
Ecole Nationale de la Santé Publique

**Organization of Palliative Care in Brittany: Lessons
learned for Armenia and Republic of Moldova**

Kate Tairyan

Otilia Scutelnicu

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List of acronyms used

DRSM – Direction Régionale du Service Médical

CRAM – Caisse Régionale d'Assurance Maladie (Regional Health Insurance Fund)

ENSP – Ecole Nationale de la Santé Publique

SROS – Schéma Régionale d'Orientations Stratégiques

ARH – Agence Régionale d'Hospitalisation

NGO – Non governmental organisation

ICC – Informational and Consultative Centre

COTER – Comité Technique Régional (Regional Technical Committee)

AIDS – Acquired Immunodéficience Syndrome

PCU – Palliative Care Unit

MT – Mobile team

GP – General Practitioner

HAH – Hospital at Home

IB – Identified beds

SAMU – Service d'assistance médicale d'urgence (Medical emergency assistance)

SMUR – Service médical d'urgence (Medical Emergency Service)

NGAP – Nomenclature Générale des Actes Professionnels (General Nomenclature on Professional Acts)

T2a – Tarification a l'activité (Tarification per activity)

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To cure, occasionally

To relieve, often

To comfort, always

Hippocrates (5th century BC)

Introduction

The present report is the result of professional study work done as part of the EUROPHAMILI health management program conducted in French National School of Public Health (ENSP), Rennes, France.

Regional Department of Health Services (Direction Regionale du Service Medical-DRSM) of Brittany which is the organization within the structure of Regional Sickness Fund (CRAM) was assigned as a professional study placement. This department is involved in planning and organization of health services in the region and responsible for the development of Regional Strategic Health Plan (Schema Regional d'Organisation des Soins - SROS) under the authority of Regional Hospital Agency (Agence Régional de l'Hospitalisation-ARH).

Currently DRSM is working on SROS of third generation designed for the period of 2006-2011, which is a strategic plan of health care development of hospital services at the regional level. There are 18 regional technical committees (Comite Technique Regional - COTER) working on different fields of health services and priority areas. These working groups consist of various specialists, representatives of different stakeholders from wide range of organizations and different levels of health care system. Each COTER based on national standards and detailed local need assessment in particular field (internal medicine, surgery, oncology, palliative care; etc) develops a draft strategic plan. This initial document after long process of discussion with various interested actors (health care providers, health financing agencies and consumers) and further elaboration is presented to the regional health conferences to be adopted.

As the DRSM is engaged in performing a broad range of tasks it was necessary to narrow the topic under investigation in order to conduct more precise research in the limited time frame devoted to the research activity. Taking into consideration the authors'

own professional interest and the fact of absence or lack of palliative care services in their respective countries it was decided to focus research on the development and organization of palliative care services in France generally and in Brittany particularly. The initial interviews with field and academic tutors and especially with Director of ARH Brittany (Madam A. Podeur), aiming to define research topic, revealed that the region is advanced in field of palliative care in France. Besides that the development of palliative care services in Brittany are defined as a priority area for SROS III.

Situation in Armenia

According to the World Factbook 2005 (<http://www.cia.gov/cia/publications/factbook>) the estimated number of the population in Armenia will be 2,982,904 (July 2005) 10.9 % of what are 65 years and over. Cancer is the second leading cause of death. In year of 2002, 25 554 deaths were registered in Armenia, 4 233 of those (16 %) from cancer (1) .

In 2002 there were 535 hospital beds specialized on oncology care. The table presented below shows that cancer morbidity has increased; registered cases per 100 000 population has grown about four times (1). The rapid increase in morbidity is attributable to the major risk factors of cancer (smoking, nutrition and diet, stress, air pollution, access to diagnostic and curative services, etc)

Years	MORBIDITY OF POPULATION WITH ONCOLOGY DISEASES	
	Incidence	Prevalence
	Per 100000 people	Per 100000 people
1970	109.6	288.2
1975	116.3	396.0
1980	125.4	410.6
1983	131.9	487.4
1984	137.3	504.0
1985	140.6	522.0
1986	144.1	548.0
1987	148.8	578.7
1988	151.0	613.4
1989	150.9	632.0
1990	145.1	588.2
1991	135.7	602.6
1992	121.1	585.6
1993	122.9	580.7
1994	120.5	578.4
1995	125.2	565.3
1996	126.1	548.1
1997	124.4	543.4
1998	135.6	568.8
1999	142.5	593.9
2000	142.3	577.8
2001	149.1	617.1
2002	178.6	759.6

Source: Health Care in Armenia-2002, Official Statistical Report, MOH

While the incidence and prevalence of cancer are constantly growing and a majority of cases are being diagnosed in incurable stages, the need of palliative care becomes an

emerging necessity. On the other hand there are no structured palliative care services available in the country. Cancer patients are cared for in secondary and tertiary level highly specialized oncology centers and hospitals and die mostly in this hospitals or in their homes. Patients with limited prognosis who prefer to stay at home are managed by the oncologists from out-patient clinic and General Practitioners (GP) who do not have specific training in palliative care or pain management.

Since 1985 the number of hospital beds in oncology care has reduced and currently is 1.7 per 10 000 population (2.0 - in 1985) (1). The reduction in hospital bed number was a result of health care reforms started in 1999. Main direction of reforms on hospital care was to reduce the oversupply of hospital beds. On the other hand underutilization of hospital capacities due to decreased access to secondary and tertiary care put the downsizing of hospital beds on the reforms' agenda.

Home based palliative services also are not well developed and appropriate pain and other symptom control plans are not applied, not even speaking about social and spiritual counseling and bereavement services. Terms "hospice" or "palliative car" are not mentioned in legal acts, in spite of cancer patients rights stated in Basic Benefit Package to receive free-of-charge treatment and medications. The Health Care System does not allocate specific funds to provide services for patients beyond curative stages of diseases, which are left out from accepted sequence of health care services- "prevention-diagnosis-treatment-rehabilitation-(recovery)". Palliative care is not included in medical university or nursing school curricula. There is no post-graduate specialization in this particular field.

In the materials from Cornell Seminar in Salzburg "Palliative Care 2002" Armenia is not even mentioned as country requesting funds for palliative care programs (amongst countries listed are countries with similar political and health system background: Georgia, Azerbaijan, Moldova, Mongolia, etc.)(2).

Situation in Republic of Moldova

According to the results of the census conducted in October of 2004 the population number of Republic of Moldova officially counts about 3 360 000 people. Life expectancy at birth in 2002 was 68,5 years and it is inconstantly increasing in last ten years. On the other hand since 1990 the natural grow rate is decreasing resulting in aging of the population. Another factor which contributes to this process is the fact that around 1 million of active people work abroad.

Republic of Moldova is a small in land country and currently the spread of family within the country is not considered as a problem yet as it is in Western Europe, but with current migration rate it could emerge.

The incidence and prevalence of oncology diseases is constantly increasing (Figure 2,3)

Figure 2 (Source WHO database)

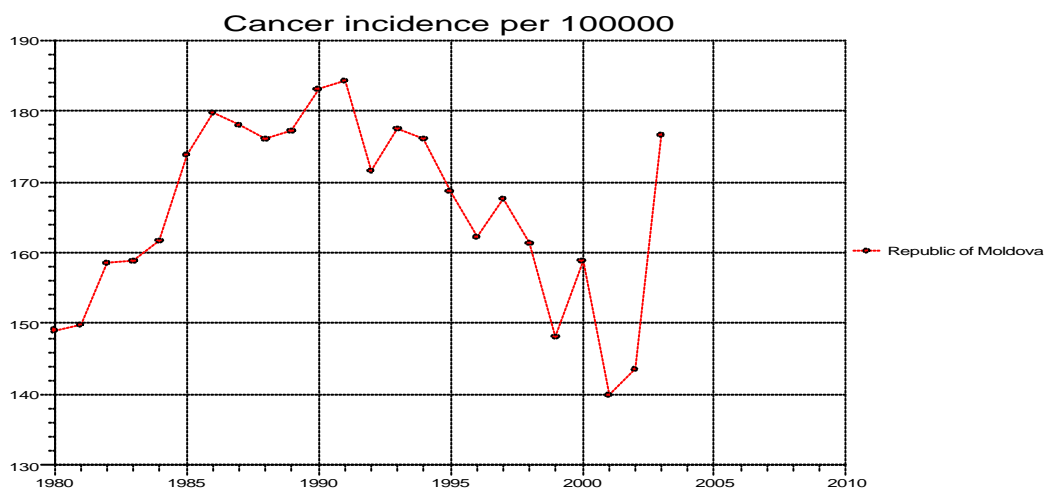
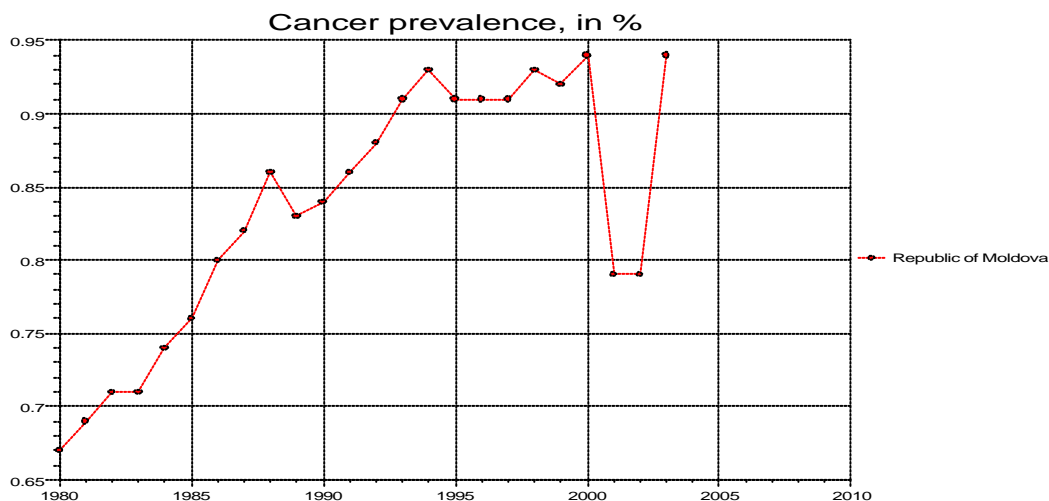


Figure 3. (Source WHO database)



The statistical data show that around 28,8% of new cases in 2003 was being diagnosed in incurable stages (Ministry of Health of Republic of Moldova).

In year of 2003 the general mortality rate was 12,0 deaths per 1000 inhabitants 11,6% of which-from cancer. As in Armenia cancer is the second leading cause of death in Republic of Moldova.

The response of the health care system to these needs of population consists in the maintaining more or less the number of high specialized beds while the general number of hospital beds was substantially reduced during the health system reforms. In 2003 there were 930 hospital beds for oncology care (including for radiological and chemotherapy treatment) or 2,6 beds per 10 000 population. It represented 4,3% of the whole number of hospital beds. These figures didn't change substantially during last four years.

Cancer patients are cared for in secondary and tertiary level highly specialized oncology departments and centers. If the doctors consider the patient as terminally ill, he/she refers him under control of the family physician to spend rest of life at home, where medical assistance is provided by family physicians and nurses. In the case of emergency or instability of symptoms the patients are hospitalized to high specialized departments or centers, where care is expensive. This care contains more or less elements of palliative care. Usually morphine is used as analgesic, but the doses are not sufficiently and individually adjusted to insure painless quality of life for terminally ill patient. Specific palliative care services are not available and terms "hospice" or "palliative care" are not indicated in legal acts. Countrywide home based palliative services also are not developed and appropriate pain and other symptom control protocols are not sufficiently applied, not even speaking about social and spiritual support to patient and family. The treatment for cancer patients is guaranteed by the state within the framework of the National Cancer Program.

Several NGOs (non governmental organizations) received support from Soros-Foundation to develop palliative care projects. The Nursing Association of the Republic of Moldova and Palliative Care Hospice Society has developed palliative care services at home and within Health Care Institutions. Informational and Consultative Center (ICC) on Palliative Care and Telephone Hot Line (THL) was established in January 2003 involving volunteers. Consultations by the psychologist, physician and nurse are offered to family doctors, nurses, relatives. The staff of the center organizes visits to the northern counties of Moldova, workshops, conferences about palliative care to inform medical community. Future plans include legal improvement concerning oral use of Morphine, introduction of palliative care as a separate package of the Medical Assurance Company, founding of day

care centers for incurable patients, further development of palliative care and implementation across the country, cooperation with European Palliative Care Association, International Association of Hospice and Palliative Care and other international organizations.

Goal

Critically analyze and investigate development and current organization of palliative care services (PCS) in France and in the region of Brittany in order to give recommendations for integration of PCS into current health care infrastructures of Armenia and Republic of Moldova.

Methods

The methods used to produce this report were literature review, review of working materials and official documentation, site visits, and interviews with key informants. Participation in daily work in DRSM and the planning process were also the component of study.

Literature review was conducted by appraisal of the wide range of scientific articles on history, development and current situation on palliative care services. Existing research and literature review articles in English and French languages were retrieved from an initial review of the literature and were used to determine the starting point for further evidence on French palliative care development. The literature review was also used to identify studies that characterize current practice patterns and targeting the end-of-life care in French Health Care System. The bibliography search strategy was designed to exclude commentaries and letters.

Participating in daily work in study placement and site visits were done during the three months (ARH, Clinique St. Laurent, Hopital Hôtel-Dieu). Working documents, official publications by the Ministry of Health, DRSM, ARH Bretagne and COTER on Palliative Care were reviewed and analyzed. The process of discussion and elaboration of "Orientations Stratégiques" on palliative care were followed by participating in working group meetings and conferences.

During the first week of study the key informants to be interviewed on different level of health care system in the region were identified. Overall 8 interviews were conducted. Interviews aimed to find out the opinion, attitude and concerns of professionals directly involved in organization, planning and delivery of palliative care services in the region of Brittany. Part of interviews was done in French with English translation. Health professionals from DRSM, ARH, hospital palliative care unit and mobile medical team were interviewed.

Results

Context of palliative care development

The rapid growth of the elderly population, epidemiological transition and changes in main causes of death, chronic versus acute diseases and emerging HIV/AIDS epidemic has shifted the demand for health services. The increasing financial burden of long-term-care for chronically ill patients on individuals and governments has focused attention to issues related to alternatives of expensive hospital care to more cost-effective health initiatives.

Every year more than 50 million people die worldwide, many of them die with unrelieved suffering and pain, with uncontrolled physical symptoms and psychosocial, spiritual problems and finally in fear and loneliness (3). About five million people die from cancer each year, to which can be added the number of patients dying with AIDS and other diseases (4).

Talking about end of life, attitude of human being towards the death is still difficult because the theme usually is touched by people who had not been confronted it and who have been touched only by the bias of the death of others. During the Middle Ages death has been familiar, public, tamed. Since XIX century death has not been communitarian but more individual. People spoke more about “my death”. In XVIII century death became dramatic, romantic. The human being was more involved emotionally in death of close person than in his own. People started to speak more about “your death”. Since the XX century the hospital became the main place of modern death allowing surviving people to accept it easier and tolerate better. Today death is hidden in the hospital which is the sanctuary of the progress. (5)

In the modern western society the important progress realized by the medicine and the technological progress have allowed to move away the limits of death and to revive our wrong phantasms and dream of immortality. But the human being has to understand that the technical hope has its own pillar and he is finally always disarmed against the own limited nature. The actual society values the beautiful, the active, and the powerful; death doesn't find its place among it. This denial of death distinguishes us from other period of human history (5).

The society tends to create a gap between “curative” and “palliative”, between the recovery and the incurable, between life and death. Meanwhile the end of life and the suffering stimulate fear in the mind of human beings (5). The fact that many people (amongst them children) die with unnecessary or untreated suffering has been well documented in many studies and published in scientific papers and reports. This is a big burden of human suffering and decreased quality of life that could and should be addressed and prevented with palliative care.

Definition of palliative care

World Health Organization gave a comprehensive definition and called palliative care to be included in every country's health services (WHO, 1990) (4). According to that definition "Palliative care is the active and total care of patients whose disease is not responding to curative treatment. Control of pain, of other symptoms, and psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life of patients and their families facing the problems associated with life-threatening illness".

History and development of palliative care

The symptomatic palliative therapy in order to reduce the physical and psychological suffering of the terminally ill patient came from Antiquity with the utilization of the opium. The morphine was separated in 1816 and used for the first time in subcutaneous injections in 1859. The salicylic medicines appeared with Aspirin in 1899.(6)

The idea and the term “hospice” (root is hospitality) come from XVII-XIX centuries when first hospices were found (like Hospital of Saint Joseph in 1905) in UK and Ireland. However, the first modern hospice, St. Christopher’s Hospice, was established in London by Dame Cicely Saunders in 1967.(7) Doctor Cicely Saunders played a fundamental role in the further development and progress of palliative care ideology and principles in the UK. One of the remarkable innovations was the treatment of pain using oral morphine, administrated in sufficient doses, at prescribed time and especially as prevention before the pain appears. She also promoted creation of interdisciplinary teams involving health professionals, the ministries of cults, and, a new element, the volunteers, to take care of terminally ill patients. It was the first facility founded as a “place” to care for the dying.(6)

The accompaniment delivered to ensure the patient with moral, spiritual and psychological support has existed and developed under the influence of charity and religious movement in French hospitals with the interventions of catholic or protestant Orders. The most famous were “Les Filles de la Charité”, les “Caméliens”, les “Diaconesses”. Hospice first became associated with dying in France in 1842, when Jeanne Garnier created an association of widows “Les Dames du Calvaire”. She was standing at the very roots of the hospice movement in France (6).

In 1974, the first United States of America (USA) hospice was established in Connecticut based on a home care model. In 1975, Balfour Mount, MD, founded the Palliative Care Service in The Royal Victoria Hospital in Montreal (8). Historically, the movement of palliative care started from the private sector of health care system. The public sector and the university settings opened their doors towards the palliative care in Canada with the first palliative care units in 1975 and then moved to USA; the concept of “palliative care” in North America was established (6).

In 1987 a definition of palliative care was adopted in Great Britain. Palliative medicine is “the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is quality of life” (Doyle, Hanks, & MacDonald, 1998) (8).

Palliative care was initially aiming to support cancer patients, since cancer is one of main cause of death worldwide. Due to its slow and, silent early development, cancer is mostly detected in advanced stages. After 2nd World War, a new movement on global care was originated, which included two elements: the therapy and the accompaniment (6). Today, in many countries palliative care is delivered across the whole healthcare continuum and not just in hospice. It become accessible to other types of chronic pathologies with uncontrolled symptoms in the terminal stages of illness, such as organ failures, neurological disorders, AIDS, etc.

According to Woodruff (1999), who summarized the stages of palliative care movement worldwide, the development of modern palliative care has included (9):

- establishment of inpatient hospice care facilities, providing comprehensive interdisciplinary care,
- development of home-based programs, incorporating the principles of interdisciplinary care

- establishment of hospital-associated hospices and hospice wards, pushing palliative care into health facilities,
- development of consultative palliative care services in hospitals

Context of palliative care development in France

“All demographic forecasts indicate that the number of elderly is going to increase. In 2020, there will be six million (of 75.2 million) people over 85 years of age in France, and 21 000 over the age of 100 years. Today in France, almost 81 % of deaths involve patients over 65 years, 59 % over 75 years, and 35 % of patients over 85 years” (2). 70% of people in the terminal stage want to die at home near their family (Survey IFOP/Sante/1991) (10). 10-15% of surveyed prefer to stay at hospital due to fear of complications of the main disease. Even if dying at home is considered preferable, 70 % of patients 75 years or older now die in a hospital, clinic, nursing home, or long-term care environment (2).

Like in other countries in France care provided in end of life has raised different and discussable opinions at the same time (11). What is it palliative care? Which are the opinions of people and health care system towards the palliative care? The society is ambivalent. From one part people ask to enlarge the response to the necessity in palliative care and to improve it. From another part there is certain distrustfulness against these facilities which frighten people. The results of the survey have shown that the population is preoccupied by the pain asking a good management of it (5). Most of people prefer to have their own GP responsible to treat the pain with whom they can be more confident (12, 13). Meanwhile, in delicate situations, they are more trustful in a health care facility and in its technology (5). The cultural evolution of the society is much more prominent among the younger people. They want to be listened, assisted and considered as a human being in the whole his dignity at the end of their life (14, 15).

There is persisting confusion between practices of the end of life care: the limitation and the stopping of active therapy, palliative care and the deliberate action to provoke the death. Some terminally ill patients arrive to ask their death under the pressure of the isolation or the shame to be dependent, and to be a burden on their relatives (11). All these factors determine the quality of remaining life.

In France approximately 200000 new cases of cancer are diagnosed each year. A national French study shows that pain is present in over half of cancer patients, that more than two thirds rate their worst pain as impairing their ability to function, and that half of

patients in pain do not receive adequate treatment. Doctors underestimate the severity of their patients' cancer pain and provide inadequate treatment (16).

The law of 9 June 1999 declares that each person, whose health status requires it, has the right to access palliative care or an accompaniment in hospital or at home, guaranteeing universal access to palliative care services.

Organization of palliative care in France

From 1977 to 1985, there were no specific recommendations on palliative care in France. (2) Since 1985 public authorities have been engaged in organization and delivery of palliative care services.(10) In August 1986 (followed by the special study conducted by Madame Genevieve Laroque) a document from the minister – “Circular”¹ (Circular DGS/3D n 86/32 bis), recommended that tertiary palliative care units be created to train health professionals in palliative methods and to encourage them to spread the knowledge throughout the healthcare system (10). The first unit opened in Paris in 1987. In 1999 there were 84 mobile teams (MT), 74 Palliative Care Units (PCU) and 18 networks at the national level. During the next three years (1999 – 2001) the number of these entities was increased: 184 MTs, 87 PCUs and 28 networks (10, 17). In 2003 there were 291 MTs in France, 91 PCUs, and about 10 PCUs for specific gerontological palliative care (2).

The term palliative care first was used in 1991 within the framework of the law on hospitals' reform (10). The first results on the organization of palliative care were presented in 1993 in the report of Henri Delbecque (10, 11). In 1994 the ministry of health published another “circular” on the organization of care in case of chronic pain (18). The law from 1995, more emphasizing the social aspects of the hospital care organization, introduced the article L710-3-1 into Public Health Code, prescribing to the health facilities to manage the pain of patients in hospital (19). The Circulaire DGS/DH/AFS nr. 98.213 from 24.03.1998 on the organization of care for cancer patients also covers palliative care dimension of total care for patients with cancer diagnosis (10). The next report was published in 1999 (Mr. Lucien Neuwirth and Mr. Donat Denisier) which led to the law voted by the Parliament in the same year (11).

Since 1999 the article L.6121-3 of the law n 99.477, of the French Public Health Code guarantees rights of French population to access the palliative care (10). Laws and

¹ “Circulaire” is an official document issued by the government to decentralized authority
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regulations require use of protocols to evaluate and treat the pain, to multidisciplinary pattern of this type of care, the follow-up education of health care professionals. According to the new law on social security financing (1999) the regional health authorities could finance the coordination and cooperation activities of general practitioners (GPs) in the field of palliative care. The Circulaire DH/EO2/2000-295 from 30.05.2000 on the organization of Hospital at Home (HAH) gives recommendations on the development of palliative care within these structures (20). In 2002 by the Circulaire DHO/O2/DGS/SD5D nr.2002-98 the national authorities gave practical recommendation on the organization of palliative care in France to increase the patients' rights to access care and to reduce inequalities between regions and departments. In this document for the first time the national authorities demanded from all regions to develop palliative care and include in their next strategic health plan-SROS. Also for the first time they proposed models of organization of palliative care in France.

To sustain, support and develop palliative care movement in France several Associations have been established since 1983. The association JALMALV was created in Grenoble in 1983. A year later, in 1984, Association pour le développement des soins palliatifs (ASP) started its activity in Paris. Variety of other associations, such as Bordeaux Alliance, Albatros in Lyon, Clement in Alsace etc. are represented within the French Association for Accompaniment and Palliative Care. The French Society of Palliative Care (Société Française d'Accompagnement et de Soins Palliatifs, SFAP) was created in 1989, at the same time the first physicians were trained in palliative care (diplomes universitaires de soins palliatifs).(6) It is required for nurses to take an introduction to palliative care as of 1993, and third-year medical students as of 1995. (2)

Development of palliative care in Brittany

In Brittany, as a regional priority, the development of palliative care strategy by the regional health authorities started officially in 2001 by the joint decision of ARH and URCAM (21). Prior to that, in 1999 within the framework of the first national plan Pain/Palliative Care, some health care structures received money to develop this initiative. In 2000 URCAM Bretagne initiated a work group to elaborate a guide to set up palliative care networks in order to assist terminally ill patients at home (21). The regional health authority gave a special experimental tariff to the policlinic of Saint-Laurent to provide palliative care for terminally ill patients (22). In 2000 the local health insurance funds received financial resources to cover work and some equipment, furniture supply

expenses in order to deliver palliative care and to train volunteers. Since 2002 this initiative has been presented to the “sanitarian conferences” in order to stimulate the health facilities in the region to include and develop palliative care services within their structures. The objective of this initiative has been the rationalization of health care supply conforming to needs and expectations of the population. Quality, safety and accessibility of care should be ensured (10).

Officially the regional health authority launched its activity taking as a starting point the definition of palliative care as a care to be provided during last three months of life (10). According to interviews with key informants from regional health authority the definition of palliative care as presented in the law is accepted in Brittany, but it does not ignore that there are other dependent patients whose life is longer than the time limits in the given definition. In order to get some practical experience in field of planning, delivery of palliative care in the region the authority distinguished two type of care: for patients with 3 months up to the end of life and for patients with a prolonged care. It stimulated health facilities to develop palliative care (10). Even if not all health facilities have identified beds or special units for palliative care, 65% of them ensure a “certain” palliative care and have trained their staff on palliative care and pain management (22, 23).

The following table presents organizational structures and the level of development of palliative care as a result of SROS II.(22, 23)

Table 2. Distribution of palliative care structures in the region of Brittany in dynamics at the start and end of SROS II.

Sanitary Sector ²	Start of SROS II (2001)	End of SROS II (2005)
Palliative Care Units		
Sanitary Sector 1	10	18
Sanitary Sector 2	0	0
Sanitary Sector 3	8	8
Sanitary Sector 4	0	8
Sanitary Sector 5	30	35
Sanitary Sector 6	17	17
Sanitary Sector 7	0	8
Sanitary Sector 8	0	0
Total beds	65	94
Identified beds		
Sanitary Sector 1	0	13
Sanitary Sector 2	0	2
Sanitary Sector 3	0	8
Sanitary Sector 4	0	11
Sanitary Sector 5	0	5
Sanitary Sector 6	0	5
Sanitary Sector 7	0	10
Sanitary Sector 8	0	6
Total beds	0	61
Mobile teams		
Sanitary Sector 1	1	0
Sanitary Sector 2	1	0
Sanitary Sector 3	0	1
Sanitary Sector 4	0	1
Sanitary Sector 5	1	2
Sanitary Sector 6	1	0
Sanitary Sector 7	1	0
Sanitary Sector 8	0	0
Total per region	5	8
Networks		
Sanitary Sector 1	0	3
Sanitary Sector 2	0	0
Sanitary Sector 3	0	0
Sanitary Sector 4	0	0
Sanitary Sector 5	0	1
Sanitary Sector 6	0	0
Sanitary Sector 7	1	1
Sanitary Sector 8	0	0
Total per region	1	6

Source of data: DRSM.

² Sanitary sector – geographical territory in the region used for planning of hospital services in France
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SROS III in Brittany

For the SROS III the chapter addressing palliative care in the strategic health care plan is mandatory for all regions. The SROS III (2006-2011) in Brittany promotes development of a territorially divided and coordinated offer of palliative care. Territorial approach considers that each sanitary sector should be responsible for the organization of broad range of palliative care services in its territory.(22) The result of the survey conducted in 2003 showed that in Brittany most of patients who attended palliative care were from the same sanitary sector.(23) It is planned to develop scientific, research and education activities on palliative care for the whole region, along with the health care services offered in two university hospitals (Rennes and Brest).(22) This academic approach to the organization of palliative care in the region is one of the distinctive features of the SROS III.

Epidemiological data, provided from the national level was the basis to calculate the need in palliative care services. It is estimated that at the national level the supply of palliative care beds has to be 5 per 100 000 population. About 6000-7500 of patients dying every year in Brittany need to receive palliative care services in specific facility. Taking into account the high proportion of elderly population in Brittany the acceptable supply of palliative care beds in this region is estimated to be 10 per 100 000 population. To cover this estimated need for palliative care services it is necessary to have 300 beds for the region (PCU-Identified Beds). Based on the calculation done according the nationally recommended ratio (5/100000) the number of beds has to be 146 (21, 22).

If we look at the global national data on palliative care beds, Brittany is fourth, while it is thirteen by the number of population. The large number of palliative care structures is due to historical dynamics of the development of palliative care in the region. Brittany was one of the first regions that established delivery of palliative care services and executed traditions in this field (22). According to the words of key informants regional health authorities promoted establishment of beds supposed to provide palliative care in hospitals. This type of beds so called “support beds”, existed in the region before national recommendations on palliative care arrived. Another possible reason for a big number of beds in Brittany is due to number of “support beds” not fully corresponding to the quality criteria set by the Ministry of Health. That is why the SROS III emphasizes the effective utilization of existing resources in each sanitary sector rather than the creation of additional structures. Nevertheless the establishment of one palliative care unit is a priority

of the next SROS. Up to 2005 only 2 out of 8 sanitary sectors in Brittany don't have this kind of structure. Another priority of SROS III is to transform the "support beds" into identified beds. This transformation is recommended to the health facilities with enough resources to support the process. The estimated number of beds has to be reached during five-year period by 20% increase in number during each year (22).

Palliative care is delivered according to the models presented in the Circulaire DHO/O2/DGS/SD5D nr.2002-98 (22, 24)

1. Palliative care provided in health care facilities:

- Palliative care units (PCU): one per sanitary sector. Department with beds specially to deliver palliative care. It can be a separate department or a component of another one. But the beds are dedicated only to deliver palliative care. The main mission of this structure is to provide care, education and research activities. The human resources include doctors, nurses, help/support nurses, administrator, physiotherapist, and clinical psychologist. This kind of services deal with most difficult cases in clinical, human, psychological, technical, aspects. Also they have to respond to the local needs. Almost every key informant conformed that the demand for this kind of departments is very high. There are waiting lists two or three times exceeding the capacity of units. The patients are selected according to the following criteria: clinical, socio-economical and the quality of palliative care available at home. Unfortunately, some patients from the waiting-lists can die before their turn arrives. The average length of stay in PCUs is 21 days (23), but there are some variations. The reason to hospitalize the patient is to adjust the treatment and to manage the symptoms. In some cases patients are hospitalized to decrease the burden on the family taking care of the terminally ill patient during long time. Usually, in 90% of case this kind of hospitalization has a temporary pattern. Conforming to the results of the survey the most of these units have shortage of paramedical staff (21, 23). Interviewed key informants from hospital unit providing palliative care shared with their perception of the environment and working conditions as a depressive, especially for less experienced paramedical staff, that is why there is a high turnover amongst them.

- Mobile team (MT): is an interdisciplinary and multi professional team which moves to the bed of the patient and/or to health care professionals on their demand. The missions of these teams are: counseling, education, and research. The professionals involved in MTs are assigned counseling, advising and assisting role; they perform transversal activity within the health facility. The key concept to deliver palliative care through mobile teams is to assist the health professionals directly working with patient in

hospital and outside, to educate them and to modify their practices, to provide support in somatic, psychological, socio-familial and ethical issues both to caregivers and family. The mobile status of the team members enables them to meet a great number of groups of caregivers. They have the chance to discuss matters and explain how to improve the acutely ill patient's environment in a general hospital through palliative care (25). They are not involved in providing any medical procedure; this is the responsibility of the doctor treating patient. The intervention of these teams can be applied inside or outside of hospitals to assist the GPs who follow-up the patient. The average length of care provided by MTs is 52 days (23). The most recent trend in the activity of mobile teams is to assist patients and care providers more outside than inside of hospital facilities. Consequently, according to the opinion of interviewed key informants, there are number of cases when hospital's need in MT assistance is not covered. Nevertheless the new strategic plan requires mobile teams not to limit their activity within hospital settings (22).

- Identified beds: There are beds within general medicine, long term care and rehabilitation departments which are used as palliative care beds for patients from proximity in the case of necessity. The idea of these beds in general hospitals is to cover local needs of palliative care for patients close to their home. These services are designed to deal with more simple cases. Not all of the department staff has specialized training to deliver palliative care, but at least one of them has to have specialization in palliative care or pain management. The services have to be equipped with the whole required supplies to provide quality palliative care. Also, identified beds in the hospital can serve as good platform for developing a mobile team. In absence of patients in need of palliative care these beds are used for the authorized needs of the department till the palliative care patients are admitted. Palliative care could be provided in the department only in case of available free beds. The regional health authority of Brittany stimulates hospitals to have identified palliative care beds to meet patients need in these particular services. But there still are "support beds" considered as identified not corresponding to the quality criteria (interview).

2. Palliative care at home: These structures are created in order to ensure the palliative care at home:

- Palliative Care Networks - aim to mobilize and link health and social resources around the patients on territorial basis. The coordination team of palliative care network, who doesn't intervene at the patient level, is in charge for overall coordination and organization, trying to ensure the interdisciplinary approach between networks on pain

management, elderly care and oncology services. They have to mobilize competences of different stakeholders for the best of patient's needs (24).

- Teams working at home presented by private professionals or for a health care facility and provide services to terminally ill patients preferring to stay at home. The staff of this team usually includes GP and nurse. They supposed to ensure the interdisciplinary and continuity approaches in palliative care and to sustain the relatives of the patient. The members of this team are chosen by the patient or the family. The coordination of the team is done by one of the team members (24).

- Hospital at Home structures. The main activity of HAH is to deliver home based palliative care services (24). Palliative care represents 30% of HAH activity. Some research show that HAH is a principle structure to take care of terminally ill patients (26). The HAH structures allow volunteers to play an important role in end of life care. Although their contribution is significant in moral and psychological support of families, their activity towards patients needs is not recognized (20).

One of the objectives of this SROS III is to harmonize the care offered to the patient. This objective is supposed to be achieved based on the principle of a coordinated care in network of all health actors in each sanitary sector. The distance between two actors or two facilities is measured in time needed to reach patient. The task is to cover the whole territory by offering access to palliative care at home, in health care facility in the proximity area to the patient in need and ensure complementarities in activity of all health actors (GPs, private nurses, HAH, etc). This approach is a baseline for the development of effective communication and information exchange between health providers to make sure that the patient has nonstop access to health facilities, to avoid the unnecessary transfer from emergency department to a specialized structure. Cooperation with SAMU or SMUR might reduce the number of undesirable hospitalizations or unreasonable revival (22).

As it was assumed as a result of critical analysis of draft version of SROS III and from several key informants' interviews there is a new emerging context for development of palliative care in Brittany:

1. Aging population with an increasing life expectancy and better quality care for elderly
2. Evolution in the definition of palliative care which is not more limited to the last three months of the life, even if this phase of life has its specificity

3. Evolution of the society which demands improved care for terminally ill patients and right to access palliative care services.

4. As a response to the ever increasing question of euthanasia the new law on end of life suggests the development of palliative care service delivery (22).

Concept of supportive care

According to results of analysis of official documents and information obtained from interviews the future development of palliative care in Brittany is based on the concept of supportive care. The definition for palliative care as a care for the last three months of life is reviewed ; more complex and coherent approach to the end-of-life care is rising (22). The origin of this concept comes from supportive care to cancer patients (27). The definition given for this kind of care is as following: “supportive care is the all type of care and assistance needed by patient and provided in parallel with the specific treatment during the serious illness”. “This definition integrates both the field of curative care with all possible after-effects and palliative care” (28). “The coordination of supportive care is necessary as a consequence of the multidisciplinary nature of health care and hyper specialization of professionals, as well as due to poor communication between teams and administrative obstacles mentioned by teams involved in supportive care” (28).

There are two periods in palliative care: “initial” and “terminal” phases. In the “terminal” phase there is no any specific treatment of the causal disease (concept of palliative care in sixteenths). This phase contents also the agony when the fixed or mobile structures in palliative care are more required by the patients. In “initial” palliative care phase the specific treatment is applied with an objective to get a temporarily complete or partial response, and/or a stabilization of the disease and/or an improvement of the quality of remaining life, which could last months or even years (22). In case of severe symptoms the intervention of palliative teams, fixed or mobile, is required even during the curative and “initial” palliative care phases (28).

The quality of end of life of a cancer patient depends on the quality of the notification of diagnosis. All actors involved in the delivery of care at home as well as in hospital have to ensure the continuity, the coherence and the quality of care during the resting life of the patient. That is why these patients have to be assisted from the beginning of the illness up to the end of life. During this period they can need different kind of medical assistance as well as social or psychological support. The most frequent needs to be addressed are:

pain, nutritional problems, and social difficulties, immobility and disability, psychical suffering, accompaniment at the end of life (22). It is now agreed that global approach should be used for terminally ill patients, with continuity between curative and palliative care (29).

Health professionals' perspective on palliative care issues

According to the survey conducted in France (2005) there are two profiles of doctors. First profile represents 38,7% of surveyed doctors, who has restrictive vision on the role of palliative care, less agree with the fact to extend palliative care to the urban medicine, has more distrust towards palliative care in general and the pain management. They are less reluctant to the specialization in palliative care. Among them there were more neurologists. Doctors representing second profile (61,3%) have larger vision than the former on the role and the place of palliative care, more agree with the diffusion of palliative care in urban medicine, less distrust towards palliative care in general and the pain management. They are more distant with the idea of a specialization. Among them there were more oncologists and doctors who followed up more terminally ill patients and with work experience in palliative care networks (30). So they were more open to deliver this kind of care.

Doctors don't like to prescribe morphine due to its adverse effects (31). It is confirmed that a good pain management and treatment with morphine could improve end-of-life care for dying patients. The utilization of strong opiates in pain management will contribute to a better relationship between doctors and patients and will decrease the number of demands for euthanasia (32). Even the pain management practices are accepted in France (33), there is a resistance to prescribe opiates (34, 35) due to national tradition which doesn't facilitate wide prescription of morphine (36).

The uncertainty syndrome is very frequent in terminal phase and destabilizes the patients, the staff who care of them, and the involved people. Caregivers consider the psychological burden of managing patients with advanced illness to be heavy (29). The gap between patient and staff provokes a defense mechanism to the staff and result in the isolation of the patient. Patient feels at risk and behaves aggressively. It is another challenge to assist affected family who doesn't recognize the person they knew as a family member or a friend. The medical literature largely articulates the existing problem of

tension on the medical staff forced by the situation in end of life (31) and increased turnover rate of paramedical staff.

Discussion

In spite of international experience, WHO recommendations to promote palliative care principles, access to palliative care and quality of life in terminal stages of incurable disease remain less than adequate in majority of countries. But even in countries with well developed palliative services barriers to these services are recognized: factors related to physician, patient, social norms and access to care.

In France as in many other European countries change of society has resulted in spread of the family members across the whole country (work, study). Increasing number of elderly people living alone requires considering coherent and organized manner for the end of life care in medical, social and interpersonal aspects. The development of palliative care services has been slower than in other European countries. The institutional line which restricts the palliative care only for the end of life could become an obstacle for a real diffusion of this kind of practices to non specialized teams. Despite various positive results and successful legal, organizational and social initiatives the access to palliative care remains unequal through regions and departments (21).

The results of several surveys come to prove that the pain management and psychological assistance are not well organized and fairly delivered. There are a lot of terminally ill patients who continue to receive unnecessary specific treatment despite the permanent non-response of threatening disease (17). The lack of identification of the terminal phase is an obstacle to transfer patients to more appropriate care in health facility or at home. The shortage of beds in palliative care units is also mentioned as a problem to meet over increasing demand of palliative care (37).

There are a lot of discussions concerning the ambiguity related to the euthanasia. Euthanasia and all forms of assisted suicide are forbidden in France, as in most European countries (38). It is imperative to distinguish euthanasia from the limitations and the stopping of inefficient treatment or treatment refused by the patient which represents good medical practice. Also it is important to distinguish euthanasia from some practices to manage the resistant pain or the unsupportable fear which can cause unexpected death.

The survey conducted in 2002-2003 showed that in Brittany 4 Palliative Care Units out of 9 have had financial problems without the official recognition from the part of administrative or medical staff. The mobile teams have had a shortage of human

resources which compromise the extra hospital activity (21, 23). These are problems jeopardizing the continuity of the system in general and palliative care services in particular. It is obvious that access to the palliative care services in residential structures and by mobile teams was improved. The palliative care service has a transversal cooperation without vertical hierarchy. Thus the most complex task was and still is the creation of networks with coordination and collaboration between care delivering units and professionals working outside of care services, and the medico-social service in each sanitary sector.

The most important limitations to develop palliative care at home are attributable to absence of financial remuneration for more time spent by GPs (listening to the patient and family, coordination of care) with terminally ill patient, which is not listed in NGAP (as a separate activity. The GPs are not motivated to perform active role in this field, in spite of financial support negotiated by the Health Insurance Fund (10, 21). In hospitals there was also the financial aspect because of reduced value of palliative care measured in ISA (Indice Synthétique d'Activité) points (10). The new financing mechanism T2A (tarification a l'activite) is under the development. In this context the new plan consider financial compensation for private professionals (working out of health care services) offering palliative care to their patients at home (22).

Furthermore palliative care as a new domain is not yet far and widely recognized (21). The participation of doctors in specialized trainings organized in university settings is limited. The absence of university department, of professors in this field put palliative care at the limit of existence as separated discipline (21).

Although the SROS III cover many aspects of palliative care organization in the region, it doesn't provide any recommendations concerning the organization of the activity of networks, mobile teams and HAH structures. The only recommendation the strategic document is offering to these structures is to maintain critical size, a variety of activities and to perform on complementary basis. One general recommendation is to develop alternatives to the traditional hospitalization, maintaining patient at home and providing the necessary care (22).

Sharing the best practices helps to change the perception and attitudes towards palliative care, which in its turn generates new modified practices to be shared. The continuous process of development and promotion of good knowledge and practices in

end-of-life care and follow-up could largely contribute in improvement of doctor-patient relationship in benefit of patients care and increased quality of life.

There is an emerging need to establish coordination and collaboration network between palliative care units, hospitals with identified beds, mobile teams, networks, HAH facilities, elderly care establishments and medico-social structures. An example of this kind of collaborative activity is the weekly meeting of professionals from sanitary sector of Rennes to discuss the cases and find joint solutions for each problematic patient. It is planned to support coordinating activity of health professionals by the implementation of software particularly designed for that purpose.

Lessons learned and recommendations

The results of literature review, information obtained from key informants' interviews, critical analysis of official documentations on palliative care services and end-of-life practices and other evidence found out on the development of palliative care in France proved that the process took long time and was not smooth and simple. The long process of development of the field passed several stages to formulate public opinion, to overcome resistance of health care providers, to build up and expand legal framework, to design educational programs for physicians and nurses. All these developments were supported by surveys and research activities aiming to provide scientific background for better need assessment and effective planning.

There is no doubt that the concept of palliative care and access to these services were improved tremendously. Formal organization, governmental support to develop quality end-of-life care to terminally ill patients in order to increase the quality of life for patients with life threatening serious diseases became a priority for French health care system. Nevertheless, number of obstacles and barriers were faced by health professionals and health authorities.

French experience to implement palliative care services confirm that interest, and "good will" of dedicated professionals and opinion leaders are not enough for sufficient implementation. Even if in some regions of the country, like Brittany, palliative care movement started and was developed before formal initiatives by national and regional authorities, political will and legal support are required to organize and deliver high quality palliative care services and implement adequate pain management practices. Government support and subsidies are important to ensure fair distribution of resources, universal access to services and to minimize inequalities between different regions and even different sanitary sectors of the same region. The role of regional health authorities is essential for proper local need assessment and planning of palliative care delivery.

Another significant obstacle to overcome is the lack of awareness and information exchange amongst medical professionals. This problem was addressed by specialized educational programs and interdisciplinary approach to the palliative care. The role of professional medical associations (French Association for Accompaniment and Palliative Care. The French Society of Palliative Care) is very important to solve these problems, to develop protocols and disseminate evidence based on best practices.

Low motivation of GPs to be involved in provision of palliative care services to their patients at home is one of the major barriers to develop home-based palliative care

services, although most of French people prefer to die at home and want to see their GP as a coordinator of end-of-life-care.

Availability of resources allocated to develop palliative care is limited. As the activity of multidisciplinary palliative care teams, consisting from various specialists (doctors, nurses, physiologist, psychologist, and volunteers) includes broad range of interventions (medical assistance, psychological support to the patient and family), it is not easy to measure and reimburse. Clear financial mechanisms and compensation system should be developed and implemented.

Taking into account the lessons learned from French palliative care experience the following recommendations are drawn for implementation of PCS in Armenia and Moldova:

- Develop appropriate legislation on end-of-life care
- Conduct a need assessment analysis to estimate population need in palliative care services and types (freestanding hospice facilities, hospital units and beds, mobile teams, etc)
- Conduct a research on population opinion about palliative care and end of life decisions
- Conduct a research on opinion of health care professionals (in hospitals and out-patient clinics) and decision makers at national and regional level on palliative care
- Develop and/or adopt pain and other end-of-life symptoms' management protocols and best practices
- To include palliative care in medical university and nursing school curricula
- To establish post-graduate specialization on palliative care and organize continuous education of health professionals involved in palliative care practices
- Develop reporting and information system to support sustainable financing of palliative care services and spread of best practices
- Create associations of health professionals working in field of palliative medicine
- Establish cooperation with international organizations working on the field palliative care.

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Kate Otilia	Tairyan Scutelnicuic	28 June 2005
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Organization of Palliative Care in Brittany: Lessons learned for Armenia and Republic of Moldova		
<p><i>Abstract :</i></p> <p>Palliative care is a complex, active and intensive type of care, promoting the quality of life of the terminally ill patients and their families. The development of palliative care services in France has been slower than in other European countries. Palliative care is provided in France by variety of types and models of care in hospital and at home: palliative care units, mobile teams, identified beds and palliative care team home services. The beneficiaries of palliative care services are patients with advanced progressive chronic diseases and limited life expectancy, with uncontrolled symptoms and psycho-social needs. The institutional line restricts the palliative care for last three months of life. The lack of identification of the terminal phase is an obstacle to transfer patients to more appropriate care in health facility or at home. The palliative care service has a transversal cooperation without vertical hierarchy. Furthermore palliative care as a new domain is not yet far and widely recognized. Thus the creation of networks with coordination and collaboration between care delivering units and professionals working outside of care services, and the medico-social service in each sanitary sector is considered as a priority. Low motivation of GPs due to insufficient financial remuneration is another limitation to develop palliative care at home. The SROS III covers many aspects of palliative care organization in the region, it doesn't provide any recommendations concerning the organization of the activity of networks, mobile teams and HAH structures. The message of palliative care is that whatever the disease, however advanced it is, whatever treatments have already been given, there is always something which can be done to improve the quality of life remaining to the patient. Recommendations given to develop palliative care in Armenia and Republic of Moldova are drawn based on assumption to avoid obstacles and problems faced in France.</p>		
<p>Key words : Palliative care, terminally ill patients, multidisciplinary, interdisciplinary, pain management, SROS, circulaire, health system, mobile team,</p>		
<p><i>The opinions expressed in the memoranda are not necessarily those of the schools that are members of the AESCULAPIUS network: these opinions must be considered to be those of their authors only.</i></p>		

