Offenlegung potentieller Interessenskonflikte

1. Anstellungsverhältnis oder Führungsposition
2. Beratungstätigkeit
3. Aktienbesitz
4. Honorare
5. Finanzierung wissenschaftlicher Untersuchungen
6. Gutachtertätigkeit
7. Andere finanzielle Beziehungen

Keine!


9. Int. Sylter Palliativtage

Anke Olscher

Anke Olscher

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Anke Olscher

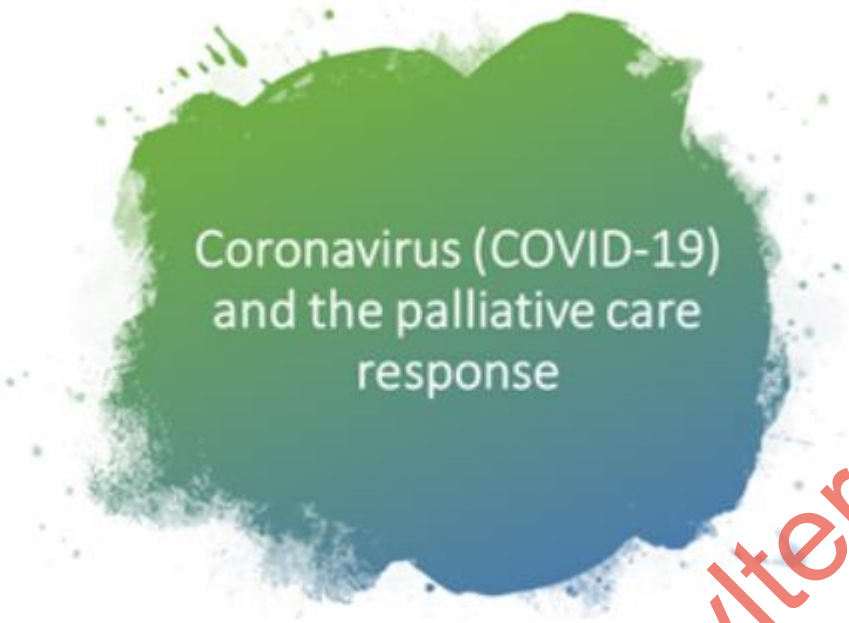
Palliativversorgung in der Pandemie im internationalen Vergleich

Christoph Ostgathe, Präsident

European Association for Palliative Care (EAPC)

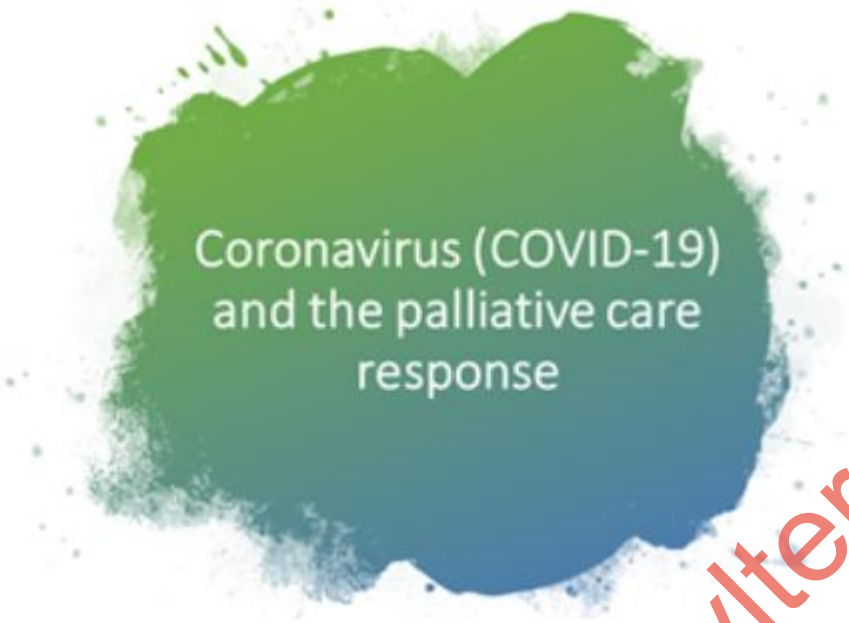
EAPC ‘one voice and one vision’

- … ist ein Forum für alle, die in Europa und darüber hinaus in der Palliativversorgung aktiv sind oder sich für Palliative Care interessieren
- … hat 60 Mitgliedsverbände, drei aus Australien und 57 aus 33 europäischen Ländern sowie Einzelmitglieder aus 52 Ländern weltweit
- … multiprofessionelle Mitglieder engagieren sich für Palliativ-versorgung über die gesamte Lebensspanne hinweg aus einer Reihe von Perspektiven: u.a. spezialisierte und allgemeine Palliativversorgung, Ausbildung, Politik und Forschung.
- … ist Fürsprecherin für die Entwicklung der Palliativversorgung durch ihre Aktivitäten und ihre Arbeit bei der Weiterentwicklung der Praxis der Palliativversorgung in Europa und der Welt
- … ist vom Europarat anerkannt
- … fördert die Forschung u.a. durch Beteiligung an EU-Projekten



Sammlung von (Internet-) Ressourcen, u.a. Nationale Handlungsempfehlungen aus Australien, Belgien, Kanada, Frankreich, Deutschland, Irland, Italien, Portugal, Spanien, Schweiz, England, USA.

https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response



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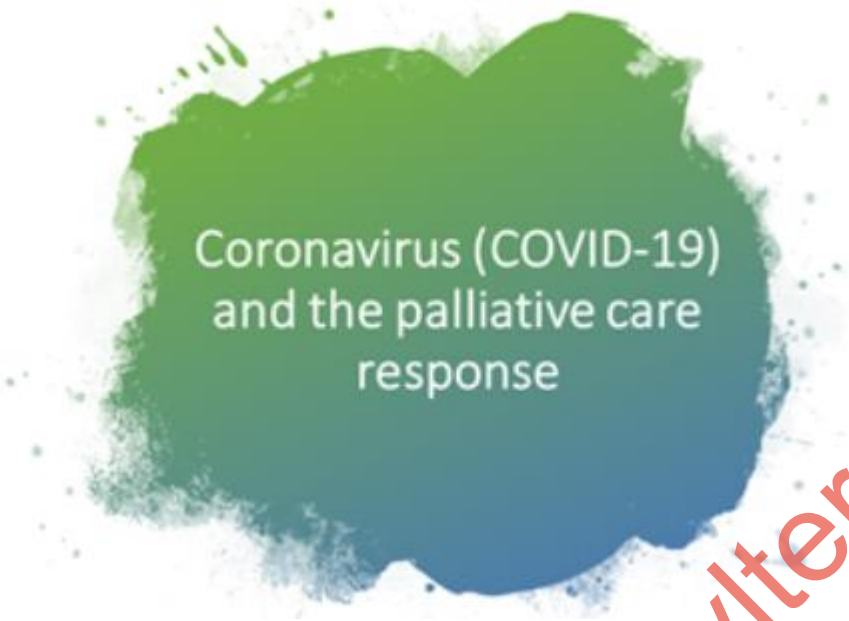
April 2020: 12.000 Zugriffe

https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response



Einheitliche Themen international

- Sicherstellung des Zugangs zu Medikamenten (wie z.B. Opioiden) und Schutzausrüstung
- Symptomkontrolle
- Triage
- verstärkter Einsatz von Telemedizin
- Advance Care Planning
- Schulung und Vorbereitung des Gesundheitspersonal
- Förderung der Rolle von Ehrenamtlichen und der Gesellschaft
- Kommunikation
- Trauer / Angehörige

https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response

Vorbemerkung Pandemie

Kein Gesundheitssystem der Welt ist auf eine Pandemie vorbereitet!

Allgemeine Folgen einer Pandemie (mit Auswirkungen auf die Palliativversorgung):

- **Re-Allokation von Ressourcen, z.B.**
  - Mitarbeiter
  - Räume / Gebäude / Geräte
  - Finanzen
- **Politik fokussiert auf das Gesundheitswesen**
  - Erfolg / Misserfolg misst sich an Anzahl der Verstorbene
- **Die Menschen, die Versorgung notwendig haben, laufen Gefahr diese nicht zu erhalten (z.B. wg. Quarantäne, Lockdown, Isolationsmaßnahmen)**

Vorbemerkungen CoVid-19

- Das SARS-COV2 Virus ist so - wie bisher kaum kein anderes - an unser Bedürfnis nach Nähe, Berührung und Interaktion adaptiert. Das macht die Infektion - als relativ harmlose Erkrankung - durch die schiere Menge der potentiell Infizierten so gefährlich.

Vorbemerkungen PC und CoVid-19

- Palliativversorgung ist schon in guten Zeiten weltweit unterfinanziert; ggw. befinden wir uns in keinen guten Zeiten!
- Risikogruppe hat große Schnittmenge mit Patienten, die wir in der Palliativversorgung sehen

AGE GROUPS

All ages ×
15-44 years ×
65+ years ×
+

0-14 years
45-64 years
65-74 years
75-84 years
85+ years

WEEK RANGE

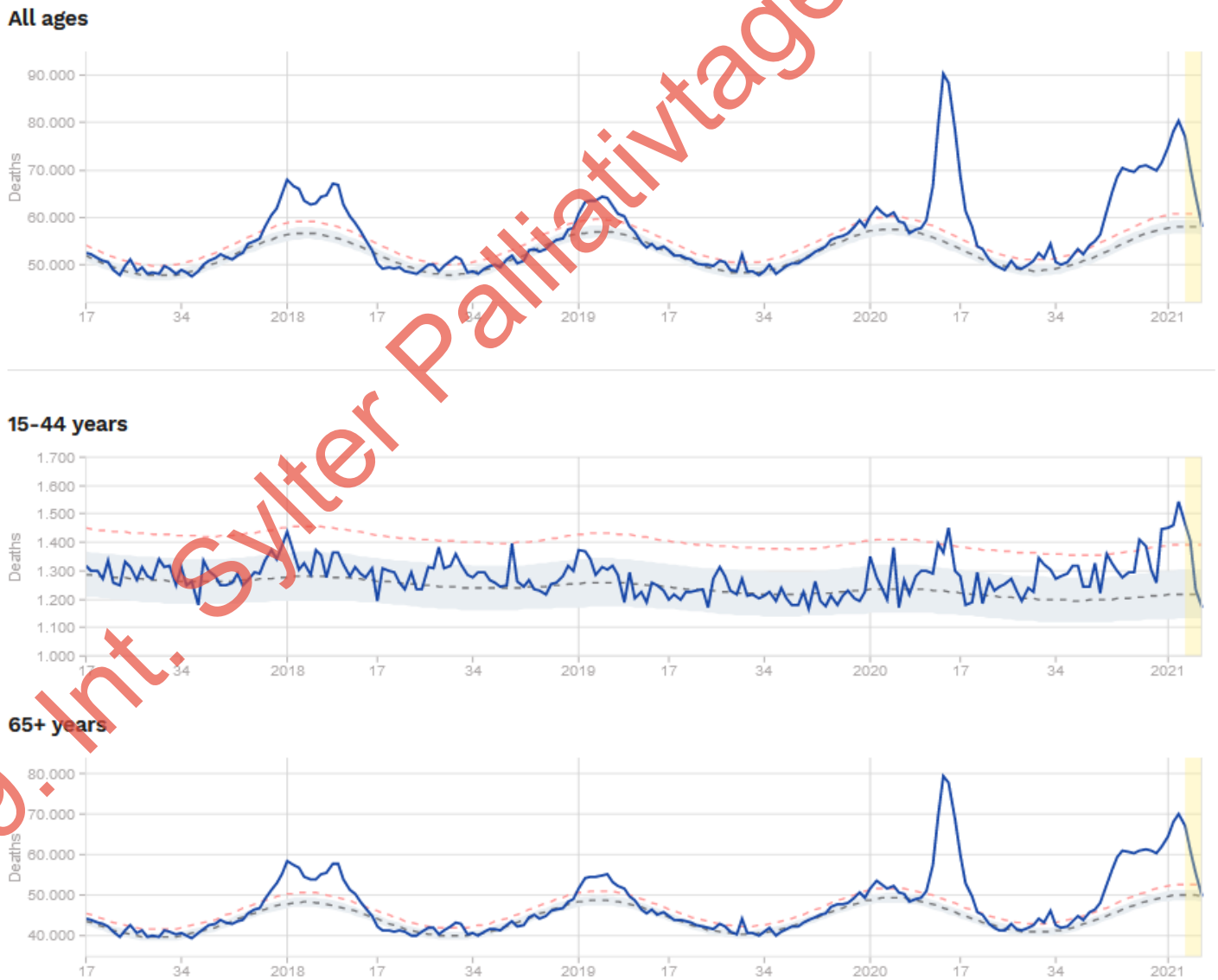
2017-17 — 2021-07

SHOW

Number | Z-scores

What is a z-score?

Pooled deaths | Normal range | Baseline | Substantial increase | Corrected for delay in registration



https://www.euromomo.eu/graphs-and-maps
Zugriff 1.03.2021

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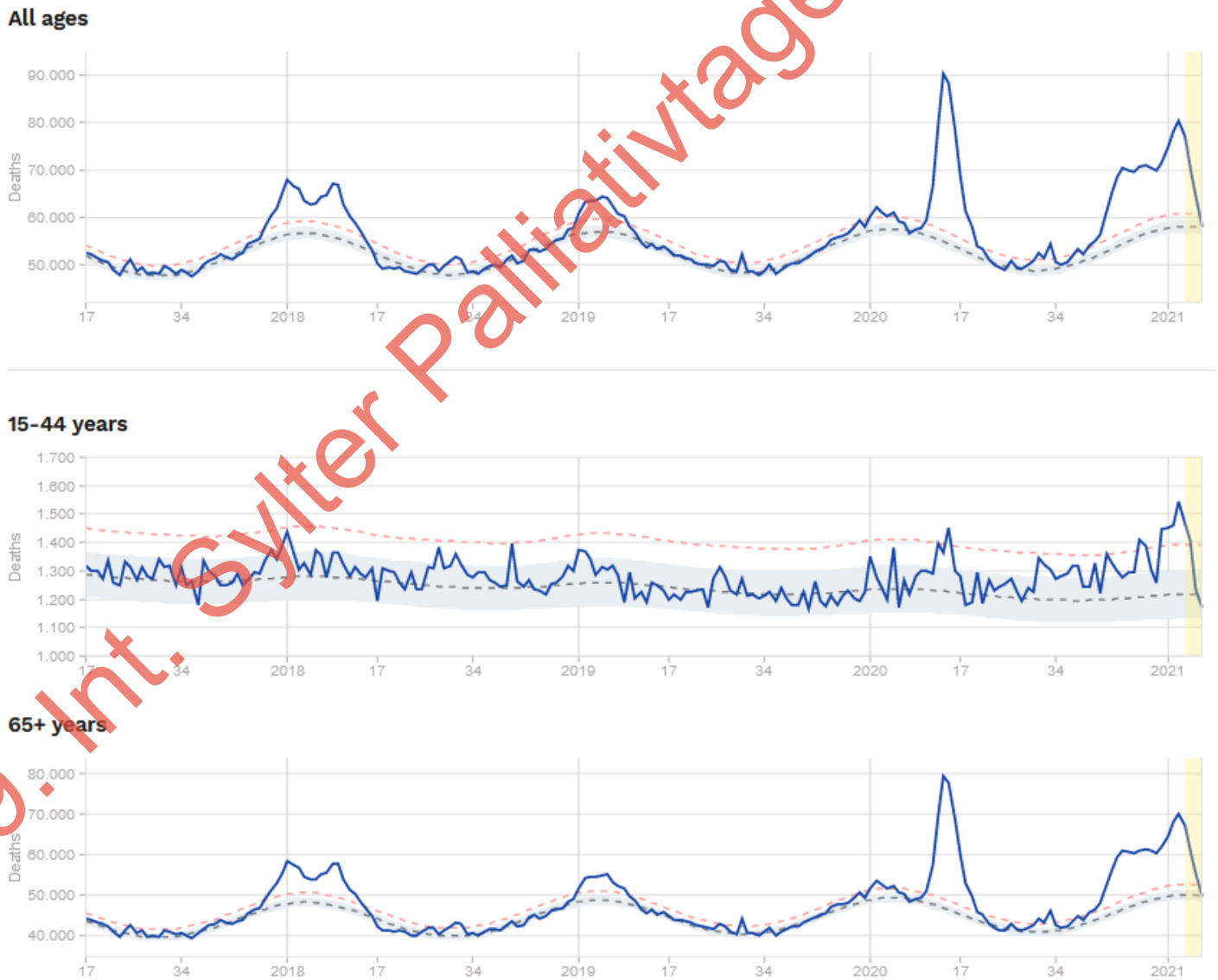

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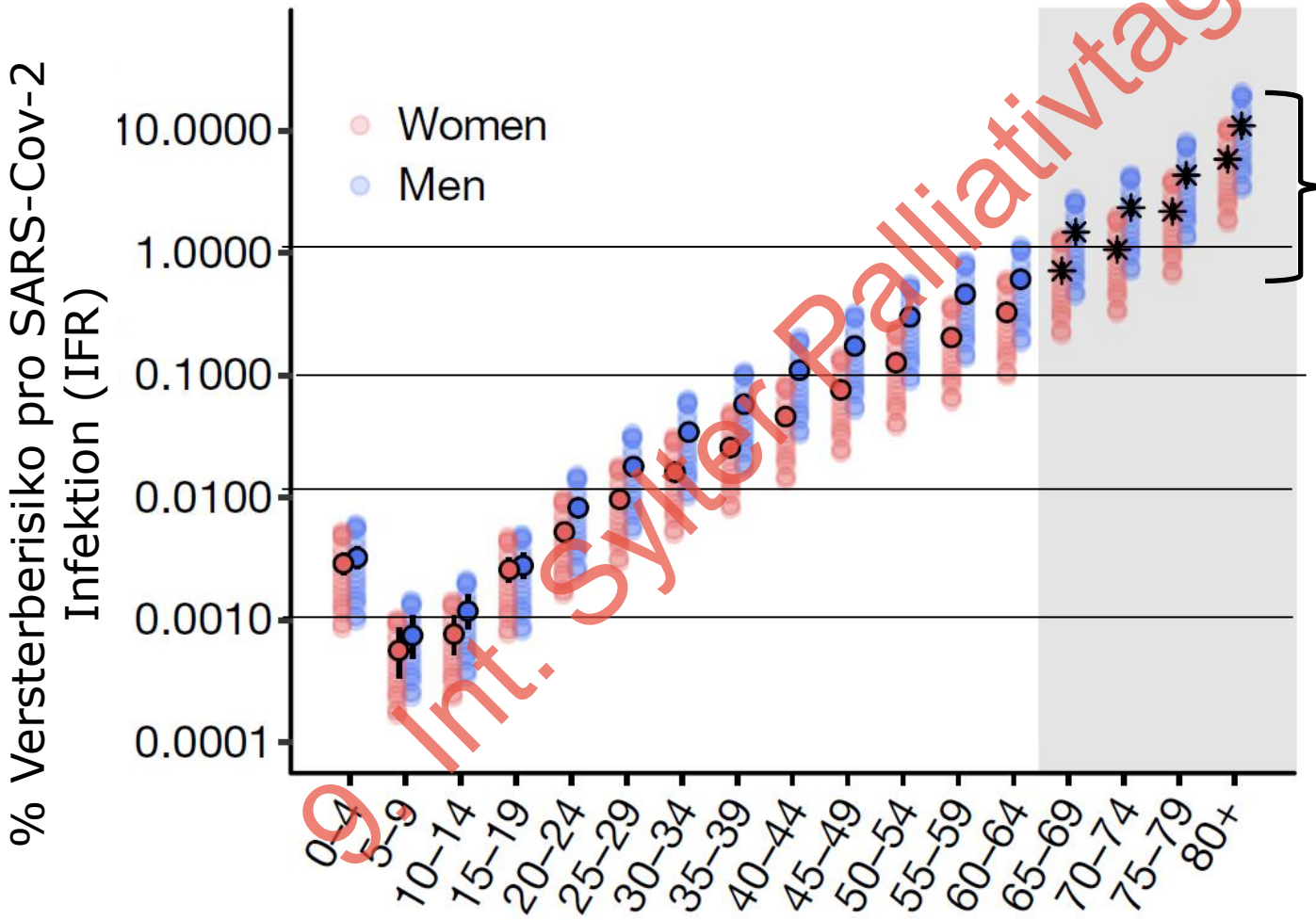
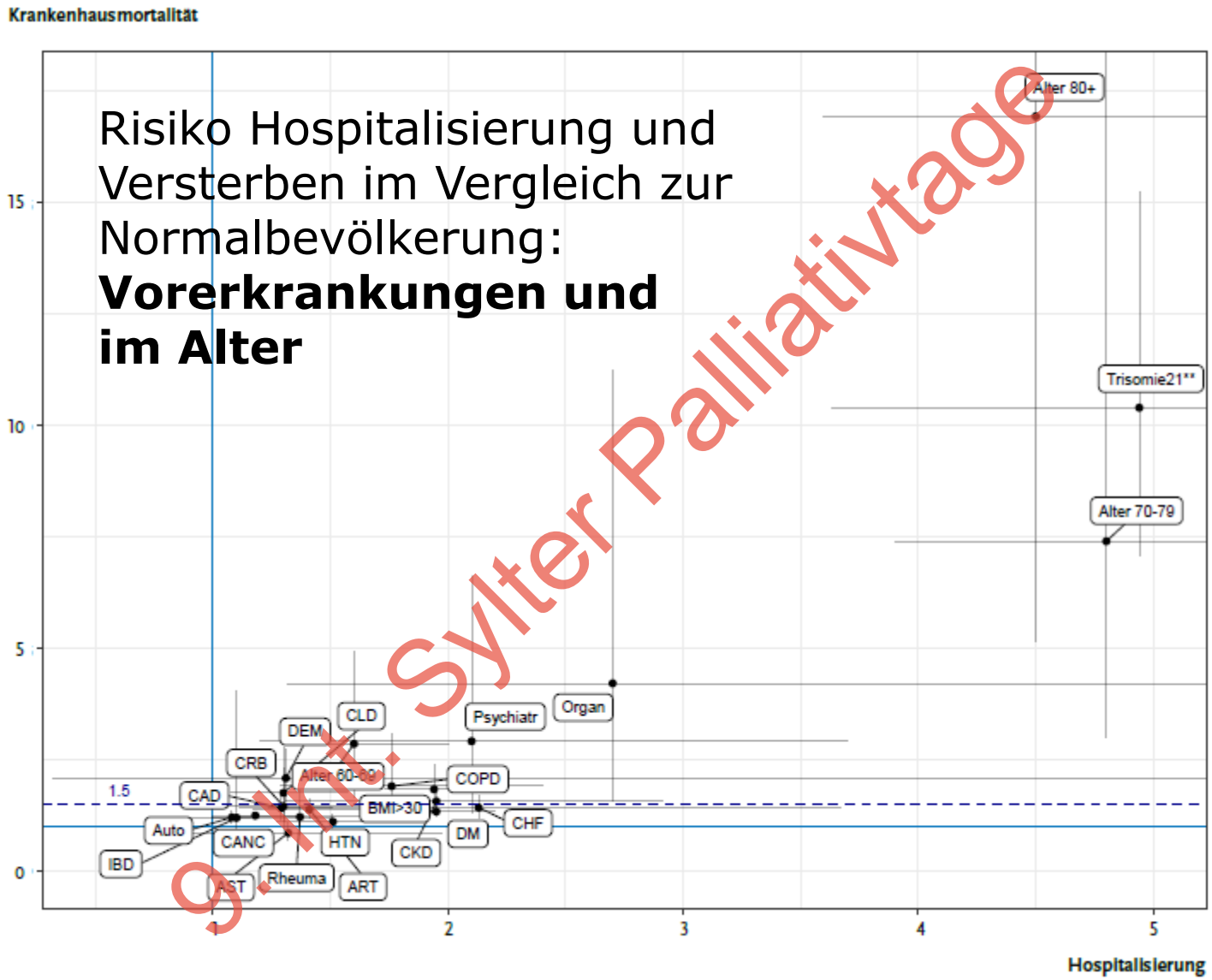
Zugriff 1.03.2021

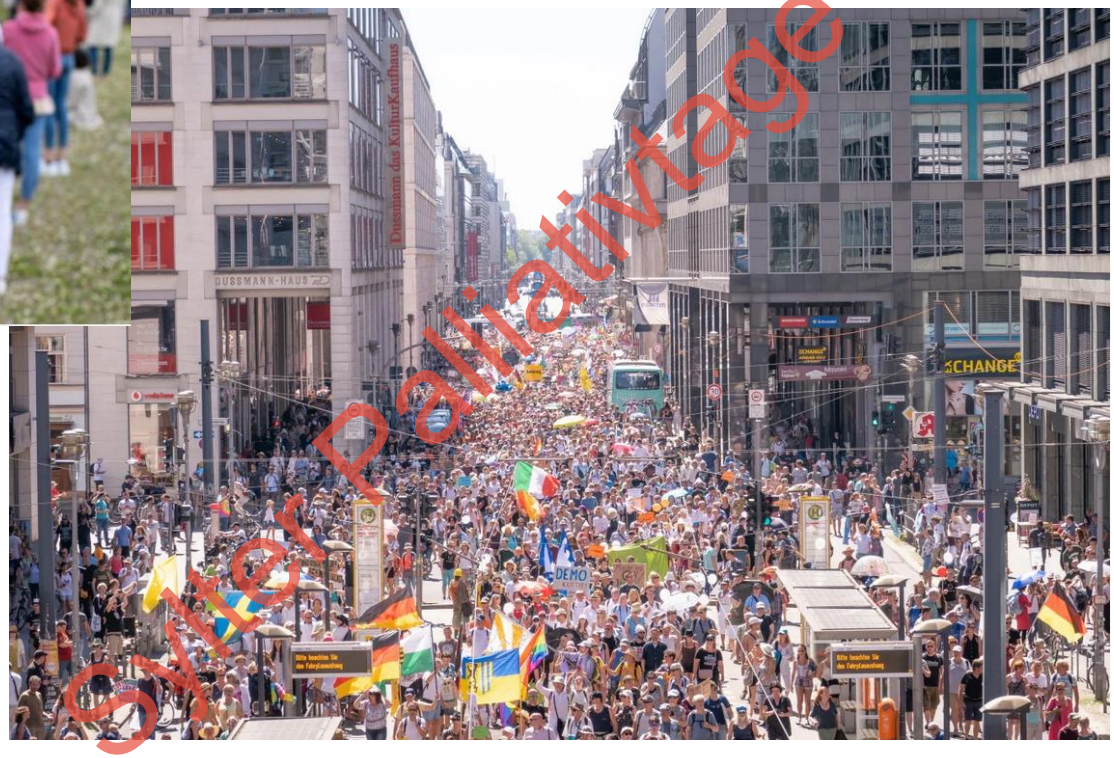
Verstorbene nach Altersgruppen

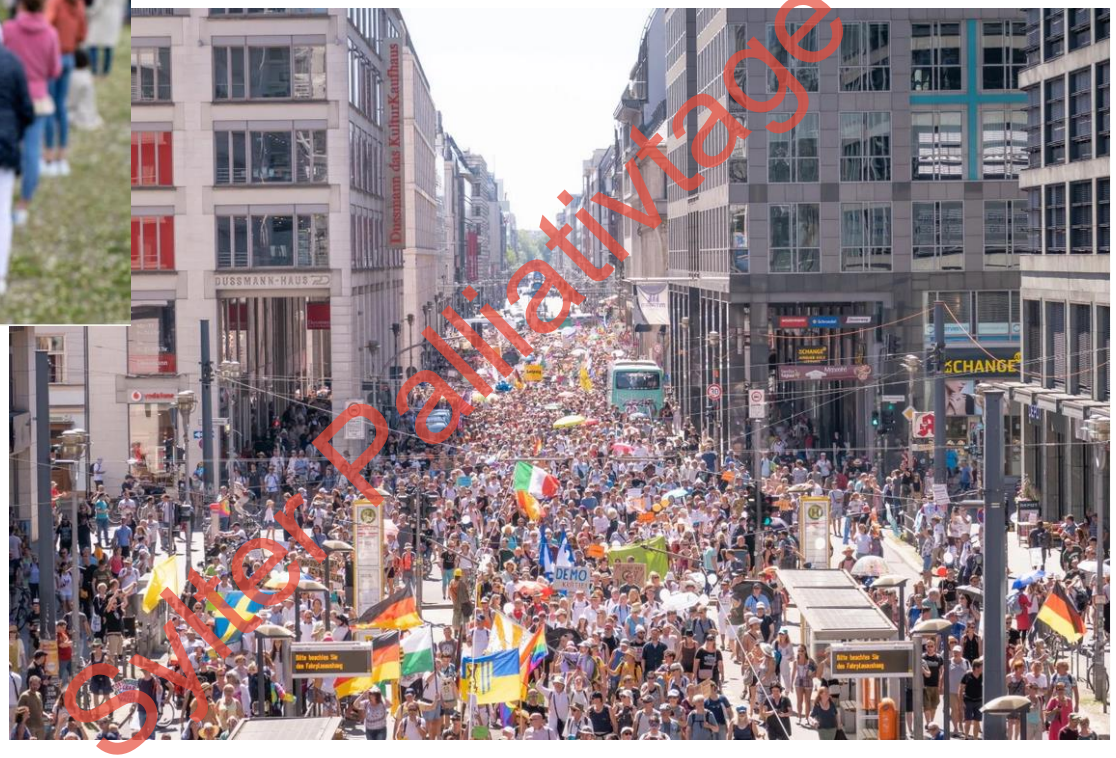


>90% der Sterbefälle bei >65-Jährigen

Megan O'Driscoll et al., Nature; 2020

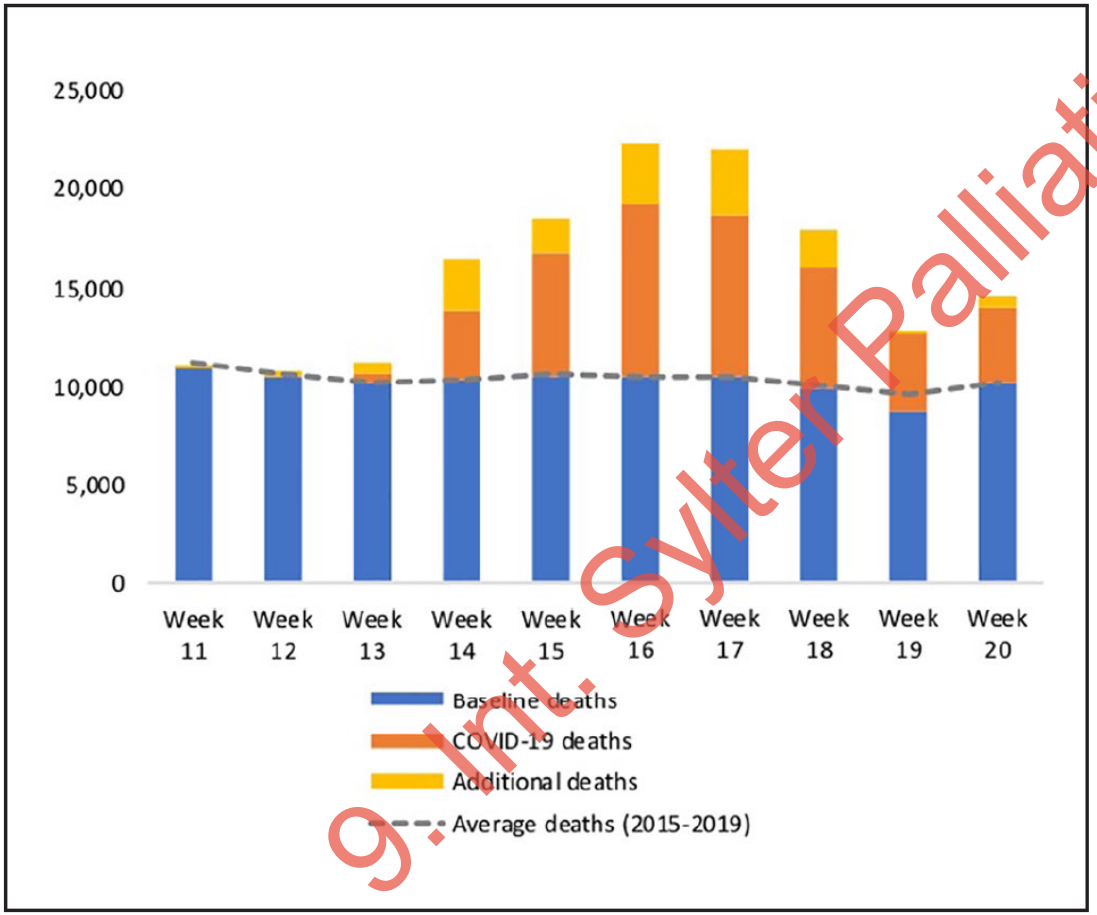

Krankenhausmortalität
Risiko Hospitalisierung und Versterben im Vergleich zur Normalbevölkerung:
Vorerkrankungen und im Alter
Alter 80+
Trisomie21**
Alter 70-79
Organ
Psychiatr
CLD
DEM
CRB
COPD
CAD
BMI>30
CHF
DM
Auto
CANC
HTN
CKD
IBD
AST
Rheuma
ART
1.5
15
10
5
0
1
2
3
4
5
Hospitalisierung
9. Int. Sylter Palliativtage



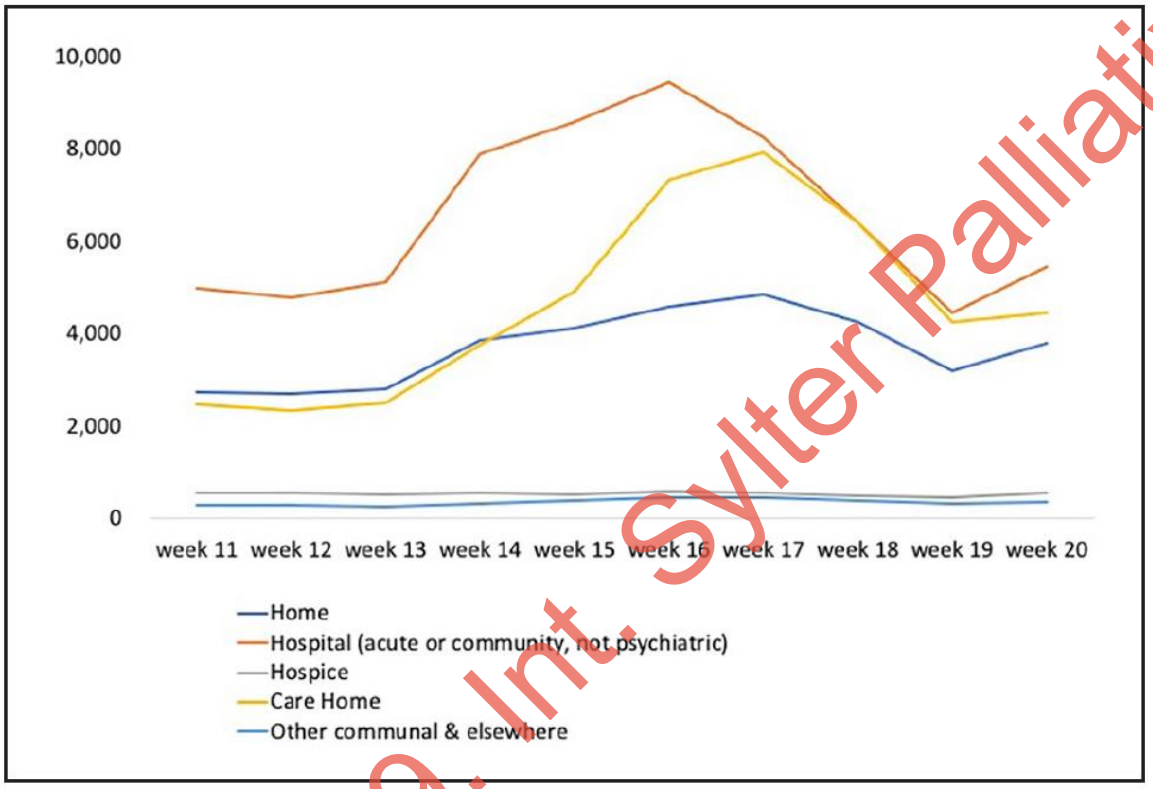


„Immer wieder ist ja erstaunlich, wie viele Menschen stolz darauf sind, nichts zu kapieren“ Kommentar SZ 2.8.2020 Detlef Esslinger

Übersterblichkeit England / Wales



Sterbeorte England / Wales



CoVid-19 UK **Sterbeort**:

- Krankenhaus **65%**
- Pflegeheim **28%**,
- Zu Hause **5%**
- Hospiz **1%**

~ 22% (13%-31%) der CoVid-19 -Todesfälle waren Betroffene, die sich - in Abwesenheit der Pandemie - möglicherweise im letztes Lebensjahr befunden haben.

Vorbemerkungen PC und CoVid-19

- Palliativversorgung ist schon in guten Zeiten weltweit unterfinanziert; ggw. Befinden wir und in keinen guten Zeiten
- Risikogruppe hat große Schnittmenge mit den Patienten, die wir in der Palliativversorgung sehen
- Fachgesellschaften / Forscher / Einzelpersonen sehr aktiv
- Bisher wenig Evidenz zum Stand der PV International.
- Anekdotisch: Palliativversorgung international sehr heterogen in die Reaktion der Gesundheitssysteme auf CoViD-19 eingebunden

Patientenzahl seit CoViD - USA

deutlich weniger	17%	43%
weniger	26%	
keine Änderung	19%	
mehr	22%	39%
deutlich mehr	17%	

Survey CAPC in den USA; n= 239

Inhalte der PV seit CoViD - USA

- Tele-Palliativversorgung 76%
- Planung & Organisation 69%
- Unterstützung bei der Therapiezielfindung 67%
- Kollegen ausbilden 65%
- Wohlbefinden der Kollegen 60%
- Verstärkte Präsenz auf der Intensivstation 46%
- Telebetreuung zu Hause 32%
- Erhöhte Präsenz in der Notaufnahme 25%
- Hotline für Kollegen 8%

Survey CAPC in den USA; n= 239

Beispiel Spanien

The severity of the COVID-19 pandemic in Spain has resulted in limited provision of palliative care. Palliative care physicians and nurses have often been deployed to deliver emergency care for people with COVID-19. In a context of resource constraints, priority has been given to interventions aimed at saving people's lives over palliating discomfort among seriously ill people and their families.

The Clínica, a non-profit hospital with two venues, one in northern Spain and a second one in Madrid, is specializing in providing cancer care. In northern Spain, the hospital has a unit for palliative care consisting of three physicians, two nurses and one psychologist. They work in inpatient and outpatient settings, following up patients proactively from diagnosis of advanced disease until the end of life.

Under state of emergency legislation enacted in Spain on 15 March, all private hospitals in the country came under direct control of the government. The Clínica was no exception, and as of 20 May it had seen more than 800 people with COVID-19 in northern Spain and 750 in Madrid. The hospital had to adapt health care service delivery to address the COVID-19 emergency, often at the expense of providing palliative care.

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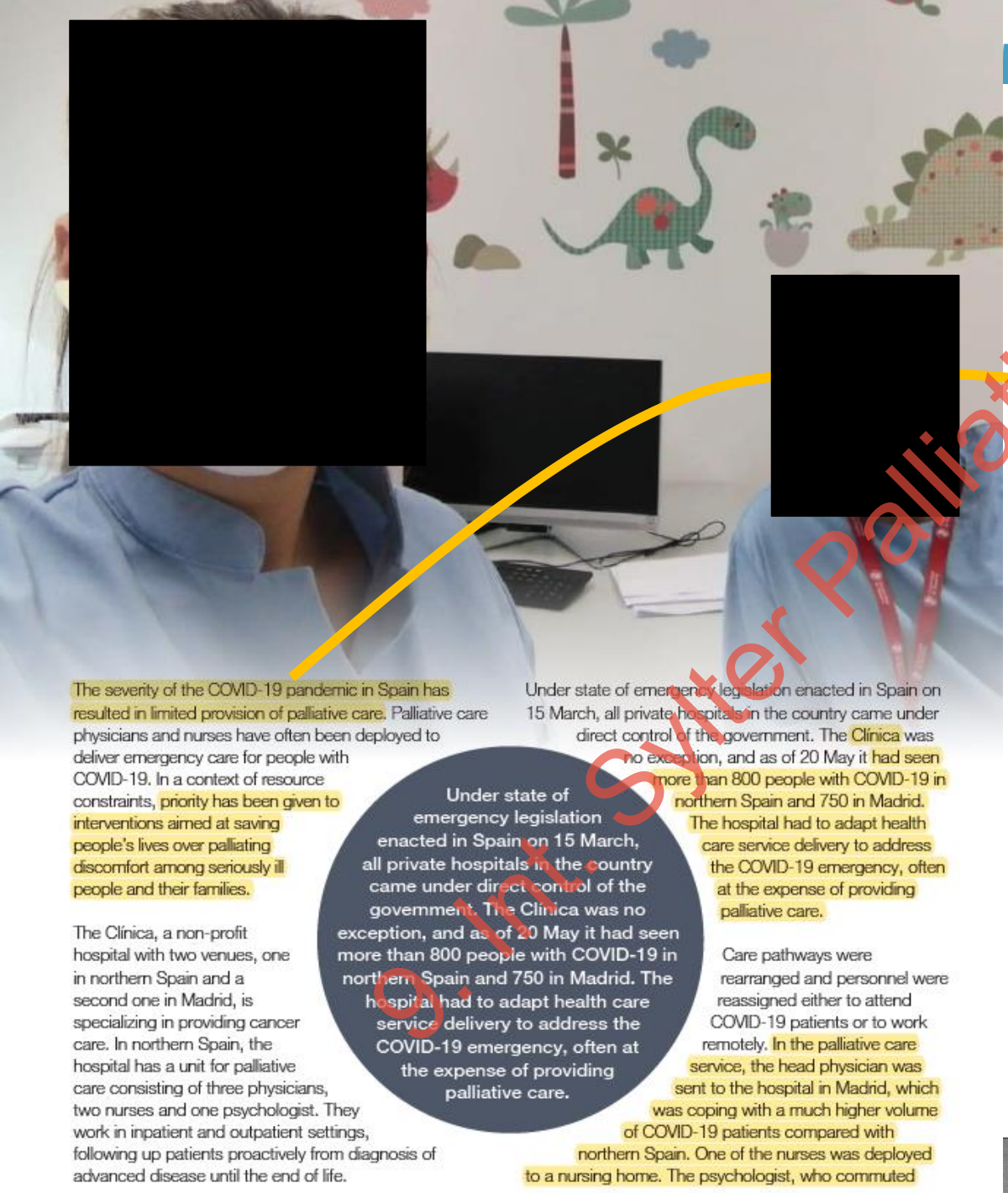
Care pathways were rearranged and personnel were reassigned either to attend COVID-19 patients or to work remotely. In the palliative care service, the head physician was sent to the hospital in Madrid, which was coping with a much higher volume of COVID-19 patients compared with northern Spain. One of the nurses was deployed to a nursing home. The psychologist, who commuted

https://www.euro.who.int/__data/assets/pdf_file/0008/445553/palliative-care-COVID-19.pdf

Beispiel Spanien

Die Schwere der COVID-19-Pandemie in Spanien führte zu einer begrenzten Bereitstellung von Palliativversorgung



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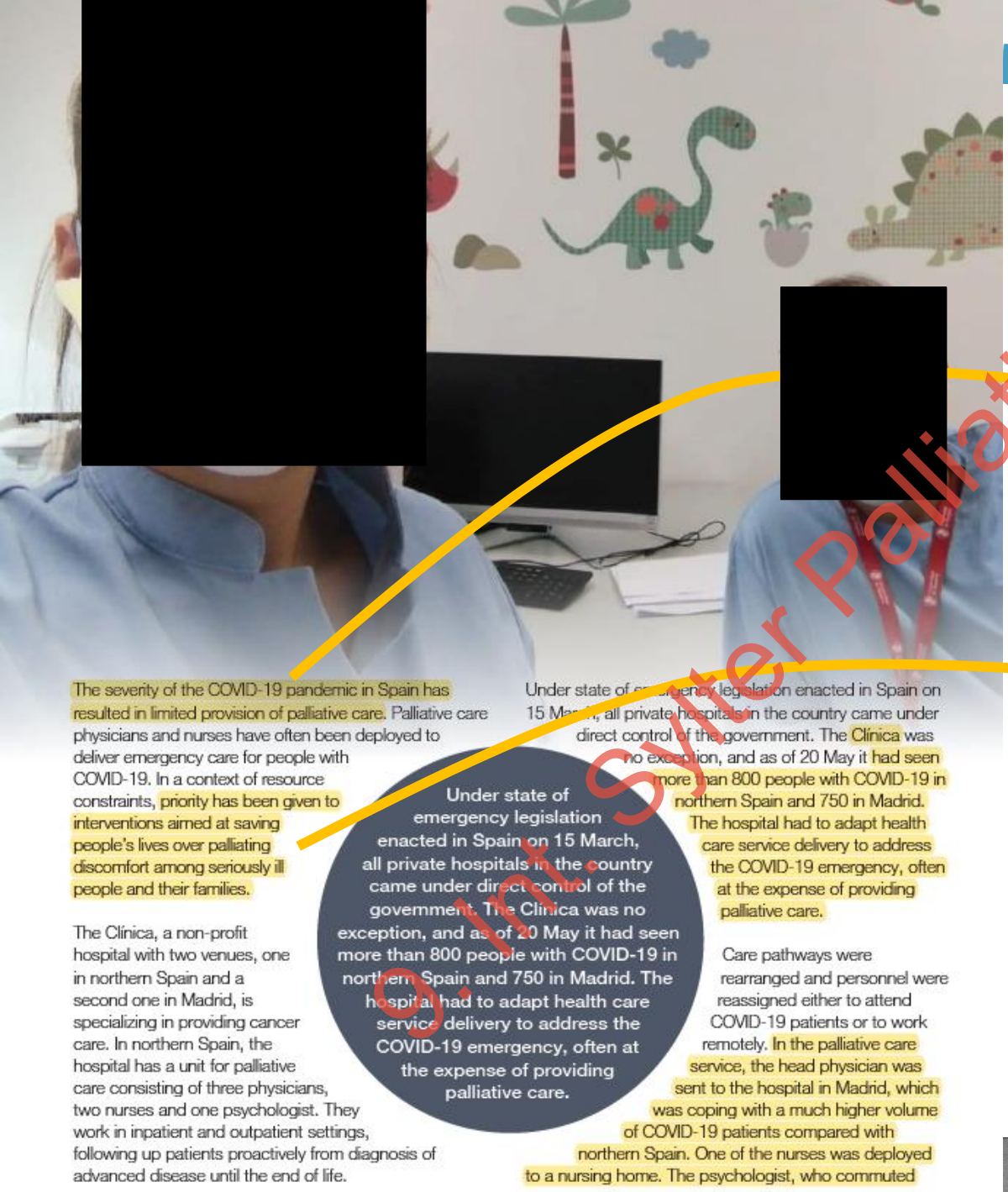

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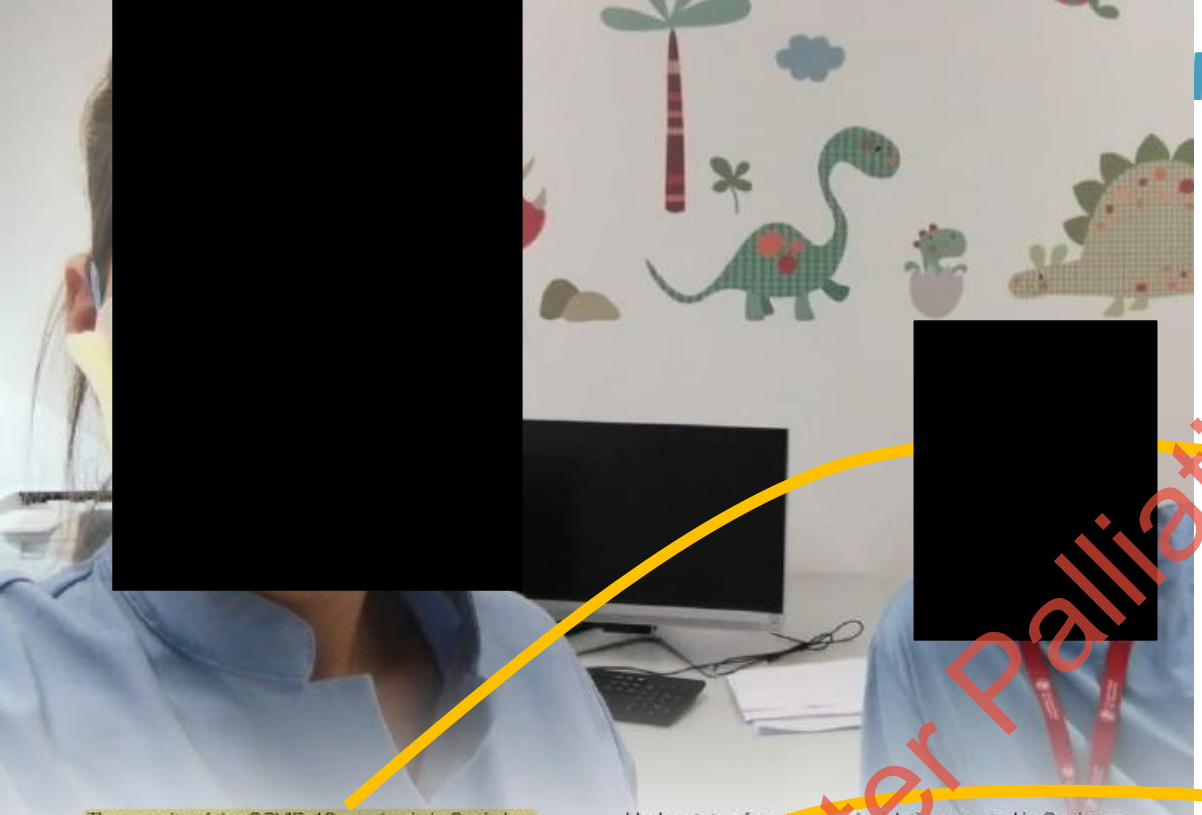

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Prioritär war Lebensrettung

Mitarbeiter wurden anderen Abteilungen zugeteilt

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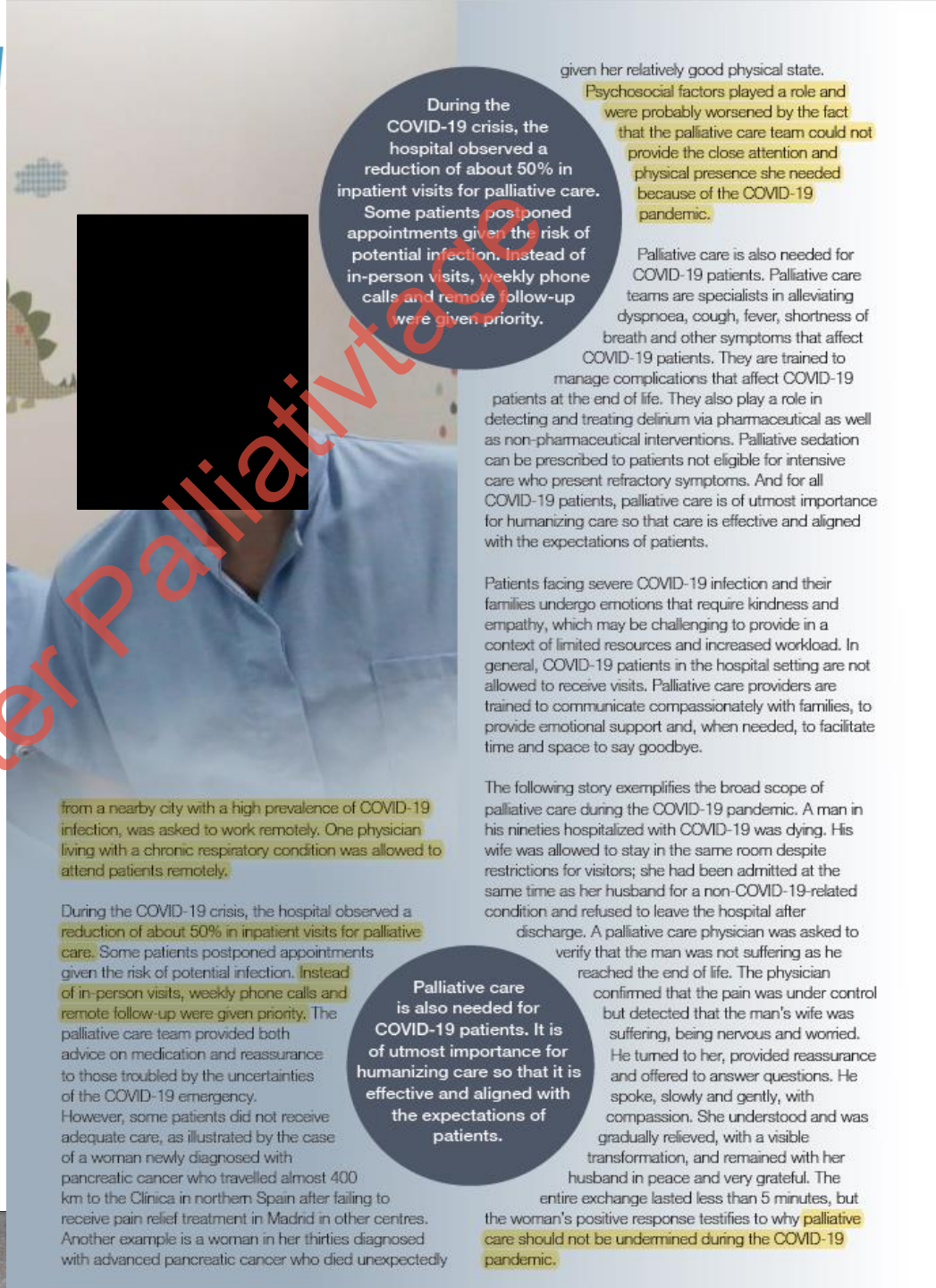
Beispiel Spanien



During the COVID-19 crisis, the hospital observed a reduction of about 50% in inpatient visits for palliative care. Some patients postponed appointments given the risk of potential infection. Instead of in-person visits, weekly phone calls and remote follow-up were given priority.

from a nearby city with a high prevalence of COVID-19 infection, was asked to work remotely. One physician living with a chronic respiratory condition was allowed to attend patients remotely.

During the COVID-19 crisis, the hospital observed a reduction of about 50% in inpatient visits for palliative care. Some patients postponed appointments given the risk of potential infection. Instead of in-person visits, weekly phone calls and remote follow-up were given priority. The palliative care team provided both advice on medication and reassurance to those troubled by the uncertainties of the COVID-19 emergency.
However, some patients did not receive adequate care, as illustrated by the case of a woman newly diagnosed with pancreatic cancer who travelled almost 400 km to the Clínica in northern Spain after failing to receive pain relief treatment in Madrid in other centres. Another example is a woman in her thirties diagnosed with advanced pancreatic cancer who died unexpectedly

Palliative care is also needed for COVID-19 patients. It is of utmost importance for humanizing care so that it is effective and aligned with the expectations of patients.

given her relatively good physical state. Psychosocial factors played a role and were probably worsened by the fact that the palliative care team could not provide the close attention and physical presence she needed because of the COVID-19 pandemic.

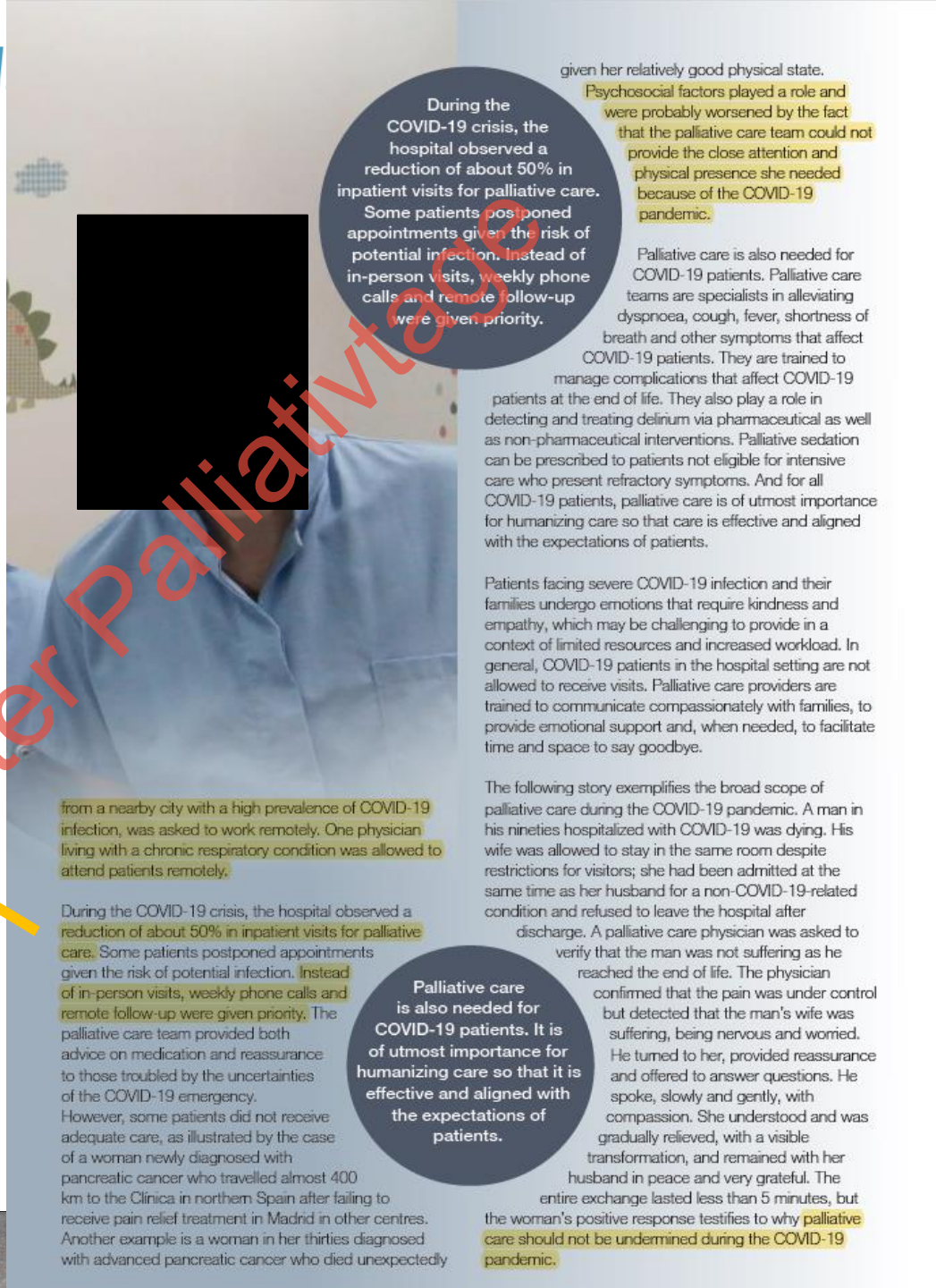
Palliative care is also needed for COVID-19 patients. Palliative care teams are specialists in alleviating dyspnoea, cough, fever, shortness of breath and other symptoms that affect COVID-19 patients. They are trained to manage complications that affect COVID-19 patients at the end of life. They also play a role in detecting and treating delirium via pharmaceutical as well as non-pharmaceutical interventions. Palliative sedation can be prescribed to patients not eligible for intensive care who present refractory symptoms. And for all COVID-19 patients, palliative care is of utmost importance for humanizing care so that care is effective and aligned with the expectations of patients.

Patients facing severe COVID-19 infection and their families undergo emotions that require kindness and empathy, which may be challenging to provide in a context of limited resources and increased workload. In general, COVID-19 patients in the hospital setting are not allowed to receive visits. Palliative care providers are trained to communicate compassionately with families, to provide emotional support and, when needed, to facilitate time and space to say goodbye.

The following story exemplifies the broad scope of palliative care during the COVID-19 pandemic. A man in his nineties hospitalized with COVID-19 was dying. His wife was allowed to stay in the same room despite restrictions for visitors; she had been admitted at the same time as her husband for a non-COVID-19-related condition and refused to leave the hospital after discharge. A palliative care physician was asked to verify that the man was not suffering as he reached the end of life. The physician confirmed that the pain was under control but detected that the man's wife was suffering, being nervous and worried. He turned to her, provided reassurance and offered to answer questions. He spoke, slowly and gently, with compassion. She understood and was gradually relieved, with a visible transformation, and remained with her husband in peace and very grateful. The entire exchange lasted less than 5 minutes, but the woman's positive response testifies to why palliative care should not be undermined during the COVID-19 pandemic.

Beispiel Spanien

50 % weniger Besuche durch das Palliativteam



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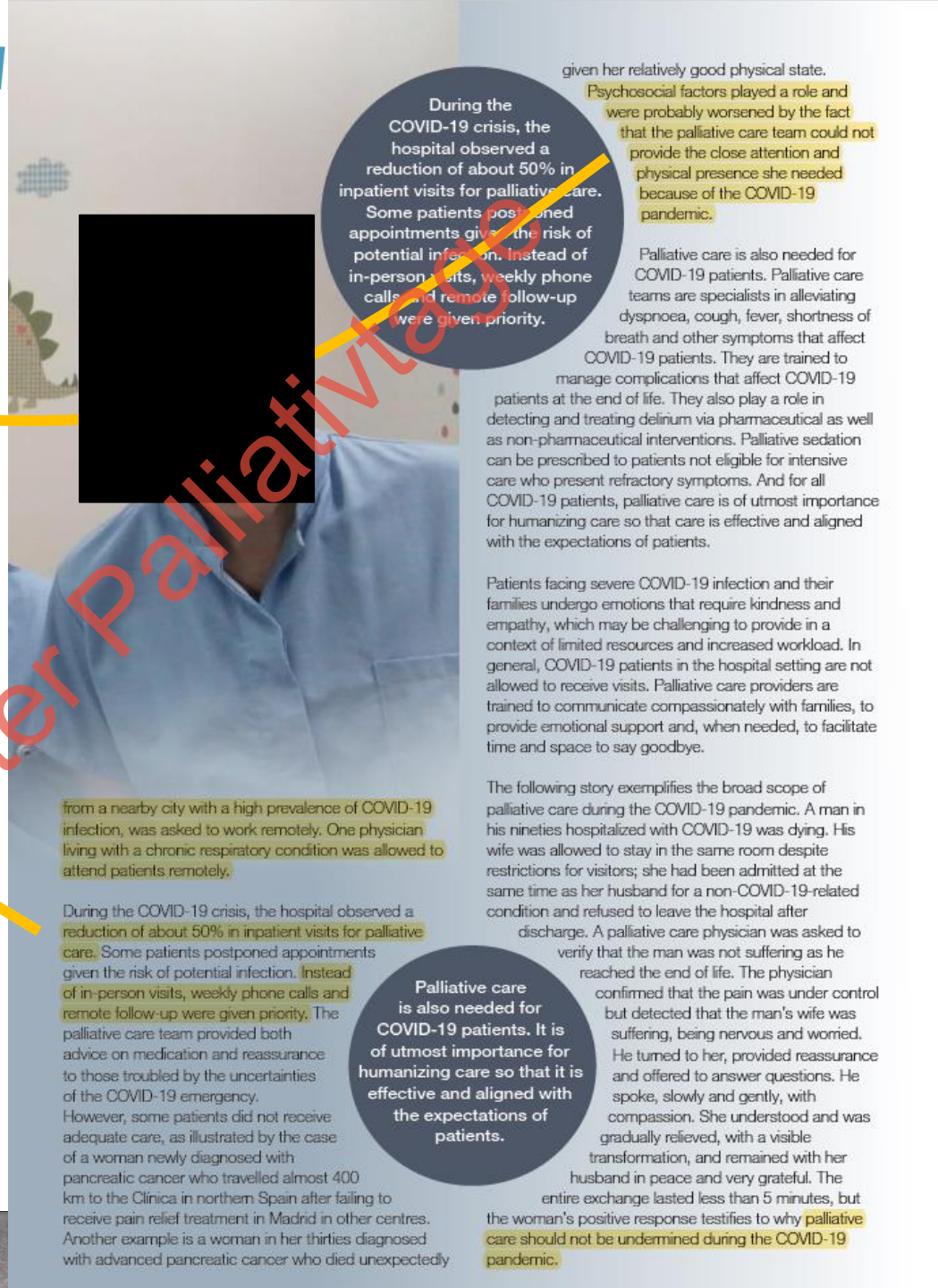
Beispiel Spanien

Psychosoziale Faktoren spielten eine Rolle und wurden wahrscheinlich durch die Tatsache verschlimmert, dass das Palliativteam nicht in der Lage war für die nötige Zuwendung und Anwesenheit zu sorgen.

50 % weniger Besuche durch das Palliativteam



During the COVID-19 crisis, the hospital observed a reduction of about 50% in inpatient visits for palliative care. Some patients postponed appointments given the risk of potential infection. Instead of in-person visits, weekly phone calls and remote follow-up were given priority.

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During the COVID-19 crisis, the hospital observed a reduction of about 50% in inpatient visits for palliative care. Some patients postponed appointments given the risk of potential infection. Instead of in-person visits, weekly phone calls and remote follow-up were given priority. The palliative care team provided both advice on medication and reassurance to those troubled by the uncertainties of the COVID-19 emergency.
However, some patients did not receive adequate care, as illustrated by the case of a woman newly diagnosed with pancreatic cancer who travelled almost 400 km to the Clínica in northern Spain after failing to receive pain relief treatment in Madrid in other centres. Another example is a woman in her thirties diagnosed with advanced pancreatic cancer who died unexpectedly

Palliative care is also needed for COVID-19 patients. It is of utmost importance for humanizing care so that it is effective and aligned with the expectations of patients.

given her relatively good physical state. Psychosocial factors played a role and were probably worsened by the fact that the palliative care team could not provide the close attention and physical presence she needed because of the COVID-19 pandemic.

Palliative care is also needed for COVID-19 patients. Palliative care teams are specialists in alleviating dyspnoea, cough, fever, shortness of breath and other symptoms that affect COVID-19 patients. They are trained to manage complications that affect COVID-19 patients at the end of life. They also play a role in detecting and treating delirium via pharmaceutical as well as non-pharmaceutical interventions. Palliative sedation can be prescribed to patients not eligible for intensive care who present refractory symptoms. And for all COVID-19 patients, palliative care is of utmost importance for humanizing care so that care is effective and aligned with the expectations of patients.

Patients facing severe COVID-19 infection and their families undergo emotions that require kindness and empathy, which may be challenging to provide in a context of limited resources and increased workload. In general, COVID-19 patients in the hospital setting are not allowed to receive visits. Palliative care providers are trained to communicate compassionately with families, to provide emotional support and, when needed, to facilitate time and space to say goodbye.

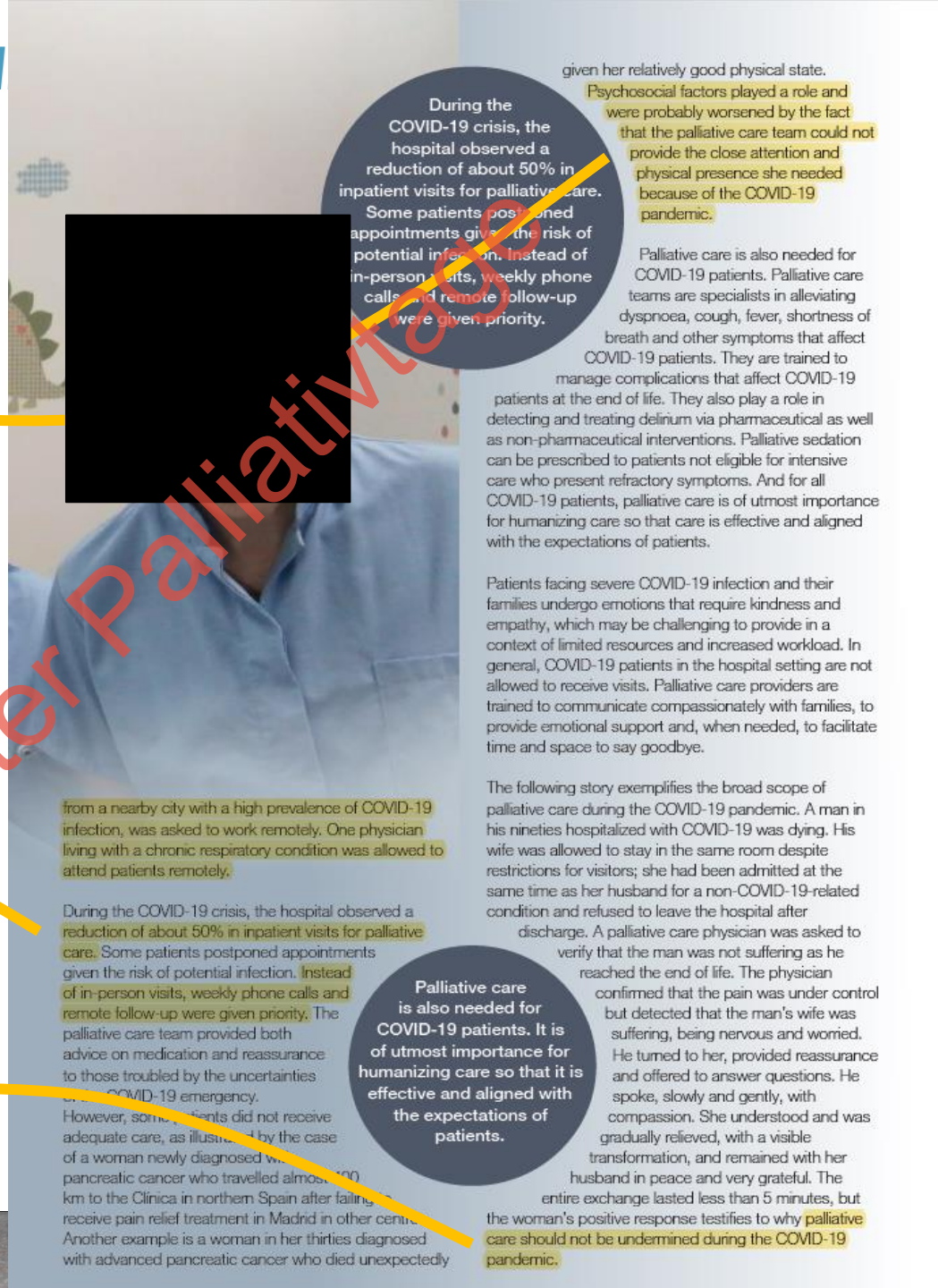
The following story exemplifies the broad scope of palliative care during the COVID-19 pandemic. A man in his nineties hospitalized with COVID-19 was dying. His wife was allowed to stay in the same room despite restrictions for visitors; she had been admitted at the same time as her husband for a non-COVID-19-related condition and refused to leave the hospital after discharge. A palliative care physician was asked to verify that the man was not suffering as he reached the end of life. The physician confirmed that the pain was under control but detected that the man's wife was suffering, being nervous and worried. He turned to her, provided reassurance and offered to answer questions. He spoke, slowly and gently, with compassion. She understood and was gradually relieved, with a visible transformation, and remained with her husband in peace and very grateful. The entire exchange lasted less than 5 minutes, but the woman's positive response testifies to why palliative care should not be undermined during the COVID-19 pandemic.

Beispiel Spanien

Psychosoziale Faktoren spielten eine Rolle und wurden wahrscheinlich durch die Tatsache verschlimmert, dass das Palliativteam nicht in der Lage war für die nötige Zuwendung und Anwesenheit zu sorgen.

50 % weniger Besuche durch das Palliativteam

Palliativversorgung sollte in der Pandemie nicht unterminiert werden



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2020, Vol. 34(7) 889–895

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Am Ende dieser Geschichte wird Palliative Care in Italien und anderswo ganz anders sein als zuvor

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Schwierig, die Menschlichkeit der Palliativversorgung in dieser Situation aufrecht zu erhalten

WHA - CoViD-19 response

SEVENTY-THIRD WORLD HEALTH ASSEMBLY **WHA73.1**

Agenda item 3 **19 May 2020**

COVID-19 response

The Seventy-third World Health Assembly,

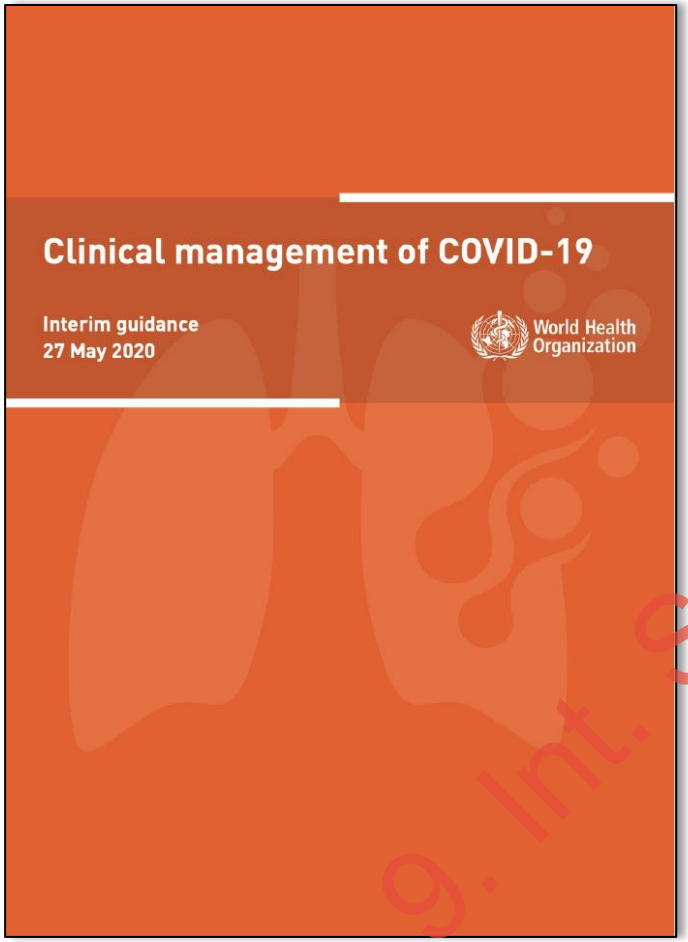
. . .

7. CALLS ON Member States,[1] in the context of the COVID-19 pandemic:

. . .

(7) to provide access to safe testing, treatment, and palliative care for COVID-19, paying particular attention to the protection of those with pre-existing health conditions, older people, and other people at risk, in particular health professionals, health workers and other relevant frontline workers;

WHO - CoViD-19 Clinical Management



21. Palliative care and COVID-19

Palliative care is a multifaceted, integrated approach to improving the quality of life of adults and paediatric patients and their families facing the problems associated with life-threatening illness such as COVID-19. Palliative care focuses on prevention and relief of suffering by means of early identification, assessment and treatment of physical, psychosocial and spiritual stressors. Palliative care includes but is not limited to end-of-life care *(200)*. Palliative interventions should be integrated with curative treatment *(200)*. Basic palliative care, including relief of dyspnoea or other symptoms and social support, should be practised by all doctors, nurses, social workers and others caring for persons affected by COVID-19 *(200, 201)*. Refer to the WHO guide *Integrating palliative care and symptom relief into responses to humanitarian emergencies and crises (200)*.

- Wir empfehlen, bei allen Patienten zu ermitteln, ob sie eine Vorausverfügung (PV , ACP /BVP) für COVID-19 haben (z. B. Wünsche nach intensivmedizinischer Unterstützung) und ihre Wünsche zu respektieren, um die Versorgung maßzuschneidern und unabhängig von der Wahl der Behandlung die beste Versorgung zu bieten.
- Palliativangebote sollten in jeder Einrichtung, die Personen mit COVID-19 betreut, zugänglich gemacht werden.

- The GREEN symbol denotes a strong recommendation or a best practice statement in favour of an intervention.
- The RED symbol denotes a recommendation or a best practice statement against an intervention.
- The YELLOW symbol denotes a conditional recommendation in favour of an intervention, or a recommendation where special care is required in implementation.

WHO - CoViD-19 Clinical Management

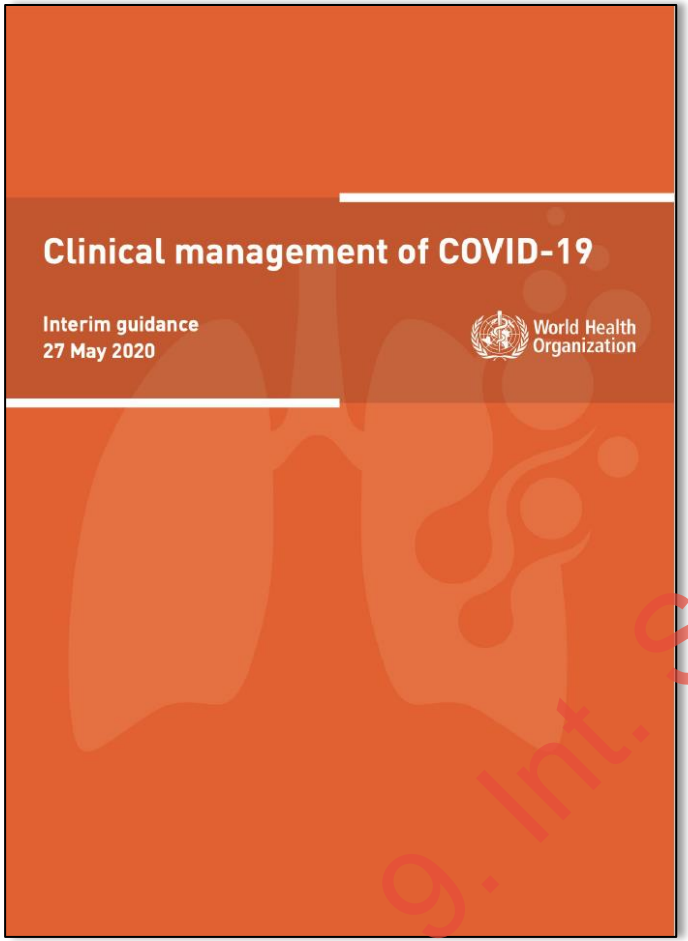
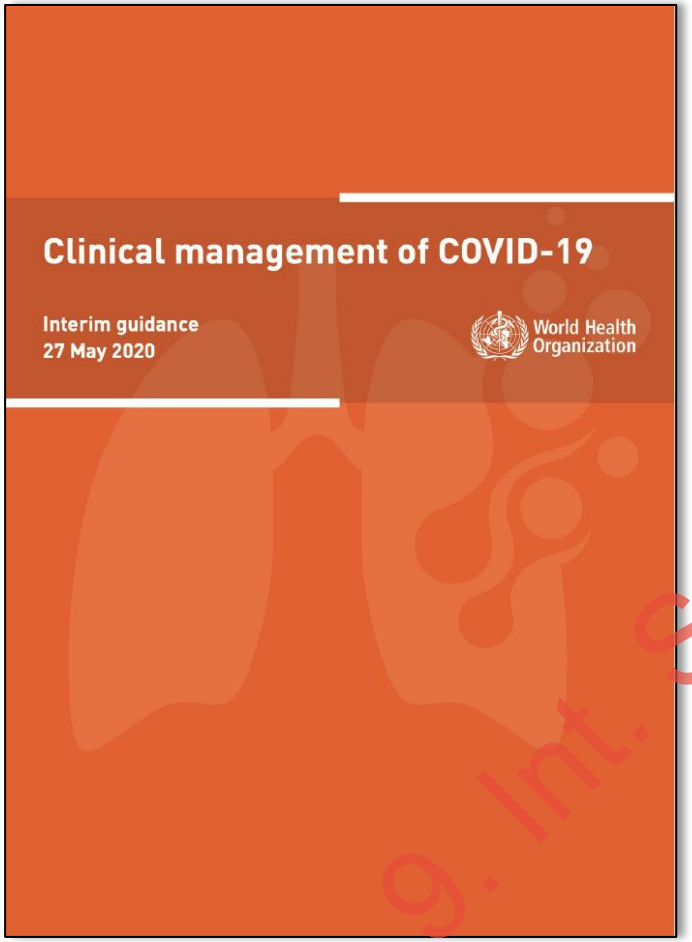


Table A3.1 Essential package of palliative care: interventions, medicines, equipment, human resources and social supports

	Inputs			
Interventions	**Medicines[a]**	**Equipment**	**Human resources[b]**	**Social supports**
Prevention and relief of pain or other physical suffering,[c] acute or chronic, related to COVID-19	– Amitriptyline, oral – Bisacodyl (senna), oral – Dexamethasone, oral and injectable – Diazepam, oral and injectable – Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate), oral and injectable – Fluconazole, oral – Fluoxetine, oral – Furosemide, oral and injectable – Haloperidol, oral and injectable – Hyoscine butylbromide, oral and injectable – Ibuprofen (naproxen, diclofenac, or meloxicam), oral – Lactulose (sorbitol or polyethylene glycol), oral – Loperamide, oral – Metaclopramide, oral and injectable – Metronidazole, oral, to be crushed for topical use – Morphine, oral immediate release and injectable – Naloxone, injectable – Omeprazole, oral – Ondansetron, oral and injectable[d] – Oxygen – Paracetamol, oral – Petroleum jelly	– Pressure-reducing mattresses – Nasogastric drainage and feeding tubes – Urinary catheters – Opioid lock boxes – Flashlights with rechargeable batteries (if no access to electricity) – Adult diapers or cotton and plastic	– Doctors (with basic palliative care training) – Nurses (with basic palliative care training) – Community health workers (if available)	

All interventions described in Appendix 3 should be accessible at each institution that provides care for persons with COVID-19. Efforts should be made to assure accessibility of interventions at home *(200)*.

WHO - CoViD-19 Clinical Management



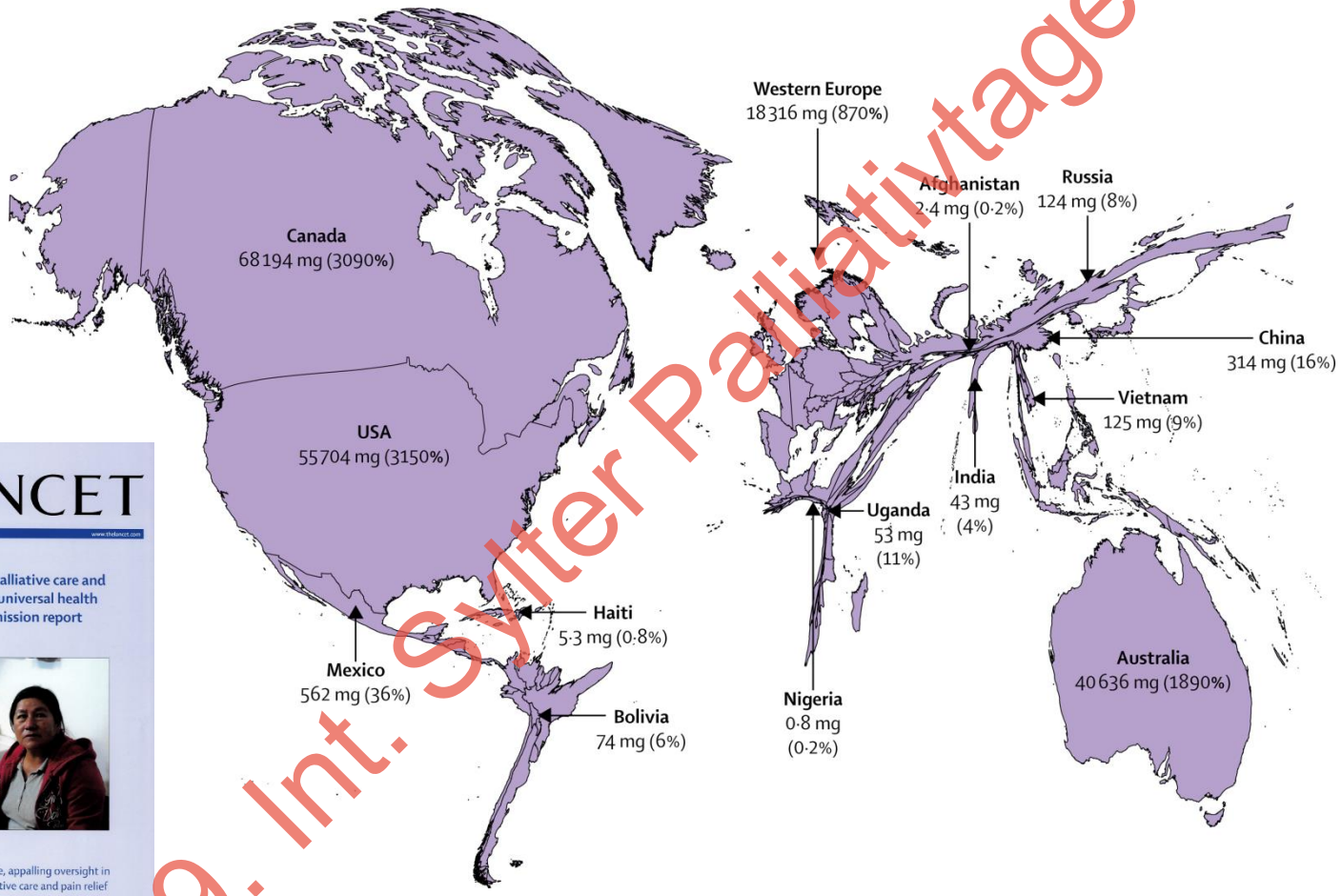
1. Alle in Anhang 3 beschriebenen Angebote sollten in jeder Einrichtung, die Personen mit COVID-19 versorgt, zugänglich sein. Es sollten Anstrengungen unternommen werden, um die Zugänglichkeit von Interventionen zu Hause sicherzustellen

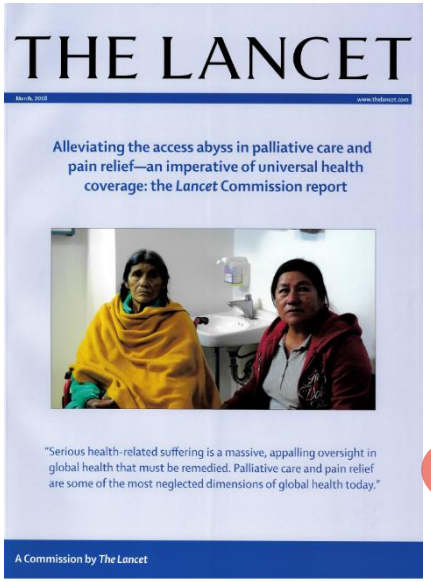
2. Palliativpflege ist nicht beschränkt auf das Lebensende. Palliativversorgung sollte in die kurative Behandlung integriert werden. Allgemeine Palliativversorgung, wie Linderung von Dyspnoe oder anderen Symptomen und soziale Unterstützung sollte von allen Ärzten, Krankenschwestern, Sozialarbeitern und anderen Personen geleistet werden, die sich um die von COVID-19 betroffenen Personen kümmern.

3. In Krankenhäusern ist für die Palliativversorgung keine separate Station oder Abteilung erforderlich. Palliativversorgung kann in jeder Umgebung angeboten werden.

4. Ziehen Sie Opioide und andere pharmakologische und nicht-pharmakologische Interventionen in Betracht zur Linderung von Dyspnoe, die therapierefraktär zur Behandlung der zugrundeliegenden Ursache ist und/oder als Teil der Betreuung am Lebensende. Die schmale therapeutische Breite von Opioiden bei der Behandlung von Dyspnoe macht es erforderlich, dass Opioide in Übereinstimmung mit evidenzbasierten Behandlungsprotokollen verschrieben werden und dass die Patienten genau überwacht werden, um negative unbeabsichtigte Wirkungen aufgrund einer unangemessenen Anwendung von Opioiden zu verhindern. Die Leistungserbringer sollten ihre institutionellen Standards in Bezug auf den potenziellen Einsatz von Opioiden bei Dyspnoe bei Patienten mit COVID-19 beachten.

Opioide weltweit




THE LANCET

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report

"Serious health-related suffering is a massive, appalling oversight in global health that must be remedied. Palliative care and pain relief are some of the most neglected dimensions of global health today."

A Commission by *The Lancet*

Beispiel Indien

Vor der Pandemie

- 10 Millionen Menschen mit Schmerzen und anderen schwerwiegenden gesundheitlichen Problemen („serious health related suffering“)
- kaum Zugang zu primärer Gesundheitsversorgung / Palliativteams machen dort so sie existieren häufig Primärversorgung
- ~363 Millionen (~30%) Inder leben unterhalb der Armutsgrenze – keine Ersparnisse, abhängig vom Tageslohn
- Jährlich rutschen 55 Millionen Menschen unter die Armutsgrenze durch individuell sehr hohe Gesundheitsausgaben

Beispiel Indien

Vor der Pandemie

- Bei 20 % der Suizide liegen gesundheitliche Gründe vor
- 90% der Menschen arbeiten ohne Vertrag / ohne Absicherung
- 139 Millionen Arbeitsmigranten aus dem eigenen Land

Beispiel Indien

Seit Beginn der Pandemie

- 120 Mio. Menschen haben im Lockdown ihre Arbeit verloren (Arbeitslosigkeit zwischenzeitlich 23%)
- Social Distancing kaum möglich (z.B. Mumbai Slums mit 700.000 auf 2 (!) km²)
- Produktion von Medikamenten / Lieferketten sind unterbrochen
- Nationale Medikamentenreserven sind aufgebraucht
- Mangel an / Nichtvorhandensein persönlicher Schutzausrüstung

Beispiel Indien

- mangelnden Zugang zu sauberem Wasser und Desinfektionsmitteln

- Viele Patienten mit schwerem COVID-19 werden zu Hause leiden und sterben und von Familienmitgliedern
  - ohne Schutzkleidung,
  - ohne Zugang zu relevanten Informationen,
  - Schulungen oder
  - Palliativmedizin versorgt.

- Familienmitglieder werden sich wahrscheinlich selber infizieren und die Krankheit verbreiten

- Schwerkranke Patienten ohne CoViD werden im Rahmen der Ressourcen-Reallokation aus dem System gedrängt

- Humanitäre Krise!

Beispiel Indien

- mangelnden Zugang zu sauberem Wasser und Desinfektionsmitteln
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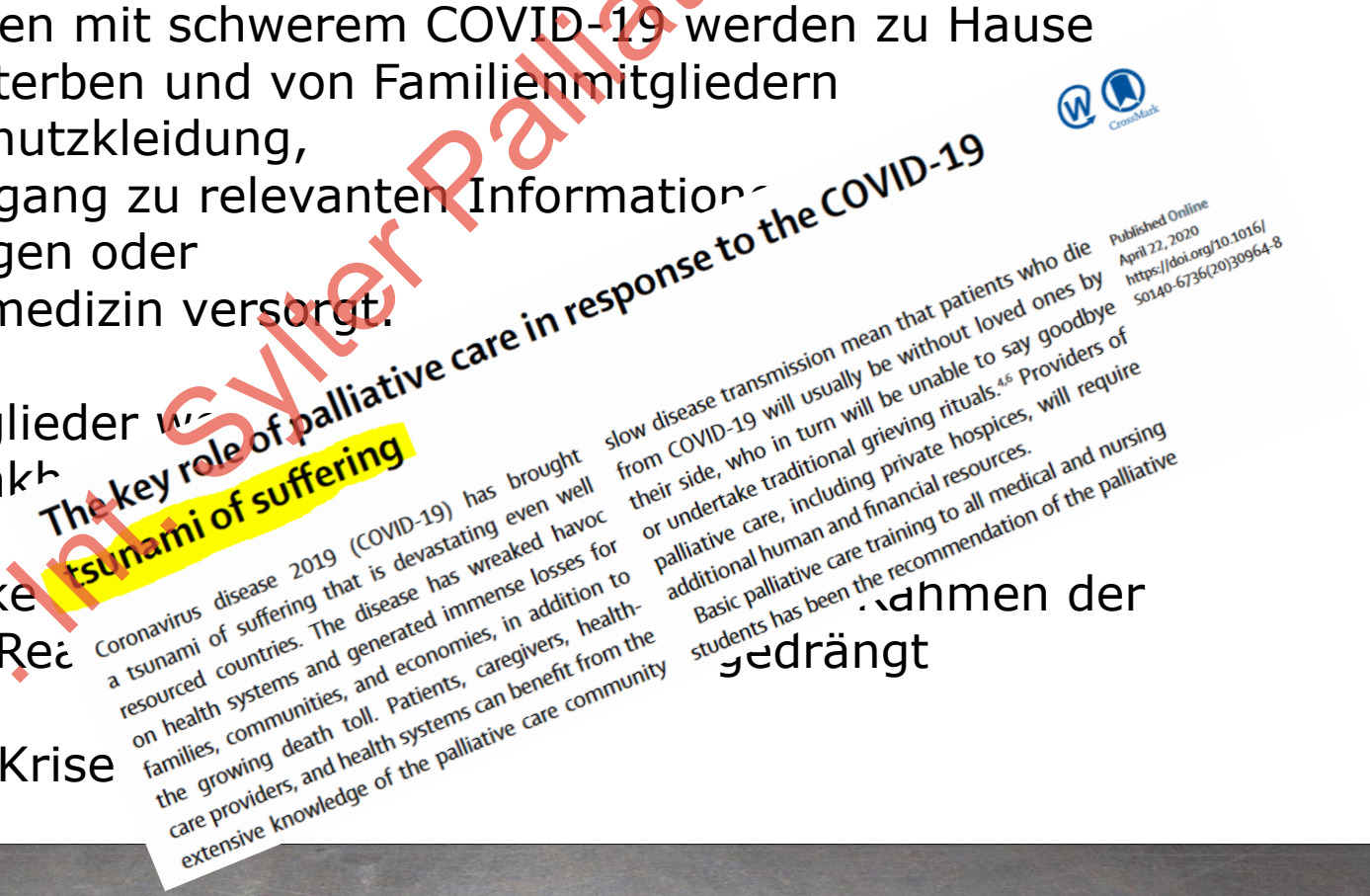

The key role of palliative care in response to the COVID-19 tsunami of suffering

Coronavirus disease 2019 (COVID-19) has brought a tsunami of suffering that is devastating even well resourced countries. The disease has wreaked havoc on health systems and generated immense losses for families, communities, and economies, in addition to the growing death toll. Patients, caregivers, health-care providers, and health systems can benefit from the extensive knowledge of the palliative care community slow disease transmission mean that patients who die from COVID-19 will usually be without loved ones by their side, who in turn will be unable to say goodbye or undertake traditional grieving rituals.[4,5] Providers of palliative care, including private hospices, will require additional human and financial resources. Basic palliative care training to all medical and nursing students has been the recommendation of the palliative

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Panel: Strategies to extend palliative care during and after the COVID-19 pandemic

Immediate responsiveness to adapt to pandemic parameters

Optimise cooperation and coordination

- Initiate formal and informal pathways for collective action and exchange by governments, bilateral and multilateral organisations, civil society, and the private sector based on the principle of solidarity.

Preserve continuity of care

- Ensure the availability and rational use of personal protective equipment and encourage self-care among palliative care health-care professionals and all caregivers.
- Ensure an adequate and balanced supply of opioid medication to all patients for relief of breathlessness and pain by instituting the simplified procedures of the International Narcotics Control Board.
- Conduct rapid training for all medical personnel to address additional palliative care needs of COVID-19 patients.
- Engage technology partners to equip community health workers with telehealth capabilities to virtually conduct home-based palliative care activities.
- Enable families to virtually visit and partake in health decisions with loved ones, especially at the end of life to address the almost universal fear of dying alone.

Enhance social support

- Enlist informal networks of community-based and faith-based organisations to mobilise and train a citizen volunteer workforce that is ready and able to teleconnect with patients in need of basic social support, delivering on palliative care's cornerstone feature—compassionate care.

Assess emerging needs

- Link with contact tracing activities and testing sites to collect data from the general public to better understand the social dimension of pandemic suffering.

Long-term preparedness strategies that embed palliative care into the core of medicine

- Expand all medical, nursing, social work, and community health worker curricula, as well as training of clergy, to include core palliative care competencies.
- Establish standard and resource-stratified palliative care guidelines and protocols for different stages of a pandemic and based on rapidly evolving situations and scenarios.

Radbruch L; Lancet 2020

Abschluss

Every facet of ordinary life is affected, from celebrations to funerals, from grocery shopping to employment, from household cleaning to visiting older relatives. And frankly, although research is progressing on treatment and vaccines, we all know this new normal will be sustained for an indefinite amount of time

Jede Facette des Alltagslebens ist davon betroffen, von Feiern bis zu Beerdigungen, vom Lebensmitteleinkauf bis zum Arbeitsleben, von der Haushaltsreinigung bis zum Besuch älterer Verwandter. Und ehrlich gesagt, obwohl die Forschung bei der Behandlung und den Impfstoffen Fortschritte macht, wissen wir alle, dass dieses neue Normal auf unbestimmte Zeit aufrechterhalten werden wird.

EAPC
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17th World Congress Of The European Association For Palliative Care

Live sessions 6 – 8 October 2021 | Online

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