



CLINICAL PRACTICE

Difference in quality of life of referred hospital patients after hospital palliative care team intervention

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In 2001 Selma Browde created an expanded definition of palliative medicine in South Africa that reads as follows: 'Palliative Care supplies active comprehensive care for the physical, emotional, psychosocial and spiritual suffering of the patient and the family. It starts at the moment of first contact with the patient with any illness at any stage and continues for the duration of the illness. If and when the illness becomes incurable, Palliative Care then plays the major or total role.'¹ In the same year, Browde established a hospital palliative care team (HPCT) at the Johannesburg General Hospital. There are now six such teams in South Africa, yet no systematic evaluation had been carried out before this research.

Functions of the hospital palliative care team

The HPCT functions as an advisory body on pain and symptom control. The aim is to assist in alleviating patients' suffering. The suffering may be caused by a physical problem together with emotional, psychosocial and/or spiritual issues; in relieving the suffering there is an improvement in the patient's quality of life (QOL). Two palliative care-trained professional nurses and two part-time doctors currently staff the Johannesburg General Hospital team. The team is run according to a 'nurse-run, doctor-directed' framework, meaning that the nurses review all the patients and direct the doctor/s to the difficult cases in need of urgent review. A doctor co-ordinates the team.

We serve a wide community covering the following hospital wards: surgery, medicine, oncology, the specialist units and outpatient clinics. There is a monthly average of 160 patient reviews in the wards and clinics. The team acts as a link between the government hospital and outside community services, for example hospices and home-based care. The HPCT nurses therefore form a link with the community staff in

these facilities and advocate on behalf of the patients and their families.

We advise on medication together with social, spiritual and emotional issues that may be contributing to the pain. Counselling is a large part of the HPCT role; referrals for emotional issues are dealt with in the form of one-on-one sessions informally in the ward and support group workshops. Information delivery to patients needs to be individualised, with particular attention paid to process at all stages of illness. Patients and families use secondary sources of information to complement and verify information given by health carers.

Palliative care promotes an ethos in the doctor/nurse/patient relationship that is patient-orientated and not disease-orientated; it requires a non-judgemental attitude and a multidisciplinary team approach.^{2,3} The team has links with the hospital social workers; this facilitates the team in addressing the social issues of patients, for example disability grants. Another vital function is spiritual care of patients, which is aided by links with the pastoral support available at the hospital. Currently two volunteer members lead the pastoral team. Spiritual needs change with time and circumstances. Supportive and Palliative Care for Adults with Cancer together with The National Institute for Clinical Excellence guidance publication in March 2004,⁴ acknowledges this and recommends that health care teams ensure accurate and timely evaluation of spiritual issues through regular assessment. This reflects the increasing emphasis on spirituality as a factor contributing to wellbeing and coping strategies.⁵ It has long been recognised that if the philosophy of palliative care is to be of benefit to the majority, then that philosophy must be embraced by teaching.⁶ The ongoing education of ward staff in our team is regarded as essential. Education occurs informally in the wards and through in-service training. This service is provided on request by the medical ward staff.

Results

The FACT-G questionnaire, used to measure QOL, was completed by the patient group before and after HPCT intervention. A sample of 24 was available to participate. Seven subjects were excluded from the research as they did not complete the post-intervention questionnaire. Tables I and II reflect identifying details of the sample.

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Table I. Gender of sample of HPCT patients

Gender	Frequency	%
Female	13	54.17
Male	11	45.83
Total	24	100.00

Table II. Age of sample of HPCT patients

Age (years)	
Mean	52.3
Median	51
Standard deviation	13.5
Range	26 - 77

For the remaining 17 subjects, results were calculated as a total percentage score, with the following four sections making up the total: (i) physical wellbeing (score range 0 - 28); (ii) social/family wellbeing (score range 0 - 28); (iii) emotional wellbeing (score range 0 - 24); and (iv) functional wellbeing (score range 0 - 28).

The total FACT-G score range of 0 - 108 was then converted to a percentage score. The results showed an improvement in the total score percentages for QOL after intervention ($p < 0.001$).

The individual section scores for all the questionnaires added together are as follows for the pre-HPCT intervention: (i) physical wellbeing (147); (ii) social/family wellbeing (305); (iii) emotional wellbeing (204); and (iv) functional wellbeing (181).

The post-HPCT intervention scores were: (i) physical wellbeing (295); (ii) social/family wellbeing (331); (iii) emotional wellbeing (270); and (iv) functional wellbeing (285).

The above results show that all individual sections of the FACT-G questionnaire improved after HPCT intervention, the highest score being physical wellbeing. The pre-score was the lowest in this category. The other large improvement was in functional wellbeing, which was also relatively low on pre-score. The smallest difference observed was in social/family wellbeing.

The total percentage scores for each questionnaire were used in the analysis. Table III reports the percentage scores

Table III. Pre- and post-intervention percentage scores obtained from the FACT-G questionnaire

Assessment	Number	Mean	Standard deviation
Post-score	17	63.35	13.73
Pre-score	17	45.53	13.14
Difference		17.82	

Paired *t*-test: $t = 6.64$, $p < 0.001$.

obtained for the FACT-G questionnaire before and after HPCT intervention. An increase in the FACT-G percentage total scores indicates an improvement in QOL. The paired *t*-test was applied to compare differences between pre- and post-intervention percentage scores.

The increase in the total percentage scores (45.53 - 63.35) is statistically significant ($p < 0.001$) using the paired *t*-test. Therefore the results show a significant difference between pre- and post-assessment QOL scores. We can therefore conclude that the HPCT interventions are creating a positive contribution to the hospital patients' QOL based on these results.

The positive research data from the present study provide motivation to extend our HPCT structure to reach more patients and improve their QOL. The usefulness of the questionnaire suggests that it is a valuable tool for continuous evaluation of intervention, consistent with international standards of monitoring requirements. The South African initiative constitutes a response to the worldwide sense of urgency in developing a service co-ordinated by nurses, in collaboration with the multidisciplinary team, to meet the current needs of patients.

1. Browde S. Expanding the definition of Palliative Medicine and integrating it into the mainstream. *S Afr Med J* 2001; **91**: 732-733.
2. McCarthy M, Higginson I. Clinical audit by a palliative care team. *Palliat Med* 1991; **5**: 215-221.
3. Jack B, Hillier V, Williams A, Oldham J. Hospital based palliative care teams improve the symptoms of cancer patients. *Palliat Med* 2003; **17**: 498-502.
4. McIlmurray MB, Francis B, Harman JC, Morris SM, Soothill K, Thomas C. Psychosocial needs in cancer patients related to religious belief. *Palliative Medicine* 2004; **17**: 49-54.
5. O'Neill W, O'Connor P, Latimer E. Hospital palliative care services: three models in three countries. *J Pain Symptom Manage* 1992; **7**: 406-413.
6. Rabow MW, Dibble SL, Pantilat SZ, McPhee SJ. The comprehensive care team: a controlled trial of outpatient palliative medicine consultation. *Arch Intern Med* 2004; **164**: 83-91.