those with special needs.

Interprofessional networking and continuity

The collaboration among different professional groups is a key element of palliative care. Mutual acceptance and respect of each other's respective skills and experiences as well as regular exchanges of information are essential for a fruitful collaboration. The continuity of care and treatment is guaranteed through the networking of involved specialists and institutions, in particular during the transition between outpatient and inpatient care and treatment and vice versa.

Open and reasonable communication

Palliative care includes empathetic, open and appropriate communication with the patient and, at his or her request, with the patient's

attachment figures. Empathy, attention and honesty vis-à-vis the patient are a prerequisite for this.

Assistance with decision-making processes

The goal is to support patients in the decision-making process and to encourage them to express their desires while their cognitive functions still fully permit.⁸ Patients should have the option at any time to redefine and update their last will. Attachment figures shall be notified thereof (as agreed upon with the patient). Patients as well as their attachment figures should be briefed clearly and comprehensively according to their needs and desires. An age-appropriate decision-making process should be pursued for children, with the inclusion of their family.

Inclusion of the personal environment (system orientation)

The timely inclusion of attachment figures and the patient's personal living situation is crucial. Attachment figures should be considered partners when it comes to planning the patient's treatment, care and support.⁹ It is particularly important to consider and include the attachment figures (parents and siblings) in the care of children.

Multi-dimensionality

Palliative care treats the patient as a whole, i.e. it is considerate of the physical, emotional, social and spiritual dimensions:

8 If a person does not (any more) have the capacity to consent, his or her potentially available advance health care directive or the presumed will should be considered. Cf. 2nd guideline "Basic values", paragraph "Self-determination".

9 Always with a focus on adhering to the patient's right to self-determination.

a) Physical dimension

All physical symptoms are documented and treated systematically, regularly and continuously. For symptom control purposes, valid measuring tools are used for the continuous evaluation of the progress. The patient's individual will and needs are relevant for the interprofessional therapeutic plan. The patient's independence should be promoted within the meaning of "helping him to help himself", taking into account his or her resources.

b) Emotional dimension

The emotional stress factors of the patient as well as the attachment figures who are caring for the patient are systematically documented. The patient's coping resources, i.e. his or her abilities and possibilities to adequately process stressful events, should be stabilised and supported. Regular conversations with the patient and his or her attachment figures should be conducted to this end. Psychological and/or psychotherapeutic interventions and services should be addressed at regular intervals, and the continuity in care and treatment should be guaranteed.

c) Social dimension

The social dimension puts the focus on the patient's lifeworld. It is guided by the person's needs, familiar lifestyle and everyday routines. The available resources and self-reliance are strengthened, allowing the patient to structure his or her daily routine independently until the end in spite of illness-related limitations. Among others, attachment figures, the circle of friends and acquaintances, the living conditions, financial and social insurance-related matters, housekeeping, child minding, work, school and leisure time are of particular significance in this dimension. Available local services and the social network of helpers are strengthened and networked. Access to appropriate services provided by various specialists and the collaboration with regional organisations and groups of informal and formal volunteer services should be addressed at regular intervals, and the continuity of the care should be guaranteed. Furthermore,

culture-specific aspects should also be included within the scope of treatment and care.

d) Spiritual dimension

Spiritual support contributes towards improving a person's subjective quality of life and the protection of their dignity in the face of disease, suffering and death. It assists people in their existential, spiritual and religious needs during their search for the meaning, interpretation and assurance of life as well as their crisis management,¹⁰ always while considering the patient's biography as well as his or her personal values and beliefs. The determination of the existential, spiritual and religious needs of everyone involved is required for this purpose. Interventions and access to adequate services relating to spiritual counselling should be discussed within the interprofessional team at regular intervals, and the continuity of the support should be guaranteed.

¹⁰ Personal spirituality can be of a religious or denominational nature or independent of religion.

4th guideline: Target groups

Palliative care focuses on the needs, symptoms and problems of affected patients as well as their attachment figures. Because of their different needs, a distinction is made between patients receiving primary care (patient group A) and patients receiving specialised palliative care (patient group B).

Since palliative care is supposed to be available to any and all patients with incurable, life-threatening and/or chronically progressive diseases (according to the 1st guideline), it makes little sense to classify patients by symptoms or stages. Therefore, a distinction is made between “patients receiving primary care” and “patients receiving specialised palliative care” (cf. Fig. 1). The transition between these two groups is fluid, meaning that a patient may belong to both groups during his or her lifetime. Because a sick person may temporarily be doing better, the phases of instability and complexity of group B alternate with phases of group A.

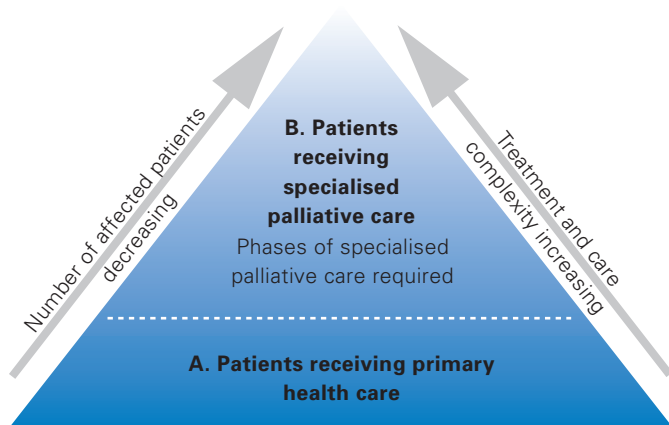


Fig. 1: Differentiation between group A “Patients receiving primary health care” and group B “Patients receiving specialised palliative care”.

**Patient group A:
Patients receiving
primary care**

This group consists of patients who are dealing with the end of life in a proactive way or have reached the final phase of their life due to the progression of their incurable, life-threatening and/or chronically progressive disease.

The principal needs of patient group A include, for example:

- Evaluation and definition of individual priorities and needs with respect to the design of the last phase of life
- Communication in order to enable the decision-making process and advance planning for medical, care-related and psychosocial issues
- Treatment of existing or expected symptoms and providing information with the goal of preserving the patient's autonomy and strengthening his or her ability to make decisions
- Evaluation of the attachment figures' existing or possible breaking points, planning of possible residence options, information about regional palliative care networks including volunteer assistance and support for attachment figures, assessment of the financing of necessary services

Patients in group A may also need the additional specific expertise of specialised palliative care (group B), for instance if the changing, episodic nature of their progressive disease or prolonged phases of instability temporarily require a more intense special treatment. Possible reasons include increasing symptoms and complexity of the disease, also taking into account the psychosocial burden for the attachment figures

Patient group B: Patients receiving specialised palliative care

This patient group is smaller in terms of numbers and includes patients who rely on the support of a specialised palliative care team,¹¹ because their medical condition is unstable, they require complex treatment or stabilisation of pre-existing symptoms, or their attachment figures start to show signs of reaching their breaking point. It also includes patients who should or would like to continue receiving primary care but whose primary care providers are reaching their limits and require additional support from specialists. However, sometimes the symptoms can be stabilised to the point where a return to patient group A may be possible.

For children, support from specialists is necessary in the majority of cases, because primary health care professionals are unable to gain sufficient experience due to the rarity of deaths in children. Therefore, children are to be assigned to patient group B systematically.

The specific needs of patient group B include:

- Relief of extremely taxing symptoms, i.e. a combination of symptoms which did not improve with previously conducted procedures and which seriously compromise the patient's quality of life
- Difficult decision-making processes, including the termination of life-extending treatments requiring an interprofessional palliative care team
- If intensive assistance is required due to the patient's poor general condition, for instance in connection with the determination of outpatient or inpatient accommodation, special challenges associated with the care environment, or in the presence of overlapping physical, emotional, social and spiritual suffering
- Intensive support of attachment figures exposed to a high degree of stress caused by the progression of the illness and other factors

¹¹ This term does not connote a firmly established team but a variety of palliative care specialists who collaborate interprofessionally within the team (not to be confused with mobile palliative care teams and services). Cf. 6th guideline "Palliative care providers".

Attachment figures

Subject to the patient's consent, attachment figures are involved throughout the entire duration of care and treatment within the meaning of a partnership approach. Depending on the situation, they help design the patient's care or receive care themselves, for instance by way of support and counselling during the grieving process. If they help design the care, they need advice and guidance (e.g. with respect to medical and care-related issues) as well as support (e.g. recognition).¹² Regular talks between the interprofessional team and attachment figures are of paramount importance. Aside from psychosocial and spiritual/religious aspects, the financing of care and treatment should also be addressed. The timely identification and understanding of, as well as the respect for, the limits of the attachment figures' resilience are important. Consequent measures to assist and relieve the attachment figures should be derived in a timely manner.

¹² Parents of seriously ill children, for instance, often play a central role in their care. Adequate advice, support and guidance are therefore indispensable. And children of seriously ill parents also have specific needs which need to be addressed accordingly.

5th guideline: Treatment and care settings

Care and treatment at home are feasible for both patient groups (A and B), subject to corresponding specialists with the necessary expertise being available. Patient group A can, for the most part, be treated within the scope of primary care (general practitioners, home health care organisations, resting and nursing homes for the elderly as well as institutions for people with special needs, acute care hospitals). In contrast, patient group B¹³ occasionally requires specialised palliative care services.

In palliative care, every patient should be able to decide independently, to the extent possible,¹⁴ on the place and nature of treatment and care. Many people wish to receive care and treatment at home. This is feasible for both patient groups (A and B), subject to close cooperation with the primary care service providers and adequate availability of specialists with corresponding expertise. A higher level of competence is usually required for patient group B, i.e. primary care providers who have acquired special know-how and corresponding qualifications as well as palliative care specialists. Additionally, 24-hour availability of a specialist may be required.

For the most part, patient group A can be treated within the scope of primary care, always subject to an adequate number of professionals with the corresponding expertise being available. In some cases, additional services may be required, such as, for instance, specialised expertise in the field of paediatrics. Additional treatment and care settings, including hospices or palliative care units or consultations at an outpatient palliative care clinic (if available) or palliative consultation services at the hospital (or nursing home), are

13 This relates to a standardised assignment of the patient groups. As described in the 4th guideline on target groups, the transition between the two groups is often dynamic. Some patients only require intermittent specialised palliative care services and can then return to receiving primary care. The patient's needs are always relevant.

14 Cf. 2nd guideline on the basic values, paragraph "Self-determination".

possible for patients of group B as well as possibly for patient group A during certain phases. Mobile palliative care teams can be used to provide assistance with the care at home or in nursing homes, aimed mainly at providing professional advice, guidance and support to the caregivers.

6th guideline: Palliative care providers

Palliative care is delivered by an interprofessional team.¹⁵ This team can consist of health care professionals with or without a university degree. Depending on the needs of the patient and his or her attachment figures, other professionals with a background in social sciences or psychology, pastoral care or other occupations are included. Volunteers can be part of the interprofessional team and of the palliative care, taking into account their qualifications and responsibilities. The specialists of the interprofessional team, the assistant staff as well as the volunteers require training and/or (internal) further or continuing education (primary care providers and specialists) geared towards their assignment in the delivery of palliative care.

In palliative care, specialists pursue an interprofessional collaboration. The interprofessional team consists (depending on the situation and need) of appropriately trained health care professionals (of various educational levels) with or without a university degree. Professionals with different backgrounds in social sciences or psychology, pastoral care or other occupations with or without a university degree are included at the request, and depending on the needs, of the patient and his or her attachment figures.¹⁶

Assistants with training qualifications outside the educational system (employees without vocational training/health care assistants) can be part of the interprofessional team as well. Family members often also contribute to providing palliative care. Therefore, they should be integrated in the interprofessional team to the extent possible.

¹⁵ Cf. footnote 11.

¹⁶ Cf. 2nd guideline "Basic values", paragraph "Self-determination".

In consideration of their respective qualifications and responsibilities, volunteers can additionally be part of the interprofessional team and the palliative care. Their adequate preparation and continuous monitoring (supervision) is key. This can best be achieved within a managed group of volunteers. In order to improve their know-how and qualifications, volunteers as well as assistant staff should be given the opportunity to obtain (internal) continuing education in palliative care.

Palliative care volunteer groups offer patients and their families support during the time of illness and in the last phase of life, thereby making a major contribution to the delivery of care to patients at the place of their choice. However, we always need to remember that volunteer groups are not qualified to replace the specialists.¹⁷ By providing relief to caregiving attachment figures, volunteer groups can support the cohesion between generations and set an example for solidarity in society through their handling of dying patients and their environment.

¹⁷ The existing structures and the Federal Vocational and Professional Education and Training Act dated 13 December 2002 (VPETA; SR 412.10) shall be complied with.

7th guideline: Intercantonal and international collaboration**Palliative care in Switzerland cultivates intercantonal and international exchange and networking.**

In order to continue its development, palliative care in Switzerland relies on intercantonal and international co-operation and exchange. This is achieved by means of national and international symposiums, the consideration of existing regional and cantonal models and services as well as by means of international quality and education standards and the participation of Swiss specialists in international research projects.

Glossary

Needs

According to Abraham Maslow's hierarchy of needs, human needs represent different "levels" of the pyramid which are built upon each other: People try to satisfy the needs of the lowest levels first, before the subsequent levels become relevant. Level 1 comprises the fundamental physical needs such as breathing, sleep, food, heat, health, residential space, sexuality and movement. Safety needs follow on level 2: law and order, protection from dangers, a secure income, safety and accommodation. Level 3 concerns the social needs, including family, friends, partnership, love, intimacy and communication. The individual needs follow on level 4: esteem derived from status, respect, recognition, wealth, money, influence, personal and professional successes, mental and physical strength. Finally, the fifth and highest level includes the needs of self-actualisation: individuality, developing one's talent, perfection, enlightenment and self-improvement.

Chronic diseases

Chronic diseases are slowly developing as are prolonged diseases such as cardiovascular diseases, COPD, Parkinson's disease, breast cancer, diabetes mellitus, multiple sclerosis, apoplexy, schizophrenia, dementia, epilepsy, gout, rheumatism, ulcerative colitis or Crohn's disease. They are characterised by a protracted development, usually associated with complications and often accompanied by low life expectancy. Chronic diseases require continuous medical care, without which the patient is at risk of life-threatening deterioration and further reduced life expectancy or permanent impairment of the quality of life.

Dialogue for National Health Care Policies

This platform was launched by the Federal Department of Home Affairs (FDHA) and the Swiss Conference of the Cantonal Ministers of Public Health (CMH). Its purpose is a better harmonisation of the federal and cantonal health care policies. Joint meetings are held three times a year. The Federal Office for the National Health Care Policy is part of the FOPH.

Primary health care

Primary health care in the field of palliative care includes the treatment of patient group A. Primary care within this framework is delivered by acute care hospitals, nursing homes, general practitioners as well as home health care organisations.

Interprofessionalism

“Inter” describes the type of collaboration, while “professionalism” indicates that this concerns the work of different groups of professionals. Palliative care is preferably delivered by an interprofessional team. This team can consist of health care professionals with or without a university degree. Depending on the needs of the patient and his or her attachment figures, other professionals with a background in social sciences or psychology, pastoral care or other occupations with or without a university degree are included.

Phases of the disease

No generally accepted definitions are available with respect to the duration of different phases of disease. The following periods are commonly used in professional circles:

- Short disease: up to 12 weeks
- Moderate duration of disease: 3 to 24 months
- Prolonged phase of disease: 2 years and longer

Curation

Medicine is built upon the three pillars “curation”, “prevention” and “rehabilitation”. The term “curare” is derived from Latin and means “to cure”. The therapeutic goal of curation is to cure the diagnosed diseases.

Multimorbidity

Multimorbidity (also known as polymorbidity) refers to the concomitant presence of several illnesses in one person. It is a characteristic phenomenon in the ageing population (linear increase with rising age).

Attachment figures

Attachment figures include persons considered as such by the patient. They can include next of kin such as parents, children and siblings, a spouse or life partner and other persons with whom the patient has a close relationship (including outside the circle of relatives).

Patient's advance health care directive, patient's rights

The patient's advance health care directive is a tool of patient self-determination. In the advance directive, a person with the capacity to consent can define which medical procedures he or she would approve or disapprove of in the event of a loss of the capacity to consent. Alternatively, it can designate a person who will discuss the medical procedures with the clinician delivering the treatment and make the corresponding decision on the patient's behalf in case of the latter's loss of the capacity to consent. The revised law on the protection of adults will govern the binding legal force of the patient's advance health care directive uniformly on a national level (art. 370 et seqq.). The revision is scheduled to enter into effect in 2013. Until then, the cantonal regulations, if available, governing patients' advance directives will apply.

Rehabilitation

Rehabilitation refers to reintegrating/rehabilitating medicine. Its purpose is to remedy or relieve health-related limitations caused by disease or accident.

Sounding board

“Sounding board” refers to a workshop method used to evaluate and reflect on the situation regularly throughout the change process or project. “Sounding board” is a musical term relating to resonance. Obtaining feedback from all involved stakeholders is essential for managing a project or process. Therefore, project members and representatives of a variety of stakeholder groups gather in a sounding board. The outcomes are subsequently used to derive measures for the successful continuation of the change process.

Specialised palliative care

Patients with complex acute symptoms, with overall very unstable health situations or other problems require specialised palliative care. A higher level of competence and specific expertise are required.

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Nationale Strategie Palliative Care 2010–2012



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CDS Conferenza svizzera delle direttrici e dei direttori cantonali della sanità

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