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| **ID** | **Task** | **Input (FR)** | **Input (EN)** | **Output (JPDS)** |
| INKA\_013\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_013\_0003-AT | editing | La légalisation de l'euthanasie et de l'aide au suicide aux Pays-Bas: un défi pour les Etats européens | Euthanasia and suicidal help law in the Netherlands: challenge for European countries | Euthanasia and Assisted Suicide Law in the Netherlands: A Challenge for European Countries |
| INKA\_013\_0011-AT | editing | Evaluation des symptômes en fin de vie et leur soulagement | End-of-life symptom evaluation and relief | Symptom Evaluation and Relief in Terminal Stages |
| INKA\_013\_0015-AB | editing | Quels sont le rôle et la place du psychologue à l’hôpital, lieu de prédilection de la médecine scientifique et plus particulièrement dans un domaine qui veut appréhender ce à quoi se heurtera toujours cette science conquérante qu’est la médecine, à savoir la mort? De sa place de tiers dans l’institution médicale, le psychologue peut réintroduire la dimension subjective du malade, d’autant plus quand le patient n’adresse pas à son médecin une simple demande de soins mais davantage le désir d’être reconnu comme sujet souffrant encore vivant. Le psychologue peut laisser émerger la parole autour de la perte de repères, la séparation, la peur de la mort. Mais, surtout, il est dépositaire de la parole du Sujet, là où elle se fait entendre. | Hospitals are considered the most appropriate site for the development of scientific medicine. Medicine is a conquering science which always has to collide against death. Psychologists are third party in the medical institution. What are thus their place and role in the hospital? We suggest that psychologists may introduce the subjective dimension of patients into the caring process. This happens when the patient does not just demand technical care but also wishes to be recognized as suffering and still alive. Psychologists may help to talk about losses, separation and fear of death. In additional above all, they listen to the patient’s words wherever these may be heard. | Hospitals are considered the most appropriate site for the development of scientific medicine. Medicine is a conquering science, yet it always collides against death. Psychologists are third parties in the medical institution; what is their place and role in the hospital? We suggest that psychologists may reintroduce the subjective dimension of patients into the caring process, particularly when the patient is not just asking to be treated, but rather to be recognized as a suffering, still living subject. Psychologists may help to talk about the loss of certainties, separation, and fear of death. Above all, they listen to the patient’s words wherever they may emerge. |
| INKA\_013\_0031-ST | editing | "Forum" | Forum | Forum |
| INKA\_014\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_014\_0005-AB | editing | Face à une maladie grave, l’entourage du patient est confronté à un double dilemme: comprendre ou ignorer la gravité de la maladie et la mort prochaine du patient; accepter ou refuser cette réalité. Les conflits naissent souvent de situations de crises: incompréhension des familles, manque de communication, saturation des équipes. En conséquence, l’expression de la souffrance peut se faire dans un climat de violence. Pour apaiser les tensions, il est proposé d’améliorer l’organisation des soins, de mieux comprendre les familles et d’éviter de créer les conditions préalables d’un conflit. | In front of a severe disorder, families are confronted with a double dilemma: to understand the disease or to ignore it together with patient’s imminent death; to accept the reality or to reject it. Conflictual situations may arise from such crisis: lack of comprehension, communication gap, staff burn out. The expression of suffering may thus become violent. In order to reduce tensions, improvement in the functional organisation of care and better understanding of families are proposed to avoid the predisposing conditions to conflict. | In the case of a severe illness, families are confronted with a double dilemma: to understand or ignore the severity of the illness, together with the patient’s imminent death; and to accept or reject this reality. Conflict may arise from crisis situations: lack of understanding of the families, lack of communication, staff burnout. The expression of suffering may thus become violent. In order to reduce tensions it is proposed to improve the functional organization of the therapies, to better understand the families, and to avoid the conditions for conflict. |
| INKA\_014\_0010-AB | editing | La dépression, l’anxiété et le souhait de mort sont des symptômes psychiques fréquemment rencontrés en soins palliatifs. Cependant cette morbidité, source fréquente de détresse et de souffrance psychologiques énormes mais méconnues, est perçue comme un processus normal chez des patients atteints de maladies incurables en phase avancée, ce qui explique qu’ils sont le plus souvent sous-diagnostiqués et sous-traités. Reconnaître les symptômes dépressifs doit faire partie intégrante de la dynamique des soins, et tant les médecins que le reste de l’équipe soignante jouent un rôle important dans l’identification de ces symptômes. C’est à travers une prise en charge adéquate, qui doit indubitablement passer par une meilleure information et formation que nous pouvons mieux aider et accompagner les patients dépressifs ainsi que leur famille dans le cheminement de processus de mort et de deuil. | Psychological symptoms are frequently seen in palliative care, such as anxiety, mood disorders and death request. However, even as a reality and clearly a major morbidity, these suffering are considered as a natural emotional processing of any terminally ill, leading most of the time, to under-diagnosis and under-treatment. Recognizing depression must be therefore integrated into routine care, and all team members have an important role in detecting these symptoms. More comprehensive and key skills training should be complemented with the screening. Such issues will substantially improve efficient management, in order to help in a better way our depressive patients and their relatives during the process of bereavement and death. | Psychological symptoms frequently seen in palliative care are anxiety, depression and a wish for death. These symptoms are often a source of distress and great, but unknown psychological suffering; yet, they are considered as a natural process in any terminally ill patients, and as a consequence they are often under-diagnosed and under-treated. Recognition of depression symptoms must therefore be integrated into routine care, and all team members have an important role in detecting these symptoms. More comprehensive training based around key skills should complement the screening. Such issues will substantially improve efficient management, in order to better assist depressive patients and their relatives during the process of bereavement and death. |
| INKA\_014\_0017-AB | editing | Par leur intervention auprès des soignants et de leurs proches en fin de vie, les équipes mobiles de soins palliatifs apportent un éclairage intéressant sur les difficultés des soignants et leur souffrance. En effet, il leur est difficile de trouver leur place entre la famille et l’équipe soignante. Trois cas concrets nous permettent d’apprécier dans cet article la réelle difficulté des soignants d’accompagner leur proche et de trouver leur juste place auprès d’eux. De même, d’autres situations évoquées, montrent les rapports souvent difficiles qu’ils ont avec les équipes soignantes. Ce travail est le fruit de nombreux entretiens et fait apparaître plusieurs questions éthiques, dans un domaine, qui, jusqu’à aujourd’hui, semble ne pas avoir été exploré. | Palliative care mobile teams may provide useful information about health carer difficulties and suffering when these professionals are in charge of a member of their own family. It may be hard for them to find the right place between their family and the nursing team. Three clinical cases describe these daily problems and few other cases also show the communication troubles which may arise with the medical and nursing team. This work raises several questions in a specific field that doesn’t seem to have been much studied up until now. | Palliative care mobile teams may provide useful information about the difficulties and suffering of health care professionals when they are in charge of a member of their own family. It may be difficult for them to find their place between their family and the health care team. Three clinical cases describe these practical problems, and some other cases also illustrate the communication issues which may arise between these professionals and the medical and nursing teams. This work raises several questions in a field that has gained little attention until now. |
| INKA\_014\_0024-AB | editing | Pour autant que les ressources nécessaires soient disponibles, le médecin dentiste peut contribuer à l’amélioration ou au maintien de la qualité de vie du patients en soins palliatifs. En effet, son action antalgique, désinfectante, cosmétique et hygiénique s’intègre facilement aux autres mesures thérapeutiques appliquées par l’ensemble des soignants. Il est donc primordial de reconnaître les besoin propres de chaque patient et ceux parfois différents de son entourage en ne cessant de garder à l’esprit la réalité quotidienne marquée le plus souvent par une espérance de vie courte. | Providing adequate resources, dentists may actively contribute to the improvement or the maintenance of quality-of-life of patients in palliative care. Through pain control, disinfections, cosmetic care and hygiene, dental care can be integrated into the general professional care process. It is thus of great importance to recognize single patient’s need and those sometimes different of care givers and family. This will help to keep in mind the daily reality that is most of the time characterized by a short life expectancy. | Provided that resources are adequate, dentists can actively contribute to the improvement or the maintenance of the quality of life of patients in palliative care. Through pain relief, disinfection, cosmetic care and hygiene, dental care can be integrated into the general professional care process. Therefore, it is important to recognize each patient’s specific needs, and the sometimes different ones of care givers and family, whilst keeping in mind a day-to-day experience that is often characterized by a short life expectancy. |
| INKA\_014\_0027-ST | editing | "Forum" | Forum | Forum |
| INKA\_014\_0032-ST | editing |   | Forum | Forum |
| INKA\_021\_0001-IT | editing | Volume 17 numéro 1 | Palliative care in nursing homes of Walloon aera | Palliative Care in Nursing Homes of Walloon Era |
| INKA\_021\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_021\_0003-AB | editing | Une enquête menée en Région wallonne (partie francophone de la Belgique) donne un aperçu de nombre de résidants qui décèdent dans leur institution, en milieu hospitalier ou en USP. Si les chiffres globaux sont stables, les différences locales peuvent être grandes et orienter vers des actions de formations ou d’information plus spécifiques. | A research conducted in the Région wallonne (french speaking part of Belgium) shows an idea of the number of residents dying in their nursing home, at hospital or in PCU. Even the final numbers are stable, there are local differences applying for more information or training. | A study conducted in the French-speaking Walloon region in Belgium reports on the number of residents that pass away either in a nursing home, at the hospital or in a PCU. While the global numbers are stable, local differences can be significant, and point in the direction of more specific information or training initiatives. |
| INKA\_021\_0003-AT | editing | Soins palliatifs dans les maisons de repos et de soins de la région wallonne | Between curative and palliative care: the role of the team in hemato-cancerology | Between Curative and Palliative Care: The Role of the Team in Hemato-Cancerology |
| INKA\_021\_0011-AB | editing | Dans un service d’hémato-cancérologie, l’équipe soignante est affrontée à deux difficultés majeures, l’une liée à l’hospitalisation en urgence d’un patient, l’autre à une nouvelle hospitalisation après une phase de rémission. Comment affronter ces difficultés alors qu’elles s’inscrivent dans la réalité d’un service, c’est-à-dire dans le vécu d’une équipe, dans un contexte familial, dans les relations entre les membres de l’équipe soignante et avec le malade? En élaborant un projet de soins continus, centré sur l’interdisciplinarité et qui tient des différents acteurs de soins dans une dimension éthique. | Caring team working in hemato-cancerology units may face two major difficulties. One is linked to the emergency hospitalization of a patient and the another to its readmission after a period of remission. How to cope with these difficulties? Indeed, they are part of the daily realities of such a unit, they occur within a family context, they take their place in the relationships between members of the team and the patient. The answer may perhaps be found within a continuous care project, truly interdisciplinary, elaborated by the different health professionals in an ethical dimension. | Medical teams working in hemato-cancerology units may face two major difficulties. One is linked to the emergency hospitalization of a patient and the other to its readmission after a period of remission. How to cope with these difficulties when they are part of the daily routine of these units? They occur in a family context, in the relationships between members of the medical team and the patient. The answer may perhaps be found within a truly interdisciplinary care project continuum, elaborated by the various health professionals in an ethical dimension. |
| INKA\_021\_0016-AB | editing | En Unité Mobile de Soins Palliatifs, pour soutenir les soignants, nous proposons et animons des groupes de paroles réguliers ou ponctuels. Cependant, nous avons repéré dans notre pratique un autre type de soutien que nous mettons à disposition des soignants: le soutien de couloir. Spécifique à notre mobilité, lors de nos déplacements quotidiens pour une situation de fin de vie problématique, notre écoute n’est pas qu’orientée sur la démarche palliative, elle accueille aussi toutes les souffrances exprimées par les soignants. Voici, d’après notre expérience, le cadre original de cet autre soutien. | To support health carers in their daily work, our mobile palliative care team suggest to lead speech groups either on a regular basis or on demand. However, we have identified another way of support and that is backstage support. Specific to our mobility and while we are moving from one place to another for difficult end-of-life situations, our listening capacity may not only directed to the palliative approach but also towards health carers own sufferings. Herewith, the original frame of this type of support is presented. | To support health care workers in their daily work, our mobile palliative care team offers and leads support groups either on a regular basis or on demand. However, we have identified another means of support: backstage support. Our listening capacity is specific to our mobile status; while we move from one place to the other for difficult end-of-life situations, it is not only directed to the palliative approach but also towards health care workers’ own sufferings. In this article we will present the original framework for this type of support. |
| INKA\_021\_0016-AT | editing | Le soutien de couloir: un soutien informel destiné aux soignants | Backstage support: an informal support for health carers | Backstage Support: Informal Support for Health Care Workers |
| INKA\_021\_0020-AB | editing | Le principe éthique fondamental d’autonomie guide la pratique de l’ergothérapie auprès de personnes en fin de vie. L’Organisation Mondiale de la Santé nous recommande d’aider ces personnes à «vivre aussi activement que possible jusqu’à la mort». Visant l’autonomie optimale, l’ergothérapeute a une place de choix dans cet accompagnement. Avec la Mesure canadienne du Rendement occupationnel, l’ergothérapeute invite la personne en fin de vie à lui faire part de ses besoins et désirs en terme d’activités. Cet outil guide le projet de soin du patient et soutient notre volonté de donner de la valeur à la vie dans le temps qui reste. | The fundamental ethic principle of autonomy is leading occupational therapy in the care of dying persons. World Health Organization recommends to help these persons «to live as actively as possible until death». Occupational therapists have thus a place of choice to optimise autonomy. With the help of the Canadian measure of occupational output, therapists invite the dying person to elicit his needs and wishes for active occupations. This tool leads the patient’s care project and supports our objective to provided life added value for the remaining time. | The fundamental ethic principle of autonomy informs occupational therapy in the treatment of terminal patients. The World Health Organization recommends helping these people “to live as actively as possible until death”. Occupational therapists have thus a place of choice to optimize autonomy. With the help of the Canadian Occupational Performance Measure, therapists invite the terminal patient to share their needs and wishes concerning activities. This tool informs the patient’s care project and supports our objective to provide value to life for the remaining time. |
| INKA\_021\_0020-AT | editing | Ergothérapie en soins palliatifs | Occupational therapy in palliative care to promote autonomy of the dying person | Occupational Therapy in Palliative Care to Promote the Autonomy of the Dying Person |
| INKA\_021\_0025-AB | editing | Le diagnostic est encore parfois annoncé à la famille plutôt qu’au patient âgé lui-même, celle-là présupposant l’incapacité de celui-ci à affronter la mauvaise nouvelle. Néanmoins, le respect de l’autonomie du patient est indispensable à la qualité d’un accompagnement en fin de vie, tant pour lui-même que pour la famille. Une situation clinique vécue lors d’une intervention auprès d’une équipe d’unité de soins interdisciplinaires gériatriques a fait émerger de nombreuses et différentes questions sur la communication et l’annonce d’une mauvaise nouvelle. | Diagnosis is end-of-life support. From a clinical situation within an interdisciplinary sometimes still announced to the family rather than to the elderly patient himself. Indeed, the family presupposes he would be unable to cope with bad news. However, respect of the autonomy of the patient is necessary to allow adequate geriatric ward, many different questions have emerged about communication and bad news. | The diagnosis is sometimes still announced to the family rather than to the elderly patient himself, as the family presumes they would be unable to cope with the bad news. However, respect for the autonomy of the patient is necessary to allow adequate end-of-life care, both for the patient and for the family. Through the analysis of a clinical intervention by an interdisciplinary tem in a geriatric ward, several questions emerge about communication and the reporting of bad news. |
| INKA\_021\_0025-AT | editing | Faut-il toujours annoncer une mauvaise nouvelle? | Should bad news always be told to the patient? | Should Bad News Always Be Told to the Patient? |
| INKA\_021\_0025-ST | editing | "Forum" | Forum | Forum |
| INKA\_021\_0030-AB | editing | Le sujet très âgé dépendant physiquement et/ou psychiquement finit souvent sa vie en institution sans que soit véritablement mise en place une stratégie spécifique de soins palliatifs. L’accompagnement de fin de vie représente une large part de l’activité gérontologique quotidienne. La pratique des soins palliatifs chez le nonagénaire nécessite une bonne connaissance des particularités de l’évaluation et du traitement de la douleur et exige une réflexion éthique sur les soins. C’est en considérant la personne dans sa globalité médico-psycho-sociale qu’une prise en charge adaptée pourra être apportée, avec des moyens financiers suffisants qui aujourd’hui font défaut en France et un autre regard de la société sur la grande vieillesse. | Physically and/or mentally impaired very old people may end their life in institutions where no specific palliative care strategy is established. In the daily gerontological activity, end-of-life care is an important part of the medical work. Palliative care in nonagenarians require extensive knowledge of pain evaluation and treatment as well as ethical questioning about care itself. The patient must be considered in its medico-psycho-social globality and adequate financial resources should be provided. Today, in France, such resources are lacking and an another eye over the oldest old is requested from the society. | Very old people that are physically and/or mentally disabled may end their life in institutions with no specific palliative care strategy. In day-to-day gerontology, end-of-life care is an important part of the medical work. Palliative care in nonagenarians requires extensive knowledge of pain evaluation and treatment as well as an ethical questioning of care itself. The patient must be considered as a medical, psychological and social whole and adequate financial resources should be provided. Today, in France, such resources are lacking and a different perspective of society on extreme old age. |
| INKA\_021\_0030-AT | editing | Existe-t-il une spécificité des soins palliatifs chez le sujet âgé? | Is there a palliative care specificity in the elderly? | Is There a Specific Palliative Care for the Elderly? |
| INKA\_021\_0030-ST | editing |   | Forum | Forum |
| INKA\_021\_0033-AB | editing | Cinquante cinq médecins généralistes de la Savoie et de l’Isère ont répondu à un questionnaire présentant six situations cliniques de fin de vie. L’objectif de cette enquête était de réaliser une sorte d’«instantané» sur leur pratique médicale. La situation de fin de vie soulève un questionnement éthique, en particulier en ce qui concerne l’autonomie du patient. Celle ci est le corollaire d’une information préalable due à tout malade quel que soit son âge ou sa pathologie. | Fifty-five general practitioners of Savoie and Isere have answered to a questionnaire on six end-of-live clinical situations. The objective of the investigation was to create a sort of «quick view» of their medical practice. The end-of-live situation raises ethic questions, particularly concerning patient’s autonomy. This is the consequence of previous information given to all patients independent of their age or pathology. | Fifty-five general practitioners in Savoy and Isere answered a questionnaire on six end-of-life clinical situations. The objective of the investigation was to take a sort of snapshot of their medical practice. The end-of-life situation raises ethical questions, particularly concerning the patient’s autonomy. This proceeds from preliminary information given to all patients, regardless of their age or pathology. |
| INKA\_021\_0033-AT | editing | Ethique médicale et fin de vie des personnes âgées: opinions des médecins | End-of-life of the elderly and medical ethic: physician’s opinions | End-of-Life of the Elderly and Medical Ethics: Physicians’ Views |
| INKA\_021\_0033-ST | editing |   | Forum | Forum |
| INKA\_022\_0045-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_022\_0049-AB | editing | Il s’agit d’une analyse de fin de vie de 151 patients de 7 médecins de premier recours dans une petite ville du canton de Genève en Suisse, au cours de 3 années consécutives. Chaque médecin a été confronté au décès de 7 à 8 patients par année dont le tiers est survenu de manière inattendue. La mise en place d’un réseau local de soins palliatifs a toutefois permis à 33% des patients cancéreux de mourir à domicile. Or ce n’est le cas que pour 9,3% d’entre eux dans le canton de Genève tout entier et la littérature rapporte des taux qui varient de 8 à 15%. D’autre part, les raisons d’une hospitalisation sont également analysées. | End-of-life of 151 patients under the care of 7 physicians over three consecutive years is analyzed in a small city of the canton of Geneva in Switzerland. Physicians where confronted to the death of 7 to 8 patients each year and one third where unexpected. Local palliative care network has allowed 33% of cancer patients to die at home. This was the case for only 9,3% in the whole canton of Geneva and for 8 to 15% in the literature. Reasons for hospitalization were also analyzed. | This article reports on the analysis, over three consecutive years, of the end-of-life of 151 patients under the care of seven primary care physicians in a small town in the canton of Geneva, Switzerland. Each physician experienced the death of 7 to 8 patients each year, one third of which were unexpected. Local palliative care network has allowed 33% of cancer patients to die at home. This was the case for only 9.3% in the whole canton of Geneva, while the literature reports a rate of 8% to 15%. The reasons for hospitalization were also examined. |
| INKA\_022\_0049-AT | editing | Médecins de premier recours et fin de vie: étude rétrospective | Primary-care physicians and end-of-life: retrospective study | Primary Care Physicians and End-of-Life: A Retrospective Study |
| INKA\_022\_0052-AB | editing | Propos: démontrer l’apport d’une unité mobile d’accompagnement et de soins palliatifs (UMASP) dans des institutions gériatriques et déterminer si cette aide permet d’éviter des hospitalisations de personnes âgées arrivées en phase ultime de leur vie. Matériel et méthodes: analyse rétrospective des dossiers de 15 patients et de questionnaires adressés respectivement à la famille, à l’équipe soignante et au médecin traitant. Résultats: les dossiers de 13 femmes et 2 hommes âgés de 86 ans en moyenne ont été analysés. 9 présentaient un cancer avancé, 2 une affection cérébrale, 2 une affection métabolique, 1 une affection psychiatrique et 1 une affection vasculaire. 6 patients étaient atteints de troubles cognitifs. C’est la présence de douleurs qui a motivé principalement l’intervention de l’UMASP à côté du soutien de l’équipe et de la famille ou de la prise en charge des autres symptômes. 14 patients sont décédés dans leur lieu de vie sans avoir été transférés dans un établissement hospitalier. 82% des familles, 73% des équipes et 75% des médecins traitants ont été pleinement satisfaits des interventions de l’UMASP. Conclusions: en prenant en charge les douleurs physiques et psychologiques ainsi que les autres symptômes de fin de vie, en évitant les hospitalisation inappropriées et en soutenant activement les familles et les équipes de soins, l’UMASP a bien démontré qu’elle répond aux besoins des structures d’hébergements gériatriques dans lesquelles elle mérite sa place. | Purpose: to demonstrate the utility of a mobile unit of accompaniment and palliative care (MUAPC) in nursing homes and to determine whether hospitalizations of elderly patients be avoided at the end of life can.Material and methods: retrospective analysis of patients files and of questionnaires to the family, the caring team and the treating physician.Results: files of 13 women and 2 men with a mean age of 86 years were analyzed. 9 presented with advanced cancer, 2 with brain disease, 2 with metabolic disorders,1 with psychiatric illness and 1 with vascular problems. 6 patients had cognitive impairment. Pain was the main reason for calling MUAPC beside support of the caring team and of the family. 14 patients died in the nursing home without being transferred to hospital. 82% of the families, 73% of the caring teams and 75% of the treating physicians were fully satisfied with MUAPC interventions.Conclusions: caring for physical pain, for psychological suffering and for end-of-life symptoms proved MUAPC to respond to nursing homes patients needs. In addition, MUAPC contributed significantly to avoid inappropriate hospitalizations and to actively support families and caring teams in their daily work. | Aim: to demonstrate the usefulness of a palliative care mobile unit in nursing homes and to determine whether the hospitalization of elderly patients at the end of their life can be avoided. Material and methods: retrospective analysis of 15 patients’ files and questionnaires completed by the family, the medical team and the treating physician. Results: the files of 13 women and 2 men with a mean age of 86 years were analyzed. Nine presented with advanced cancer, two with brain disease, two with metabolic disorders, one with a psychiatric disorder and one with vascular problems. Six patients had cognitive impairment. Pain was the main reason for the mobile unit’s intervention, besides supporting the medical team and the family. 14 patients died in the nursing home without being transferred to hospital. 82% of the families, 73% of the caring teams and 75% of the treating physicians were fully satisfied with the mobile unit’s intervention. Conclusions: As it treats physical pain, psychological suffering and end-of-life symptoms, the mobile unit responded to the needs of nursing homes. In addition, the mobile unit helped to avoid unnecessary hospitalizations and to actively support families and medical teams in their day-to-day work. |
| INKA\_022\_0052-AT | editing | Place d'une Unité Mobile d'Accompagnement et de Soins Palliatifs dans une structure d'hébergement gériatrique: à propos de 15 observations | Place of a mobile unit of accompaniment and palliative care in a nursing home: about 15 subjects | Role of a Palliative Care Mobile Unit in a Nursing Home |
| INKA\_023\_0077-ST | editing | "Éditorial" | Editorial | Editorial |
| INKA\_023\_0079-AB | editing | Face au projet de légalisation de l’euthanasie en Suisse en 2000 et à la diffusion d’une émission télévisée sur ce thème, nous avons choisit d’effectuer une enquête sur la demande d’euthanasie au sein du département de gériatrie des Hôpitaux Universitaires de Genève en septembre 2000. En effet, un patient hospitalisé ayant vu ce reportage, a sollicité les soignants à ce propos. Il nous a semblé pertinent de connaître l’approche des professionnels confrontés à ce type de question. 679 questionnaires anonymes ont été adressés à l’ensemble des soignants et 104 ont pu être analysés. Le résultat de cette démarche est plus centré sur l’origine et les raisons de ces demandes, les personnes qui ont été consulté et les raisons du changement d’avis que sur le débat traditionnel du pour ou contre l’acte d’euthanasie. Ces expériences retracent non seulement le profil des patients concerné mais nous permettent d’analyser le sens de la demande et rechercher ce qui peut être offert pour accompagner une personne vers un projet vie alors que sa demande initiale est l’euthanasie. Devant la diversité des options rencontrés, nous constatons le bénéfice d’une approche interdisciplinaire en milieu hospitalier qui permet d’approfondir la réflexion sur les soins palliatifs et les ressources que notre société met à disposition pour des adultes âgés et malades. Enfin, l’introduction de mesures sédatives dans un cadre éthique strictement structuré et l’élaboration de directives anticipées sont abordées comme pour esquisser un nouveau développement dans les années à venir. | Demand for euthanasia was formally made by a patient following a television broadcast. This stimulates us to the approach used by professionals confronted to such questions. 679 anonymous questionnaires were sent to health carers of which 104 could be analyzed. The origin of the demand and the reasons for demanding euthanasia are reported as well as the identified resource person. In addition, change of mind is also analyzed. The patient profile could be better defined and the objective of the demand could be analyzed. It was then possible to look for a life project whereas the initial demand was to obtain death. In front of multiple options, we have realized the benefits of a multidisciplinary approach in hospital palliative care and we have been able to think about the resources that our society is prepared to give to old adults and patients. Finally, within a strictly structured ethical frame, the introductions of sedation and anticipatory directives have been elaborated just as a possible future development. | A request for euthanasia was formally made by a patient following a television broadcast. This encouraged us to examine the approach used by professionals confronted with such questions. 679 anonymous questionnaires were sent to health care workers, of which 104 could be analyzed. The origin and the reasons for requesting euthanasia are examined, as well as the people consulted and the reasons for changing opinions. The patient profile can thus be better defined and the meaning of the request can be analyzed. It is then possible to identify what can be offered to support a person’s life project when their first request is euthanasia. Faced with the multiplicity of available options, we argue for the benefits of a multidisciplinary approach in hospitals: this allows for a deeper reflection about palliative care and the resources offered to the sick and the elderly. Finally, the introduction of sedation (within a highly structured ethical framework) and the elaboration of advance care directives are presented as a possible future development. |
| INKA\_023\_0079-AT | editing | La demande d'euthanasie en gériatrie | Demand of euthanasia in geriatrics | Request for Euthanasia in Geriatrics |
| INKA\_023\_0086-AB | editing | En soins palliatifs, la sédation est un procédé pharmacologique aboutissant à la perte de conscience du patient qui souffre de symptômes ne pouvant être soulagés par d’autres moyens thérapeutiques. La population étudiée comprenait les patients cancéreux faisant partie d’un réseau de soins palliatifs coordonnés à domicile. Sur les 726 patients suivis, 41 ont nécessité le recours à une sédation, soit 5,65%. 26 étaient des hommes et l’âge moyen était de 65 ans (28-83). La majorité des patients souffrait d’un cancer métastatique, 18 étaient complètement informé de leur maladie, 11 partiellement et 12 peu ou pas du tout. 9 souffraient d’une dépression. L’agitation a constitué le motif principal justifiant la sédation (n = 24), puis la douleur (n = 13) et la dyspnée (n = 12). C’est le médecin qui a proposé la sédation dans 37 cas alors que 4 patients en ont fait eux-mêmes la demande. Les médicaments utilisés ont compris le plus souvent la morphine, parfois les benzodiazépines et les neuroleptiques et le décès est survenu en moyenne 68 heures après le début de la sédation. Cette manœuvre thérapeutique ultime est donc peu souvent nécessaire dans notre pratique mais elle oblige à la distinguer très clairement d’un geste à visée euthanasique dans le respect de la règle du double effet. | In palliative care, pharmacological sedation leads to loss of conscience of a patient suffering from symptoms otherwise not amenable to relief by standard therapeutic means. Studied population were cancer patients from a coordinated home care network. 41 (5.65%) among 726 patients were sedated. 26 were men et mean age was 65 years(28-83). The majority had metastatic cancer, 18 were fully informed, 11 partially and 12 few or not at all. 9 were known to be depressed. Agitation was the main reason for sedation (n = 24), then pain (n = 13) and dyspnoea (n = 12). Doctor proposed sedation in 37 cases whereas 4 patients requested themselves to be sedated. Morphine was prefered most of the time for sedation but benzodiazepines and neuroleptics were sometimes used. Death occurred at a mean of 68 hours after initiation of sedation. This therapeutic manœuvre was thus not frequently necessary in our practice but it had to be clearly distinguished from euthanasia in the true respect of the double effect rule. | In palliative care, pharmacological sedation leads to the loss of conscience of a patient suffering from symptoms that could not be relieved by standard therapeutic means. The sample population was comprised of cancer patients from a coordinated home care network. 41 (5.65%) out of 726 patients were sedated. 26 were men, whose mean age was 65 years (28-83). The majority of patients had metastatic cancer: 18 were fully informed, 11 partially, and 12 only a little or not at all. Nine patients were known to be depressed. Agitation was the main reason for sedation (n = 24), followed by pain (n = 13) and dyspnea (n = 12). The doctor had proposed sedation in 37 cases, whereas four patients had personally requested to be sedated. Morphine was the preferred method for sedation but benzodiazepines and neuroleptics were sometimes used. Death occurred on average 68 hours after initiation of sedation. This final therapeutic measure is not often necessary in our practice, but it must be clearly distinguished from euthanasia in accordance with the principle of double effect. |
| INKA\_023\_0086-AT | editing | La sédation en phase terminale: une expérience à domicile | Home care experience of sedation in the terminal phase | Sedation in the Terminal Phase: A Home Experience |
| INKA\_023\_0093-AB | editing | La mort est l’événement commun à tous les êtres vivants. Inéluctable, incontournable, elle est cette inconnue qui met un terme à la vie. Cependant, personne ne connaît la manière dont il va mourir. Se joint à cette incertitude l’imaginaire de la mort: comment meurt-on? Pour trouver une esquisse de réponse à cette question, le regard se dirige vers l’autre qui meurt. Parfois le mourant prend le temps de mourir et les derniers instants de sa vie apparaissent alors plus fort, plus distinctement. Les personnes qui choisissent de vivre la fin de leur vie à domicile sollicitent particulièrement leur entourage. A travers les histoires de trois femmes au terme de leur vie à domicile et douze entretiens des proches présents pendant les derniers instants de la vie, l’agonie, ce parent pauvre de la vie, se dévoile. Les proches racontent ce moment de souffrance et de connaissance, ce moment fort, dur, intense, insupportable parfois. Le mourant créateur de l’événement du mourir, demeure au centre de toutes les volontés, celles des proches, celles des soignants. Il devient le maître. Il leur enseigne l’existence de ce temps ignoré, annulé, qui est encore le temps de la vie. | Death is the common event to all livings. Ineluctable, inevitable, death is the life ending stranger. However, nobody knows the way he will die. Imaginary of death comes together with such uncertainty: how does one die? To outline an answer to that question, the eye rests on the dying. Sometimes, the dying person takes his time to die and the last moments of his life appear more intense. Persons who choose to live the end of their life at home specially need their relatives.Through the history of three women ending their life at home and through twelve interviews with relatives presents during the very last moments, death’s door, this poor relation of life, is revealed. Relatives speak about this moment of suffering and of knowledge, this strong moment, hard, intense, sometimes intolerable. The dying person, creator of the dying event, remains at the centre of all wills, those of the relatives, those of the carers. He becomes the teacher. He tells them the reality of this ignored time that is still the time of life. | Death is common to all living beings. Death is an ineluctable, inevitable unknown that puts an end to one’s life. However, nobody knows the way they will die. This uncertainty is associated with images of death: how does one die? In order to answer this question, the gaze is directed onto the dying person. Sometimes, death takes some time, and in those cases the last moments of someone’s life appear more vivid, more intense. People who choose to experience the end of their life at home need their relatives in particular. Through the stories of three women who passed away at home and through twelve interviews with relatives present during their last moments, we examine agony, a forgotten aspect of life. The words of the relatives paint this moment of suffering and of knowledge as vivid, tough, intense, sometimes intolerable. The dying person, author of the death event, remains at the center of the relatives’ and the medical staff’s concerns. He/she teaches them about this ignored time, which is still part of life. |
| INKA\_023\_0093-AT | editing | Dans l'attente de la mort | In the expectation of death | Awaiting Death |
| INKA\_023\_0097-AB | editing | L’information destinée aux patients cancéreux et à leurs familles est souvent complexe et difficile d’accès. Le programme « Apprendre à vivre avec le cancer » structure et simplifie la communication entre les professionnels des soins, les patients et leurs familles. Dans un milieu hospitalier gériatrique, un quart des patients cancéreux a pu ainsi assister à l’un ou l’autre des cours alors que les familles sont restées en retrait de ce chiffre. Les observations et témoignages recueillis montrent bien que ce programme répond aux besoins des participants et que la communication entre les patients et leurs familles est notablement améliorée. | Information to cancer patients and their families may be complex and hardly accessible. The program « Learning to live with cancer » structures and simplifies communication between health professionals, patients and their families. In a geriatric hospital, one quarter of cancer patients were able to attend teaching sessions whereas families so far stayed behind. Observations and interviews show the program to answer participant’s needs. In addition, communication between patients and families was notably improved. | Information may be complex and hardly accessible to cancer patients and their families. The program “Learning to live with cancer” structures and simplifies communication between health professionals, patients and their families. In a geriatric hospital, one quarter of cancer patients were able to attend some of these sessions whereas numbers were lower for families. Observations and interviews show that the program responds to participant’s needs. In addition, the communication between patients and families was notably improved. |
| INKA\_023\_0097-AT | editing | Apprendre à vivre avec le cancer dans un milieu hospitalier gériatrique | Learning to live with cancer in a geriatric hospital | Learning to Live with Cancer in a Geriatric Hospital |
| INKA\_023\_0100-AB | editing | La personne polyhandicapée doit être appréhendée dans sa globalité en évitant toute dichotomie corps-psychisme. Malgré sa fréquente difficulté voire impossibilité à verbaliser, il est très important de l’écouter, de déchiffrer sa plainte et d’en découvrir les contenus cachés. Les tâches principales des soignants sont d’intégrer la douleur dans son contexte global, de traiter la cause si possible, de fixer des objectifs et de prévenir la douleur plutôt que d’attendre sa réapparition. La maladie ne doit plus être l’ennemi à abattre, mais un partenaire à apprivoiser. | Poly-handicapped person must be considered as a whole with no separation between body and mind. Despite frequent speech problems to manifest pain, listening to the person is of great importance as well as decoding suffering in order to discover its hidden content. Health carers have to integrate pain in the global context of the person and to treat the cause whenever possible. Therapeutic objectives have to be established to prevent the occurrence of pain rather than to wait for its manifestation. Disease shouldn’t be the enemy but a partner to deal with. | People with multiple disabilities should be considered as a whole, with no separation between body and mind. Despite these patients’ frequent difficulties or inability to verbalize, listening to them is of great importance, as well as understanding their suffering and discovering its hidden content. Health care workers have to integrate pain in the global context of the person, and to treat the cause whenever possible. Therapeutic objectives have to be established to prevent the occurrence of pain, rather than to wait for its manifestation. Disease should not be the enemy, but a partner to be tamed. |
| INKA\_023\_0100-AT | editing | Personnes polyhandicapées : pour une approche palliative de la douleur | Poly-handicapped persons: towards a palliative approach of pain | People with Multiple Disabilities: Towards a Palliative Approach to Pain |
| INKA\_023\_0103-AT | editing | La souffrance totale en onco-hématologie | Total suffering in onco-haematology units | Total Suffering in Onco-hematology Units |
| INKA\_023\_0103-ST | editing | "Forum" | Forum | Forum |
| INKA\_024\_0113-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_024\_0115-AB | editing | Le but de cette contribution est d’initier une réflexion sur les actions des intervenants médicaux lorsqu’il est question de suicide et d’assistance au suicide, afin de les orienter dans le sens du véritable intérêt de la personne qui souhaite mettre fin à ses jours en respectant le cadre légal en vigueur. Après un bref examen des diverses dispositions légales applicables à cette problématique, complétés d’un aperçu sur l’évolution future du droit dans ce domaine, sont ensuite abordées les questions liées à la responsabilité des intervenants médicaux et les critères retenus par la casuistique à cet égard.Enfin, l’auteur analyse la définition et l’étendue du devoir de confidentialité dû au patient dans le cadre des collaboration inter- et pluridisciplinaires au regard de la loi. | The purpose of this contribution is to initiate a reflexion about the medical interveners’actions within the problematic of suicide and the assistance to it, in order to allow an orientation taking into account the true interest of the person commiting suicide whilst respecting the legal frame in force. After a short overview of the various legal provisions at issue e as well as their evolution in the near future, the questions and jurisprudential criterions related to the liability of said medical actors are raised and developped.Last, the author analyses the definition and spread of the confidentiality duty owed to the patient within the inter- and pluri disciplinary co-operations with regard to the law. | The purpose of this contribution is to initiate a reflection on the actions of the medical team in relation to suicide and assisted suicide, in order to guide them toward the true interest of the person committing suicide whilst respecting the legal regulations. After a short overview of the various applicable legal provisions as well as their evolution in the near future, the legal criteria related to the liability of medical staff are examined. Lastly, the author analyzes the definition and extent of the duty of confidentiality owed to the patient in inter- and pluridisciplinary collaborations with regard to the law. |
| INKA\_024\_0115-AT | editing | Le professionnel face au suicide: Cadre juridique et responsabilités | he professional facing suicide – legal framework and responsibilities | Professionals and Suicide: Legal Framework and Responsibilities |
| INKA\_024\_0135-AB | editing | Etant donné la fréquence très élevée de la maladie cancéreuse, les soignants1 se trouvent souvent dans une situation où le traitement de réhabilitation n’est pas à proprement parler curatif mais plutôt palliatif. Ce travail fait le point sur les possibilités de contrôler les problèmes liés à la maladie cancéreuse en utilisant un instrument de soins à visée purement palliative. | According to the high incidence of cancer, care givers may find themselves in a difficult situation where rehabilitation is no longer curative but becomes palliative. We show in this paper how cancer related problems may be controlled in a palliative way by using specific therapeutic tool. | Given the high incidence of cancer, caregivers may find themselves in a difficult situation where rehabilitation is no longer curative but becomes palliative. We show in this paper how cancer-related problems may be controlled by using a specifically palliative therapeutic tool. |
| INKA\_024\_0135-AT | editing | Réhabilitation de patients souffrant d'une maladie tumorale avancée: point de vue d'une expérience palliative | Rehabilitation of patients suffering from advanced cancer: interest of a palliative approach | Rehabilitation of Patients Suffering from Advanced Cancer: The Interest of a Palliative Approach |
| INKA\_024\_0138-AB | editing | Comment repérer les ressources inexploitées d’un patient et de son entourage pour stimuler la résilience chez l’endeuillé? C’est la question étudiée par une assistante sociale au moyen d’un questionnaire auprès d’autres soignants et d’une analyse de cas faite en utilisant la «Casita», une maison inspirée de la pyramide de Maslow. L’auteur montre l’intérêt d’appliquer le concept de résilience à l’hôpital et à la problématique de la mort de la personne âgée. Elle dégage trois perspectives professionnelles pour favoriser la résilience et développer des stratégies. Dans les soins palliatifs, l’assistante sociale pourrait favoriser les relations entre patients, entourages et équipes de soins en utilisant la résilience comme dénominateur commun. | To pick up unexploited resources of a patient and his family circle in order to stimulate resilience in a person plunged into grief. This was studied by a social worker through a questionnaire passed to other health carers and with a case analysis using the “Casita”, a house inspired from the pyramid of Maslow. The author shows how valuable is the concept of resilience within a hospital and how useful it can be to the problematics of death in the elderly. Three professional perspectives are identified to favour resilience and to develop new strategies. In palliative care, the social worker could help the relationships between patients, family circle and caring team using resilience as a common denominator. | How can the unexploited resources of a patient and his family circle be utilized in order to stimulate resilience in a grieving person? This issue was researched by a social worker through a questionnaire completed by other health care workers and with a case study using the “Casita,” a house inspired by Maslow’s pyramid of needs. The author shows how valuable the concept of resilience is within a hospital and how useful it can be in approaching the issue of death in the elderly. Three professional perspectives are identified to encourage resilience and develop new strategies. In palliative care, the social worker could help the relationships between patients, family circle and medical team using resilience as a common denominator. |
| INKA\_024\_0138-AT | editing | La résilience dans le processus de deuil, vue par une assistante sociale, | Social worker’s opinion about resilience in the bereavement process | A Social Worker’s View of Resilience in the Grieving Process |
| INKA\_031\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_031\_0005-AB | editing | Le but de cette étude était d’évaluer la détresse psychologique parmi 50 patients hospitalisés en soins palliatifs au Centre anticancéreux Oscar Lambret de Lille. Nous avons utilisé deux échelles: «The Hospital Anxiety and Depression Scale» et «The Distress Thermometer Scale». Les résultats ont montré une détresse estimée à 58% par «The Hospital Anxiety and Depression Scale» et à 42% par «The Distress Thermometer Scale». Au total, ces deux échelles ont permis de dépister un niveau de détresse psychologique significatif. | The aim of this study was to evaluate the psychological distress among 50 patients hospitalized in palliative care to the anticancer center «Oscar Lambret» to Lille. We used two scales: The Hospital Anxiety and Depression Scale and The Distress Thermometer Scale. The results have shown a distress estimated to 58% with the HADS and to 42% with the DTS. On the whole, these two scales have allowed to demonstrate a significant level of psychological distress. | The aim of this study was to evaluate psychological distress among 50 patients hospitalized in palliative care at the “Oscar Lambret” Cancer Center, Lille. We used two scales: The Hospital Anxiety and Depression Scale, and The Distress Thermometer Scale. The results have shown an estimated distress of 58% with the HADS, and of 42% with the DTS. On the whole, these two scales have highlighted a significant level of psychological distress. |
| INKA\_031\_0005-AT | editing | Evaluation de la détresse psychologique en soins palliatifs. A propos de 50 observations | Assessment of psychological distress in palliative care. About 50 observations | Assessment of Psychological Distress in Palliative Care |
| INKA\_031\_0011-AT | editing | L'hypercalcémie maligne: une urgence palliative souvent négligée | Malignant hypercalcemia: an emergency that is often neglected in palliative care | Malignant Hypercalcemia: An Emergency often Neglected in Palliative Care |
| INKA\_031\_0017-AB | editing | Cet article relate une expérience de travail de parole entre des agents d’une chambre mortuaire et une psychologue d’un réseau de soins palliatifs. Il met en lumière les difficultés professionnelles de ces agents confrontés à la matérialité des corps morts et aux émotions des vivants en deuil. C’est grâce à ces rencontres régulières et la mise en mots, que se découvrent et se transforment les difficultés (en particulier celle de différencier le lieu des vivants et le lieu des morts) et que ces professionnels peuvent continuer leur travail humainement. | The experience of speaking times between mortuary room agents and a psychologist from a palliative care network is reported. Difficulties of these agents confronted to the materiality of dead bodies and to the emotions of those living in grief are illustrated. Regular meetings and appropriate wording have shown in particular the difficulty to differentiate between the place for the living and the place for the dead. This initiative may allow such professionals to continue their work with humanity. | This article reports on an experience of talk therapy between mortuary staff and a psychologist from a palliative care network. It highlights the professional difficulties of these staff members, confronted with the materiality of the dead bodies and with the emotions of the bereaved. Through regular meetings and verbalization, the difficulty to differentiate between the place for the living and the place for the dead emerges. This initiative may allow these professionals to continue their work humanely. |
| INKA\_031\_0017-AT | editing | Une psychologue à la chambre mortuaire | A psychologist in the mortuary room | A Psychologist in the Mortuary  |
| INKA\_031\_0021-AB | editing | Cet article présente le cas clinique de l’examen de fin d’année du diplôme universitaire d’accompagnement et de soutien en soins palliatifs. Issue de l’expérience de l’équipe mobile de soins palliatifs, cette situation permet aux étudiants d’aborder l’approche globale d’un patient en fin de vie. | The clinical case discussed at the final test of end-of-life and palliative care University degree is presented. From the experience of the mobile palliative care team, the situation allows students to tackle the global approach of end-of-life patient. | This article present the clinical case discussed in the final exam of the degree in Palliative Care and Support. Based on the experience of the mobile palliative care team, this event allows students to tackle a global approach to terminal patients. |
| INKA\_031\_0021-AT | editing | Prise en charge pluridisciplinaire en soins palliatifs: à propos d'une situation clinique suivie par une équipe mobile | Pluridisciplinary palliative care: a clinical case from a mobile palliative care team | Pluridisciplinary Palliative Care: A Clinical Case and the Mobile Palliative Care Team |
| INKA\_031\_0021-ST | editing | "Forum" | Forum | Forum |
| INKA\_033\_0121-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_033\_0123-AB | editing | L’obstruction intestinale est une complication relativement commune des cancers gynécologiques et digestifs. S’il convient de toujours évaluer l’indication à une intervention chirurgicale, celle-ci n’est ni possible ni appropriée chez de nombreux patients en phase avancée de leur affection. Chez ces malades, il est possible de soulager les douleurs et les symptômes digestifs consécutifs à l’obstruction, sans avoir à recourir au port d’une sonde naso-gastrique, par des analgésiques, des anti-émétiques et des médicaments inhibant les sécrétions digestives. Parmi ces derniers, l’octréotide, un analogue de synthèse de la somatostatine, a démontré une grande utilité. Les études cliniques portant sur les effets de ce peptide, ses modalités d’utilisation et ses effets secondaires les plus courants sont passés en revue. | Bowel obstruction is a common complication in patients with patients with gynecological and gastrointestinal cancer. Whereas surgery has always to be considered, it will not be helpful nor indicated in many advanced cancer patients. In these patients, pain and symptoms secondary to bowel obstruction can be controlled by analgesics, antiemetics and antisecretory drugs without the use of nasogastric tube. Among the antisecretory drugs, octreotide, a synthetic analogue of somatostatine, has been showed to be very helpful. Clinical studies related to effects of the peptide, modality of administration and common adverse effects are reviewed. | Bowel obstruction is a common complication in patients with gynecological and gastrointestinal cancer. While surgery should always be considered, it is neither helpful nor indicated in many advanced cancer patients. In these patients, pain and secondary symptoms of bowel obstruction can be controlled by analgesics, antiemetics and antisecretory drugs, without the use of nasogastric tubes. Among antisecretory drugs, octreotide—a synthetic analogue of somatostatine—has been showed to be very helpful. Clinical studies related to the effects of the peptide, mode of administration, and common adverse effects are reviewed. |
| INKA\_033\_0130-AT | editing | La compression médullaire métastatique | Metastatic cord compression | Metastatic Cord Compression |
| INKA\_033\_0137-AB | editing | Dans le canton de Vaud, une étude de faisabilité et de viabilité d’un centre de jour en soins palliatifs a été réalisée. L’objectif premier de cette structure intermédiaire serait de favoriser les retours et le maintien à domicile des personnes atteintes de maladies évolutives. Cette étude, véritable recherche-action, a la particularité de s’être déroulée dans une perspective de santé communautaire afin de vérifier que le projet correspond aux besoins d’une population spécifique et garantit un accès équitable au dispositif. Plusieurs aspects-clés ont été mis en lumière par les professionnels interviewés : le partenariat, le décloisonnement, la collaboration interdisciplinaire et inter institutionnelle. | In the Swiss canton of Vaud, feasibility and viability study of a palliative care day center was done.This intermediate structure would favour discharge home as well as home care for patients with progressive illnesses. Research-action study with health community perspective was conducted to verify that the project corresponds to the needs of specific population and guarantees equitable access to the facility. Key aspects were identified by interviewed health professionals : partnership, decompartmentalization, interdisciplinary and interinstitutional collaboration. | In the Swiss canton of Vaud, a feasibility and viability study of a palliative care day center was conducted. This intermediate structure encourages patients’ return home as well as home care for patients with progressive illnesses. The distinctive feature of this action-research study was that it was conducted in a perspective of community health, to verify that the project corresponded to the needs of a specific population and guaranteed equitable access to the facility. Key aspects were identified by interviewed health professionals: partnership, decompartmentalization, interdisciplinary and inter-institutional collaboration. |
| INKA\_033\_0137-AT | editing | Projet d'un centre de jour en soins palliatifs : une approche communautaire | Community approach project for a palliative care day center | Community Approach Project for a Palliative Care Day Center |
| INKA\_033\_0149-ST | editing | "Forum" | Forum | Forum |
| INKA\_034\_0161-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_034\_0163-AB | editing | Les réponses à quatre questions principales vont être débattues : Quand ? Plusieurs études longitudinales ont démontré que la démence est un facteur de risque de décès. Ces résultats doivent être analysés en tenant compte des comorbidités associées, du type de soins et des traitements administrés. Pourquoi ? Les études basées sur les certificats médicaux présentent certainement de nombreux biais. Une étude faite sur les autopsies a montré qu’il n’y avait pas de différence pour les causes de décès entre les patients déments et non déments et que les causes cardiaques étaient plus fréquentes chez les patients avec une démence vasculaire comparés aux patients avec une démence d’autre origine. Comment ? La fin de vie des patients atteints de démence sévère soulève de nombreuses questions d’ordre éthique. C’est souvent difficile d’accompagner ces patients dans la fin de leur vie, alors que la communication verbale n’est plus possible. Comment soutenir dans cette délicate phase de la fin de la vie les familles qui ont peur de la mort, mais aussi peur de la démence. Et après ? La souffrance des familles et des soignants doit être considérée. Ceci comprend l’optimalisation des facultés de communication des patients, des échanges interdisciplinaires aussi avec la famille afin de leur permettre d’accepter le mieux possible le décès de leur proche. | To summarize the progress of knowledge in this field, it seems possible to answer four fundamental questions. When ? Several longitudinal studies of cohorts of demented and nondemented patients showed clearly that dementia is a risk factor of early death. Patients with vascular dementia patients have the worst prognosis. These results need to be analyzed with consideration of associated comorbidity, types and intensity of care, and dementia treatment.Why ? A large autopsy study showed no difference existed in immediate causes of death between demented and nondemented hospitalized old patients. On the other hand, cardiac causes are significantly more frequent in vascular dementia than in Alzheimer’s disease or mixed dementia patients. How ? Deaths of demented patients raise a lot of ethical considerations. It is really difficult to accompany these patients, with whom communication is essentially nonverbal. During this delicate phase of the end of life, how can formal health professionals help the family members who are afraid of both death and dementia ? And after ? Suffering of family members and caregivers has to be strongly considered. This goal includes the improvement of our communication skills with the patient, and the facilitation of interdisciplinary exchanges with the caregiver’s team and with the family members to allow acceptance of death. | To summarize the progress of knowledge in the field of severe dementia, three fundamental questions are examined. 1. *When?* Several longitudinal studies showed clearly that dementia is a risk factor for death. Patients with vascular dementia have the worst prognosis. These results need to be analyzed whilst taking into account associated comorbidity, type of treatment, and administered therapies. 2.*Why?* A large-scale autopsy study showed no difference in immediate causes of death between patients with and without dementia. Also, cardiac causes are significantly more frequent in vascular dementia than in Alzheimer’s disease or mixed dementia patients. 3. *How?* The end of life of patients with dementia raises a number of ethical considerations. It is really difficult to support these patients when communication is essentially nonverbal. During this delicate phase, how can health professionals assist family members, who are afraid of death, but also of dementia? After death, the suffering of family members and caregivers has to be considered. This goal is related to the improvement of the patients’ communication skills and of the interdisciplinary exchanges with the family, so that they can accept the death of their relative. |
| INKA\_034\_0163-AT | editing | Les patients atteints de démence sévère : quand, pourquoi et comment décèdent-ils? | Patients suffering from severe dementia: when, why and how do they die? | Patients Suffering from Severe Dementia: When, Why and How They Die |
| INKA\_034\_0169-AB | editing | Jusque dans les années 80 du siècle passé, les études épidémiologiques rapportaient que 13% des maladies tumorales provoquaient des métastases du squelette. Plus récemment, l’allongement apparent de la survie des patients et les possibilités d’un examen plus soigné du squelette ont amené ce chiffre à près de 70% de tous les cancers métastatiques. Plusieurs types d’interventions thérapeutiques, aussi bien médicales que chirurgicales, peuvent aujourd’hui être envisagées pour la stabilisation des fractures avérées ou la prévention d’autres fractures chez des patients cancéreux. | Epidemiologic studies up to the eighties of last century used tovreport that 13% of tumour disorders were the cause of bone metastasis. More recently, survival increase of patients and better skeletal examinations have brought this number close to 70% of all metastatic carcinomas. Today, different therapeutic interventions, either medical or surgical, can be performed to stabilize overt fractures or to prevent new fractures in cancer patients. | Up until the 1980s, epidemiologic studies used to report that 13% of neoplasias were the cause of bone metastasis. More recently, the increased life expectancy of patients and better skeletal examinations have brought this number to almost 70% of all metastatic carcinomas. Today, various therapeutic interventions, either medical or surgical, can be performed to stabilize overt fractures or to prevent new ones in cancer patients. |
| INKA\_034\_0169-AT | editing | Les métastases osseuses dans la maladie tumorale : guérison ou palliation? | Bone metastasis in cancer disease: healing or palliation? | Bone Metastasis in Neoplasias: Curative or Palliative Care? |
| INKA\_034\_0173-AB | editing | Cet article présente la réflexion d’un jeune infirmier, frais diplômé en soins intensifs, qui s’interroge sur la place de la mort dans notre société, sur le rôle d’un soignant dans l’accompagnement de proches endeuillés. Son travail, largement basé sur une enquête auprès de proches, s’organise autour de trois axes : l’accompagnement relationnel, la présentation du corps de la personne décédée et l’aménagement de la morgue. Il en ressort quelques propositions intéressantes à mettre en place dans un hôpital et un constat cinglant : aux soins intensifs, la mort bien qu’omniprésente reste taboue. | Thoughts of a newly graduated nurse in intensive care are presented in this paper with interrogations about the place of death in our society and about the role of health carer in the accompaniment of the mourning nearest. His work is largely based on a survey of the nearest and it is organised within three directions : relational accompaniment, presentation of the body of the deceased person and fitting-out of the mortuary. Several propositions are made that could be implemented in the setting of a hospital together with a bitter statement : in the intensive care unit, death, although omnipresent, remains taboo. | This paper presents the reflection of a new graduate nurse in intensive care. He considers the place of death in our society and the role of health care workers in the support of the grieving family. His work is largely based on a survey of families and is organized around three themes: relational support, presentation of the body of the deceased person, and organization of the mortuary. Several proposals are made that could be implemented in the setting of a hospital. He concludes with a bitter observation: in intensive care unit, death (albeit omnipresent) remains a taboo. |
| INKA\_034\_0173-AT | editing | Etre infirmier aux soins intensifs ou comment faire avec la mort ? | Nurse in the intensive care unit – how to deal with death? | A Nurse in the Intensive Care Unit: How to Cope with Death? |
| INKA\_034\_0177-AB | editing | Des réseaux de soins palliatifs à domicile se sont créés récemment en Ile-de-France pour répondre à la demande de certains patients de mourir chez eux. Après avoir défini ce que sont les réseaux et les conditions d’organisation nécessaires au retour à domicile, nous proposons trois cas cliniques qui illustrent ce type de prise en charge. | Home based palliative care networks have recently been established in the Isle of France after some patient’s request to die at home. Networks’ definition and necessary conditions to organise the return home are given. Three clinical cases illustrate this type of care. | Home-based palliative care networks have recently been established in Ile-de-France after some patients’ request to die at home. The definition of networks and the necessary conditions for the return home are discussed. Three clinical cases illustrate this type of care. |
| INKA\_034\_0177-AT | editing | Bilan d'un an de travail d'une équipe mobile hospitalière et des réseaux de soins palliatifs en France | One year results of a mobile hospital team and of palliative care networks in the Isle of France | One Year of a Mobile Hospital Team and of Palliative Care Networks in Ile-de-France |
| INKA\_034\_0181-ST | editing | "Forum" | Forum | Forum |
| INKA\_041\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_041\_0003-AB | editing | Face au traumatisme d’une maladie grave et des traitements qui en découlent, des actions bénéfiques participent au réconfort du patient et de sa famille. La relation établie par le soignant avec le patient et sa famille est un élément de la qualité des soins; elle s’inscrit dans une démarche continue d’amélioration des pratiques. Cet article illustre l’importance de cette relation à travers le vécu d’un service d’onco-hématologie. | In front of trauma caused by serious illness and treatments, beneficial actions may bring comfort to patient and family. The relation established by health carer with the patient and his family is an element of quality of care; it is contained into continuous improvement of practice. This paper illustrates the importance of the relation through the daily life of onco-haematology unit. | Faced with the trauma of severe illnesses and their treatment, some beneficial actions may bring comfort to the patient and their family. The relationship established by health care workers with the patient and their family contributes to the quality of care; it is part of a continuous improvement of practice. This paper illustrates the importance of the relationship through the experience of an onco-hematology unit. |
| INKA\_041\_0003-AT | editing | Comment améliorer la relation avec le patient en onco-hématologie? | How to improve relations with the patient in onco-haematology? | How to Improve the Relationship with the Patient in Onco-Hematology? |
| INKA\_041\_0009-AB | editing | Tout au long d’une vie, des liens se tissent entre l’Homme et l’Animal. La question de la place de cette présence à la fin de la vie d’une personne hospitalisée a permis de décrire ce rapport étroit entre des patients et leurs animaux de compagnie. Cette recherche se limite à décrire le type de besoins exprimés par 13 personnes durant cette période de Soins Palliatifs. Le résultat montre la valeur de l’attachement inconditionnel durant le processus de l’accompagnement en fin de vie. | Lifelong bonds are woven between human and animals. The exact place of an animal at the end of life of hospitalised patient has allowed to describe the tight relations between patients and their pets. This research is limited to describe the needs mentioned by 13 patients in palliative care. The results show the value of unconditional attachment during the end-of-life accompanying process. | Lifelong bonds are formed between human beings and animals. The role of animals at the end of life of a hospitalized patient shows the close relationship between patients and their pets. This research is limited to describe the needs expressed by 13 patients in palliative care. The results show the value of unconditional attachment during the end-of-life support process. |
| INKA\_041\_0009-AT | editing | La relation Homme – Animal: un lien jusqu'au bout de la vie | Human – animal relation: a bond until the end of life | Human—Animal Relationship: A Bond for Life |
| INKA\_041\_0017-ST | editing | "Forum" | Forum | Forum |
| INKA\_042\_0041-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_042\_0043-AT | editing | Soins palliatifs et accompagnement des personnes en fin de vie: enquête sur le système sanitaire jurassien | Palliative care and accompaniment of end-of-life persons: survey of the Jura health system | Palliative Care and Support of Terminal Patients: A Study of the Jura Health System |
| INKA\_042\_0053-AB | editing | Quel enseignement pour quel accompagnement des personnes en fin de vie? Une expérience pédagogique originale menée avec des étudiants en soins infirmiers. – L’enseignement de l’accompagnement de personnes en fin de vie, à des étudiants infirmiers fait appel à des compétences et stratégies pédagogiques singulières. Les étudiants évoluent dans leur apprentissage et leurs questionnements vis-à-vis de la mort et de l’accompagnement des personnes en fin de vie et de leur entourage, en prenant conscience des valeurs, des questions, des préoccupations, des souffrances éventuelles qui les habitent et en ayant la possibilité de confronter avec d’autres personnes, leurs propre perception et représentations. Pour cela, ils doivent pouvoir trouver un espace de rencontre avec soi et l’autre. Une forme de contrat de groupe respectant le cheminement unique de chacun et un cadre d’écoute et de respect permettent la remise en question des idées et des pratiques de soins. Cet article décrit quelques méthodes pédagogiques propices et appréciées par les étudiants pour travailler la question de la mort et du soin infirmier. Il présente aussi certaines des questions que les étudiants se posent mais aussi les ressources et craintes qu’ils disent emmener avec eux. | Which teaching for which accompaniment of persons at the end of their life? An original teaching method conducted with nursing students. – The teaching of the accompaniment of persons being at the end of their live to nursing students calls for peculiar educational competences and strategies. The students evolve in their apprenticeship and their questions about death and the accompaniment of persons being at the end of their live together with their circle of family and friends. They become aware of the values, questions, preoccupations and possible sufferings inhabiting themselves through the possibility of confronting them with other people and their own perceptions and representations. For that, they must be able to find a meeting space with themselves and the other one. A form of group contract respecting the unique progress of each one and a frame of listening and respect allowing the calling in question of the ideas and the practices of cares. This article describes a few educational methods, appreciated by the students, favourable to work on this issue of the death and the nursing cares. It presents also some of the questions which the students ask themselves together with resources and fears that they say carrying within themselves. | Education in the support of people at the end of their life: An original training program with nursing students. – Training nursing students in the support of terminal patients calls for peculiar educational competences and strategies. The students’ evolve in their learning and their questions about death and the support of dying people and their circle of family and friends. They do so by becoming aware of these people’s values, questions, concerns and possible suffering, and by comparing their own perceptions and representations with other people. To do so, they have to find a meeting space with themselves and the other. Through a form of group contract respecting the unique progress of each individual and in a context of listening and respect, ideas about and practices of care are called into question. This article describes some useful educational methods, appreciated by the students, in order to work on this issue of death and nursing cares. It presents also some of the questions that the students ask themselves, as well as the resources and fears that they admit to carrying within themselves. |
| INKA\_042\_0053-AT | editing | Quel enseignement pour quel accompagnement des personnes en fin de vie? | Which teaching for which accompaniment of persons at the end of their life? An original teaching method conducted with nursing students. | Education in the Support of Terminal Patients: An Original Training Program with Nursing Students |
| INKA\_042\_0059-AB | editing | *Communication et fin de vie: revue bibliogaphique et approche éthique de la caresse* – Les aspects communicationnels de la vie constituent sans aucun doute un processus complexe, tant dans leur définition que dans leur appréhension par les soignants. Dans le cadre de la conférence de consensus sur «l’accompagnement des personnes en fin de vie et de leurs proches», organisée en janvier 2004, nous avons réalisé une revue de la littérature sur le sujet. Cette bibliographie que nous avons souhaitée la plus exhaustive possible nous a permis de réfléchir aux aspects philosophiques et éthiques sous-jacents en prenant appui sur des auteurs comme Emmanuel Levinas ou Marc-Alain Ouakin. | *Comunication and end-of-life: bibliographical review and ethical approach of the caress* – The communicational aspects of the end of lifetime constitute, without any doubt, a complex process, as well in their definition as in their apprehension by carer. Within the framework of the conference of consensus on «the accompaniment of the people in end and their close relations», organized in January 2004, we carried out a literature review on the subject. This bibliography that we wished the most exhaustive possible enabled us to think of the philosophical and ethical aspects subjacent by taking support on authors like Emmanuel Levinas or Marc-Alain Ouaknin. | *Communication and the terminal phase: Literature review and ethical approach to the caress* – The communicative aspects of life constitute, without a doubt, a complex process, in their definition as well as their understanding by medical staff. In the context of the consensus conference on “Support for terminal patients and their families,” organized in January 2004, we carried out a literature review on the subject. This bibliography, which we aimed to make as exhaustive as possible, enabled us to examine the underlying philosophical and ethical aspects, based on authors such as Emmanuel Levinas or Marc-Alain Ouaknin. |
| INKA\_042\_0059-AT | editing | Communication et fin de vie: revue bibliographique et approche éthique de la caresse | Comunication and end-of-life: bibliographical review and ethical approach of the caress | Communication and the Terminal Phase: Literature Review and Ethical Approach to the Caress |
| INKA\_042\_0073-AT | editing | Approche d'une démarche qualité en soins palliatifs à l'usage des services de soins | Approach of quality in palliative care for use by nursing services | Quality Approach in Palliative Care for Use by Nursing Services |
| INKA\_042\_0079-AB | editing | *A la recherche pratique de la théorie de soins de l’humain en devenir du Dr Parse* – Travaillant en oncogériatrie, l’auteure a étudié la récente théorie de soins de «l’humain en devenir» de Rosemarie Rizzo Parse. Cet article traite de la compréhension de la théorie en elle-même et des expériences vécues au cours d’un stage effectué à Toronto où la théorie est pratiquée et utilisée comme cadre de soins au quotidien. Ce cheminement montre tous les bénéfices humains de la mise en pratique d’une théorie dont les points d’orgue et le départ sont la personne. | *Towards a practical research of Parse’s theory of human becoming* – During her work in the field of oncogeriatrics, the author studied Rosemarie Rizzo Parse’s theory of human becoming. This paper deals with the theory’s self understanding and experiences gained during a training course in Toronto, where the theory is put into practice and used in the daily frame care. Human benefits obtained from the practical approach of a theory based on the person are shown through this progression. | *In Search of Parse’s Theory of Human Becoming* – During her work in the field of oncogeriatrics, the author studied Rosemarie Rizzo Parse’s theory of human becoming. This paper presents an understanding of the theory itself, and the experience of a training course in Toronto, where the theory is put into practice and frames daily treatment. This process shows all the benefits of using a theory that starts and ends with the person. |
| INKA\_042\_0079-AT | editing | Certificat d'oncologie soins palliatifs | Towards a practical research ofParse’s theory of human becoming | Diploma in Oncology-Palliative Care |
| INKA\_042\_0079-ST | editing | "Forum" | Forum | Forum |
| INKA\_043\_0097-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_043\_0099-AB | editing | Lieu de soins et d’accompagnement, la Fondation Rive-Neuve est également un lieu de stage et de formation clinique en soins palliatifs. Afin d’évaluer la qualité de l’apprentissage et de l’encadrement offerts, une vaste enquête a été réalisée auprès des stagiaires. Basée sur l’atteinte des objectifs et une auto-évaluation, elle montre l’évolution du stagiaire dans la prise en charge en soins palliatifs (amélioration de son savoir-faire et surtout de son savoir-être) et le changement de ses représentations sur la mort. Il semblerait que ce travail d’évaluation contribue aussi à la prise de conscience par les stagiaires de leurs acquis et facilite par la suite leur transfert dans leur pratique professionnelle. | The health care and palliative accompaniment facility at the Rive-Neuve Foundation also offers on-site internship and clinical training opportunities in palliative care. To assess the quality of teaching and of the educational environment, a large survey of trainees was conducted. Based on the attainment of educational goals and on self-assessment, this survey shows trainees’ evolution regarding palliative care management, their progressing skills, especially attitudinal skills, and their changing attitudes towards death. It seems that the evaluation itsself contributed to their awareness of what they had learned, and thus facilitated the application of these skills in their professional practice. | The Rive-Neuve Foundation is a Health care and palliative support facility and also offers on-site internships and clinical training opportunities in palliative care. To assess the quality of teaching and of the educational environment, a large survey of trainees was conducted. Based on the attainment of educational goals and self-assessment, this survey shows trainees’ evolution regarding palliative care management, their progressing skills (especially in terms of attitude), and their changing attitudes towards death. It seems that the evaluation itself contributed to their awareness of what they had learned, and thus facilitated the application of these skills in their professional practice. |
| INKA\_043\_0099-AT | editing | Evolution des attitudes en soins palliatifs: l'impact d'un encadrement pédagogique | Evolution of attitudes regarding palliative care: the impact of an educational approach | Evolution of Attitudes Regarding Palliative Care: The Impact of an Educational Approach |
| INKA\_043\_0105-AT | editing | Rôle de la sage-femme dans le deuil périnatal | The midwife’s role in perinatal bereavement | The Midwife’s Role in Perinatal Grief |
| INKA\_043\_0111-AT | editing | Journée dédiée à l'expérimentation et à la gestion de deux symptômes fréquents en soins palliatifs et oncologie: la fatigue et la dyspnée | A day to experience and learn to manage two frequent symptoms in palliative care and oncology: fatigue and dyspnea | A day dedicated to experimentation and management of two frequent symptoms in palliative care and oncology: fatigue and dyspnea |
| INKA\_043\_0119-ST | editing | "Forum" | Forum | Forum |
| INKA\_043\_0121-AT | editing | Bilan d'un an de présence de bénévoles d'accompagnement dans un service d'urgences | Patient accompaniment by volunteers in an emergency room: the first year | Volunteer Patient Support in an Emergency Ward: The First Year |
| INKA\_043\_0125-AT | editing | L'accompagnement palliatif de la personne polyhandicapée | Palliative care of the multiply disabled person | Palliative Care for Patients with Multiple Disabilities |
| INKA\_043\_0129-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_044\_0135-AT | editing | Sophrologie et accompagnement des personnes en fin de vie | Sophrology and accompaniment for patients in terminal care | Sophrology and Support for Terminal Patients  |
| INKA\_044\_0143-AB | editing | Dans le cadre des soins palliatifs, l’hypnose peut aider le patient à mieux faire face à cette période particulière et unique de sa vie. L’hypnose peut lui permettre de prendre le recul nécessaire, de diminuer l’anxiété, de mieux gérer la douleur et de garder un rôle actif vis-à-vis des soignants, comme de sa famille et de son entourage. L’exercice de l’autohypnose rend le patient davantage autonome lui conférant un sentiment de contrôle et de liberté. Les relations avec les soignants et l’entourage peuvent s’améliorer, et la vision de la fin de vie du patient, acquérir une dimension nouvelle plus conforme à ses désirs profonds. L’hypnose aide aussi les thérapeutes à mieux être à l’écoute du patient et éviter de décider à sa place. | Hypnosis can be a useful tool for patients in palliative care setting, to cope with this unique and very special period of their lives. Hypnosis can help patients to distance themselves from the situation they are living, to decrease their anxiety, improve pain management as well as allowing them to maintain an active role in their relationships with both the medical and nursing staff, as well as with their family. Autohypnosis empowers patients and improves their sense of autonomy and self governance which in turn allows them to perceive their end of life more clearly. As a result their relationship with the care givers thus also improves, as patients become more aware of their most intimate wishes. Hypnosis may also enable the family and the staff to have a better understanding of the patients? point of view and thus be able to respect their choices and reduce potential conflicts. | Hypnosis can be a useful tool for patients in palliative care settings to cope with this unique period of their lives. Hypnosis can help patients to distance themselves from the situation they are living, to decrease their anxiety, improve pain management, and maintain an active role in their relationships with both the medical and nursing staff, as well as with their family. Autohypnosis empowers patients and improves their sense of autonomy and independence, which in turn allows them to see the end of their life more clearly. As a result, their relationship with the medical team also improves, as patients become more aware of their most intimate wishes. Hypnosis may also enable the family and the staff to have a better understanding of the patient’s point of view, so that they can respect their choices and reduce potential conflicts. |
| INKA\_044\_0143-AT | editing | Hypnose en soins palliatifs | Hypnosis in palliative care | Hypnosis in Palliative Care |
| INKA\_044\_0149-AT | editing | Pneumonies chez les patients âgés en fin de vie | Pulmonary infection in elderly patients | Pulmonary Infection in Elderly Patients |
| INKA\_044\_0155-ST | editing | "Forum" | Forum | Forum |
| INKA\_044\_0165-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_051\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_051\_0003-AT | editing | Importance des odeurs pour le patient et pour le personnel soignant | The importance of scents to patients and health care staff | The Importance of Scent to Patients and Health Care Staff |
| INKA\_051\_0007-AT | editing | L'alimentation et l'hydratation artificielles en fin de vie : réflexion pluridisciplinaire d'une équipe de soins palliatifs | Artificial nutrition and hydration at the end of life: multidisciplinary reflection of a palliative care team | Artificial Nutrition and Hydration in the Terminal Phase: Multidisciplinary Reflections of a Palliative Care Team |
| INKA\_051\_0017-AB | editing | En phase terminale, les prescriptions médicamenteuses deviennent très complexes par l’affaiblissement des fonctions organiques et la présence de nombreuses pathologies. Les choix thérapeutiques doivent être faits en vue de l’amélioration immédiate des symptômes entravant la qualité de vie, notamment grâce à des substances pharmacologiques, et imposent surtout des retraits de prescription. A travers l’exemple de la prévention d’événements thromboemboliques, l’auteur s’interroge sur les raisons freinant les médecins à mettre cette argumentation en pratique. Est-ce par méconnaissance des signes annonciateurs d’une fin de vie proche ou par crainte de priver le patient d’un traitement considéré, hors contexte, comme indispensable ? | Dying patients’ medical prescriptions can become very complexe due to unstable organic functions and multiple pathologies. In these situations, treatment decisions should reflect the importance of immediate alleviation of symptoms that decrease quality of life. Drug withdrawals, rather than new prescriptions, are often indicated. Using the example of prophylaxis for deep vein thrombosis, the author explores possible obstacles that may prevent physicians from applying this reasoning. Might lack of recognition of signs announcing an imminent death play a role, or reluctance to deprive the patient of treatment that would be considered indispensable in a different context ? | Terminal patients’ medical prescriptions can become very complex due to weaker organic functions and multiple pathologies. In these situations, treatment decisions should be made in view of immediately relieving symptoms that decrease quality of life. Drug withdrawals, rather than new prescriptions, are often indicated. Using the example of prophylaxis for deep vein thrombosis, the author explores possible obstacles that may prevent physicians from applying this reasoning. Could it be that signs of an imminent death are not recognized, or that they do not want to deprive the patient of treatment that would be considered indispensable in a different context? |
| INKA\_051\_0017-AT | editing | Le patient polymédicamenté : de l'acharnement pharmacologique ? | The polymedicated patient: pharmacological futility? | The Polymedicated Patient: A Pharmacological Futility? |
| INKA\_051\_0017-ST | editing | "Forum" | Forum | Forum |
| INKA\_052\_0029-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_052\_0031-AB | editing | Cet article propose des outils aux aidants qui accompagnent une personne présentant une attitude de déni. Nous rappelons que l’important n’est ni de lutter contre le déni : « faire comprendre la réalit頻, ni de le traverser au plus vite : « amener la personne vers l’acceptation ». Au contraire, l’essentiel est d’en entendre toutes les subtilités, et de comprendre que ce déni nous dit beaucoup de la souffrance de la personne, mais aussi de ses capacités d’adaptation. D’autre part, le déni de la personne malade nous interroge sur le déni des soignants quand ils ne s’engagent pas dans la relation d’aide ; ou quand ils le renforcent dans un discours exagérément optimiste. Enfin, la question du déni ouvre sur la question de l’espoir au cours d’une maladie grave. Cet espoir est nécessaire. L’enjeu est de trouver le juste positionnement entre une attitude qui serait rationnelle, objective, et sombre, où l’espoir n’est pas permis (tout dire), et à l’extrême inverse, une attitude de déni de la réalité difficile, des limites de la médecine, et finalement de non-acceptation de la finitude de chaque être humain. Les outils présentés ici peuvent contribuer à trouver ce juste positionnement. Ils peuvent être utilisés par des équipes de conseil et soutien comme les Equipes Mobiles de Soins Palliatifs, ou dans le cadre de formations. | This paper proposes tools for helpers who accompany a person presenting an attitude of denial. It is important to bear in mind that the important thing is neither to fight against denial : « to have people understand reality », nor to overcome it as quickly as possible : « bringing the person towards the acceptance ». On the contrary, it is essential to perceive all the subtleties of denial, and to understand that it tells us much about the suffering of the person, but also about his/her potential for adaptation.Furthermore, the denial of a sick person questions us about the denial of the nursing staff in situations where they do not get into the helping relation ; or where they strengthen denial by an excessively optimistic speech.Finally, the question of the denial opens on the question of hope during a serious illness. This hope is necessary.The stake is to find the right positioning between a rational, objective, and gloomy attitude, where hope is not allowed (« say everything »), and at the opposite extreme, denial of difficult truths of the limits of the medicine, and finally the non-acceptance of the human finitude. Tools presented here can contribute to find this right positioning. They can be used by consulting and support teams such as Palliative Care Mobile Units, or for training purposes. | This paper offers tools to carers whose patients are in denial. The important thing is neither to fight denial (making people understand reality) nor to move past it as quickly as possible (bringing the person towards the acceptance). On the contrary, it is essential to perceive all the subtleties of denial, and to understand that it tells us much about the suffering of the person, but also about his/her potential for adaptation. Furthermore, the denial of a sick person calls into question the denial of the nursing staff in situations where they do not engage in the support relationship; or when they enforce it in excessively optimistic talk. Finally, the question of the denial leads to the question of hope in severe illnesses. This hope is necessary. The stake is to find a balance between a rational, objective, and somber attitude, where hope is not allowed (say everything), and the opposite extreme: a denial of the difficult truths of medicine’s limits, and ultimately of non-acceptance of human finitude. The tools presented here can contribute to find a balance. They can be used by consulting and support teams such as Palliative Care Mobile Units, or for training purposes. |
| INKA\_052\_0031-AT | editing | Accompagner la dénégation | Accompanying denial | Supporting Denial |
| INKA\_052\_0039-AB | editing | Lors du 1er Colloque Alpin en Soins Palliatifs de l’arc alpin (Hautes-Alpes, Isère, les deux Savoie et Genève), l’asthénie chez le patient cancéreux en soins palliatifs a été abordée. L’évaluation de ce symptôme, sa prise en charge symptomatique, la place des érythropoïétines ainsi que les aspects psychologiques ont fait l’objet de trois communications retranscrites dans cet article. | The topic of asthenia in palliative care cancer patients was explored during the 1rst Alpine Colloquium on Palliative Care (High-Apls, Isere, two Savoie and Geneva). Assessment of this symptom, symptomatic management, the place of erythropoietin, as well as its psychological aspects were addressed in three communications reported in this article. | Asthenia in cancer patients in palliative care was explored during the first Alpine Colloquium on Palliative Care (High-Alps, Isere, Savoy and Upper Savoy and Geneva). The three presentations reported in this article focus on the assessment of this symptom, its management, the role of erythropoietin, as well as its psychological aspects. |
| INKA\_052\_0039-AT | editing | L'asthénie chez le patient cancéreux en soins palliatifs | Asthenia in the cancer patient in palliative care | Asthenia in the Cancer Patient in Palliative Care |
| INKA\_052\_0047-ST | editing | "Forum" | Forum | Forum |
| INKA\_053\_0065-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_053\_0067-AB | editing | La fin de vie représente une étape cruciale de l’existence. Notre étude s’intéresse aux préférences et aux craintes des personnes âgées face à leur fin de vie. Il en ressort principalement que les personnes âgées souhaitent que leurs enfants soient le garant de leurs volontés, la moitié du collectif désire mourir à domicile, une personne sur deux craint de souffrir inutilement et la douleur doit être le symptôme à soulager prioritairement. Développer la rédaction des directives anticipées, sensibiliser les soignants à s’informer des préférences des personnes en fin de vie, privilégier l’écoute plutôt que le seul raisonnement physiopathologique sont les défis qui découlent des résultats de cette étude. | The end of life represents a crucial stage of existence. Our study explores the preferences and fears of the elderly in facing the end of their life. Our main findings are that the elderly wish their children to be those who guarantee respect for their wishes, that half of our respondents wish to die at home, and half fear that they will suffer unnecessarily. Pain is considered to be the symptom to relieve in priority.The development of advance directives, raising awareness of clinicians that they should be aware of the preferences of end of life patients, giving more priority to listening rather that being limited to physiopathological reasoning, are the challenges shown by our study to be facing clinicians. | The end of life represents a crucial stage of existence. Our study explores the preferences and fears of the elderly in facing the end of their life. Our main findings are that elderly people wish their children to be those who guarantee the respect of their wishes; that half of our respondents wish to die at home, and half of them fear that they will suffer unnecessarily. Pain is considered to be the main symptom to be relieved. Our study shows that the main challenges are the development of advance care directives, raising clinicians’ awareness of their terminal patients’ preferences, and prioritizing listening rather that being limited to physiopathological reasoning. |
| INKA\_053\_0067-AT | editing | Préférences et craintes face à la fin de vie : une réalité souvent occultée | Preferences and fears in facing the end of life: a hidden reality | Preferences and Fears Faced with Death: A Hidden Reality |
| INKA\_053\_0077-AB | editing | La réalisation d’autopsies est en plein déclin et le désintérêt encore plus marqué pour la personne âgée. Cet article rappelle les apports de l’autopsie en médecine (compréhension de maladies, contrôle de la qualité des soins, statistiques épidémiologiques, rôle dans la recherche et intérêt, notamment pour les proches, à connaître la cause du décès). Puis il s’intéresse aux raisons du déclin de cette pratique jugée archaïque au vu des progrès de la médecine, voire inutile par les soignants et les proches. Sans compter le risque infectieux pour le personnel qui les pratique, l’alourdissement de la réglementation et l’invocation de motifs religieux. Que faire pour relancer les autopsies ? Les auteurs suggèrent de former le médecin à la demande d’autopsie à la famille et, au niveau médico-légal, d’alléger la procédure. | The practice of autopsy is undergoing an important decline and this loss of interest is even greater regarding the elderly. This paper reviews the contributions of autopsy to medicine (understanding of disease, quality control in health care, epidemiological statistics, research, and the importance, especially for the family of the deceased, of knowing the cause of death). It then examines the reasons for the decline of this practice, which is viewed as archaic or useless by health care providers and patients’ families in a context of medical progress. Further obstacles include infectious risk for the staff in charge of autopsies, increasing regulatory requirements, and appeals to religious grounds. How should autopsies be fostered once more ? The authors suggest specific physician training in obtaining consent for autopsies, and simplification of the regulatory requirements. | The practice of autopsy is declining, and this loss of interest is even greater when elderly people are concerned. This paper reviews the contributions of autopsy to medicine (understanding of disease, quality control in health care, epidemiological statistics, research, and the importance of knowing the cause of death—especially for the family of the deceased). It examines the reasons for the decline of this practice, which is viewed as archaic or useless by health care providers and patients’ families, in a context of medical progress. Further obstacles include the risk of infection for the staff in charge of autopsies, the increase in regulatory requirements, and religious grounds. How should the practice of autopsy be revived? The authors suggest specific training for doctors in obtaining consent for autopsies, and a simplification of the regulatory requirements. |
| INKA\_053\_0077-AT | editing | Autopsie ou la mort au service de la vie | Autopsy: death in the service of life | Autopsy: Death in the Service of Life |
| INKA\_053\_0081-AT | editing | Vie spirituelle des patients, esthétique de la maladie et accompagnement | The spiritual life of patients, aesthetics of disease and accompaniment | The Spiritual Life of Patients, Aesthetics of Disease, and Support |
| INKA\_053\_0093-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_054\_0105-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_054\_0107-AT | editing | Les mythes de la morphine | Morphine’s myths | Morphine’s Myths |
| INKA\_054\_0117-AT | editing | La résilience en soins palliatifs : est-ce un paradoxe ? | Resilience in palliative care: a paradox? | Resilience in Palliative Care: A Paradox? |
| INKA\_054\_0121-AT | editing | Quelles sont les difficultés rencontrées par les éducateurs spécialisés dans l'accompagnement des personnes en fin de vie ? | What are the difficulties faced by specialized educators in end-of-life care? | Difficulties Faced by Educators Specialized in Terminal Care? |
| INKA\_054\_0129-AT | editing | Approche globale d'un patient en fin de vie | Global approach to an end-of-life patient | Global Approach to A Terminal Patient |
| INKA\_054\_0135-AT | editing | L'enjeu spirituel des directives anticipées | Spiritual issues of advance directives | The Spiritual Dimension of Advance Care Directives |
| INKA\_054\_0135-ST | editing | "Forum" | Forum | Forum |
| INKA\_054\_0139-AT | editing | Le temps de la relativité et la relativité du temps | The time of relativity, the relativity of time | The Time of Relativity, the Relativity of Time |
| INKA\_054\_0139-ST | editing |   | Forum | Forum |
| INKA\_061\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_062\_0045-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_062\_0047-AT | editing | Evaluation de 3 ans d'expérimentation d'un réseau de prise en charge de malades en soins palliatifs à domicile | Evaluation of 3 years’ experience in a home care network for palliative care | Evaluation of Three Years in a Palliative Home Care Network r |
| INKA\_062\_0055-AB | editing | Nous avons exploré les représentations sociales véhiculées sur l’euthanasie et les soins palliatifs au sein de la presse française. Soixante-sept articles de presse issus de 4 quotidiens nationaux (*Le Monde*, *Libération*, *Le Figaro* et *La Croix*) sur une période de 6 mois ont été analysés. Chaque journal développe une stratégie particulière de communication. Ces stratégies concernent la fréquence des articles, la place de chacun des deux thèmes, les phénomènes de propagation à partir de cas singuliers (« l’affaire Humbert ») et l’orientation explicite du contenu de l’information. Des enjeux sémantiques et idéologiques guident la diffusion de l’information sur les soins palliatifs et l’euthanasie. Les soignants doivent demeurer vigilants face aux discours véhiculés par les médias et leur rôle potentiel dans le cadre de l’interaction thérapeutique. | We have explored the social representations conveyed on the palliative care and euthanasia within the French press. Sixty-seven articles of press resulting from 4 national daily newspapers (*Le Monde*, *Libération*, *Le Figaro* and *La Croix*) over a period of 6 months were analyzed. Each newspaper develops a particular strategy of communication. These strategies relate to the frequency of the articles, the place of each of both topics, the phenomena of propagation starting from singular case (« the Humbert affair ») and the explicit orientation of the contents of information. Semantic and ideological stakes guide the diffusion of information on palliative care and euthanasia. Health care workers must remain vigilant in facing the speeches conveyed by the medias and their potential role within the framework of the therapeutic interaction. | We have explored the social representations of palliative care and euthanasia in the French press. 67 articles from four national daily newspapers (*Le Monde*, *Libération*, *Le Figaro* and *La Croix*) over a period of six months were analyzed. Each newspaper develops a particular strategy of communication. These strategies relate to the frequency of the articles, the place of each topic, the phenomena of propagation starting from singular cases (“the Humbert affair”) and the explicit orientation of the information. Semantic and ideological stakes guide the diffusion of information on palliative care and euthanasia. Health care workers must remain vigilant in facing the discourses conveyed by the media and their potential role in the therapeutic interaction. |
| INKA\_062\_0055-AT | editing | La presse française face aux soins palliatifs et à l'euthanasie | The French press facing up palliative care and euthanasia | French Press, Palliative Care and Euthanasia |
| INKA\_062\_0061-AB | editing | Face à une situation de soins complexe, chronique et évolutive, l’équipe soignante décide d’une démarche avec accompagnement de la personne, structuration d’une planification de soins afin d’apporter les meilleures réponses possibles et éviter le « burn-out » professionnel. Par la discussion en colloque interdisciplinaire, les réponses à un questionnaire interdisciplinaire, un projet de soins a vu le jour, validé par la patiente et permettant d’aborder et de réaliser des soins palliatifs en situation de maladie chronique. Suite à la réussite de cette prise en soins, l’équipe soignante a présenté un poster au congrès de la SFAP (Société Française d’Accompagnement et Soins Palliatifs). Cette expérience a pu être reconduite dans les situations similaires. | To face a complex, chronic, and developing care situation, a health care team decided to use an approach based on patient accompaniement, and structured care plans to bring the best possible responses and avoid health care provider burn-out. Through discussion in interdisciplinary meetings, and responses to an interdisciplinary questionnaire, a care project was developed, validated by the patient, and allowed the initiation of a palliative approach for a chronic disease.After this successful situation, the health care team presented a poster at the French Society for Accompaniement and Palliative Care congress. Their experience was repeated in similar situations. | To face a complex, chronic, and evolving therapeutic situation, a health care team decided to use an approach based on patient support, and a structured care plan to offer the best possible responses and avoid burnout. Through discussion in an interdisciplinary colloquium and responses to an interdisciplinary questionnaire a therapeutic project was developed, validated by the patient, and marked the start of a palliative approach to chronic disease. After the success of this approach, the health care team presented a poster at the congress of the French Society for Palliative Care and Support. Their experience was repeated in similar contexts. |
| INKA\_062\_0061-AT | editing | Evoluer, réinventer, c'est là (SLA) notre avenir | Evolving, reinventing, mind (MND) ing our future | Evolving, reinventing, MND-ing our future |
| INKA\_062\_0069-AT | editing | Encadrement des médecins internes par une psychologue dans une unité de soins palliatifs | Support of resident physicians by a psychologist in a palliative care unit | Psychological Support of Resident Doctors in a Palliative Care Unit |
| INKA\_062\_0075-AT | editing | Le premier hospice de Samara : développements et défis | Samara’s first hospice: development and challenges | Samara’s First Nursing Home: Development and Challenges |
| INKA\_062\_0079-AB | editing | L’article place d’abord quelques repères autour de la mort dans les sociétés en général, quand cette dernière vient convoquer un questionnement universel : Qui sommes-nous ? Vers quoi allons-nous ? Actuellement, la société occidentale voit coexister plusieurs modèles de la mort, issus de l’histoire des cinquante dernières années. L’étude en recense plusieurs : la mort « traditionnelle » à la maison, la mort « aseptisée » à l’hôpital, l’arrivée des soins palliatifs, les progrès fulgurants de la bio-médecine et l’exigence d’une autonomie absolue du patient. C’est dans ce contexte pluriel que s’expriment, également de manière plurielle, les religions. L’auteur examine successivement les christianismes, le judaïsme, l’islam et le bouddhisme. Il envisage d’abord leur communauté de point de vue sur certains thèmes comme l’unicité de la personne, l’importance du médecin ou le caractère précieux de toute vie. L’étude montre ensuite que ces traditions religieuses sont globalement réticentes face à l’euthanasie ou le suicide assisté, même si l’approche est parfois plus nuancée selon les traditions. La conclusion se veut interpellative : comment passer d’une attitude de contrôle absolu à l’acceptation d’une vie qui peut se confronter également à sa finitude ? Comment se laisser placer face à ses limites sans pour autant tomber dans le non-sens ou l’impossibilité de vivre ? | This paper starts by placing a few pointers around the general topic of death in societies, when it calls for universal questions : Who are we ? Towards what are we going ? Currently, Western society harbours several models of death, born of the past 50 years of history. Our study describes several : « traditional » death at home, « aseptic » death in a hospital, the arrival of palliative care, the stunning progress of biomedicine, and the claim for absolute patient autonomy. In this plural contexte, religions also express themselves in a plural manner. The author successively examines christianisms, judaïsm, islam, and buddhism. He first considers their common views on several themes, such as the unicity of persons, the importance of the physician, and the precious character of all life. This study then shows that religious traditions are generally reluctant in facing euthanasia or assisted suicide, even if some traditions adopt a more nuanced approach. The conclusion aims at further questioning.How should we pass from an attitude of absolute control to accepting a life that can confront its limits ? How can we be faced with our limits without falling into meaninglessness or the impossibility of living ? | This paper starts by outlining the general topic of death in society, as it raises universal questions: Who are we? Where are we going? Currently, in Western society, several models of death exist, derived from the past 50 years of history. Our study describes several of these models: “traditional” death at home, “sterile” death in a hospital, the emergence of palliative care, the incredible progress of biomedicine, and the need for the absolute autonomy of the patient. In this plural context, religions also express themselves in a plural manner. The author examines Christianity, Judaism, Islam, and Buddhism. First, he considers their common views on several themes, such as the uniqueness of people, the importance of doctors, and the preciousness of any life. This study shows that religious traditions are generally averse to euthanasia or assisted suicide, even if some traditions adopt a more nuanced approach. The article concludes with further questions. How should we go from an attitude of absolute control to accepting a life that can face its limits? How can we face our limits without falling into meaninglessness or the impossibility of living? |
| INKA\_062\_0079-AT | editing | L'euthanasie et le suicide médicalement assisté : apports de différentes traditions religieuses | Euthanasia and physician assisted suicide: contributions from different religious traditions | Euthanasia and Medically Assisted Suicide: Contributions from Different Religious Traditions |
| INKA\_062\_0079-ST | editing | "Forum" | Forum | Forum |
| INKA\_063\_0093-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_063\_0109-AB | editing | *L’accompagnement spirituel : entre dispositif de prise en charge et absence de discours* – Dans nos sociétés fortement médicalisées, les soins palliatifs proposent un accompagnement plus humain de la personne en fin de vie grâce à l’élaboration d’un dispositif de prise en charge basé sur les besoins du patient. L’une des composantes de cette prise en charge humanisante, l’accompagnement spirituel, paraît particulièrement innovante dans la mesure où elle s’intègre dans un champ médical laïc. Dans un premier temps, il est question dans cet article du rapport au religieux dans nos sociétés et du contexte dans lequel apparaît la nécessité de prendre en charge la spiritualité du patient. Ensuite, il s’agira de décrire la démarche entreprise et de rendre compte de certains aspects d’une enquête ethnographique réalisée à la Fondation Rive-Neuve à Villeneuve. Celle-ci a montré que les patients comme les soignants ne parlent que rarement de l’accompagnement et des besoins spirituels, alors même que cette dimension est centrale pour cette institution et qu’un certain nombre d’activités sont prévues pour permettre un tel accompagnement. Comment interpréter ce constat ? Il s’agira de discuter la possibilité d’intégrer un discours sur la spiritualité dans une telle structure, tout en se posant la question de la distinction entre l’accompagnement spirituel et le point de vue psychologique, quant à lui très présent dans les discours des professionnels. L’expression non-verbale de la spiritualité des patients soulèvera également quelques interrogations alors que le besoin de spiritualité du soignant confronté à la fin de vie du patient semble non-négligeable. | *Spiritual accompaniment: between care plan and lack of discourse* – In our highly medicalized societies, palliative care offers a more humanistic end-of-life action plan based on the patients’ needs. One of the components of this model, the spiritual accompaniment, seems particularly innovative given the lay character of the medical field. This article will first focus on the relation to religion in our societies and on the context in which the necessity to care for patients spirituality appears. Then, the approach will be described and aspects of an ethnographical survey carried out at Fondation Rive-Neuve in Villeneuve will be reported. The study showed that patients and care givers seldom speak about spiritual care or needs, although this dimension is central for this institution which planned several activities to allow spiritual care. How can this statement be understood? The possibility of introducing discussion about spirituality in such institution will be questioned, as well as the difference between spiritual and psychological care, the latter being common in the health professionals’ discourse. The non-verbal expression of the spirituality of the patients will also raise some questions whereas care givers’ need for spirituality as they face patient’s end-of-life doesn’t seem unimportant. | *Spiritual support: between care plan and lack of discourse* – In our highly medicalized societies, palliative care offers a more humane end-of-life care plan based on the patients’ needs. One of the components of this model, the spiritual support, seems particularly innovative given the secular character of the medical field. This article will first focus on the relationship with religion in our societies, and on the context in which the necessity to care for patients’ spirituality appears. Then, the approach will be described and aspects of an ethnographical survey carried out at the Fondation Rive-Neuve in Villeneuve will be reported. The study showed that patients and medical staff seldom speak about spiritual support or needs, although this dimension is central for this institution; a number of activities have even been planned to allow for spiritual support. How can this be interpreted? The possibility of introducing a discussion about spirituality in this institution will be questioned, as well as the difference between spiritual and psychological support—the latter being common in health professionals’ discourse. The non-verbal expression of patients’ spirituality will also be considered. Also, medical staff’s need for spirituality, as they face the patient’s death, seems equally relevant. |
| INKA\_063\_0109-AT | editing | L'accompagnement spirituel : entre dispositif de prise en charge et absence de discours | Spiritual accompaniment: between care plan and lack of discourse | Spiritual Support: between Therapy and Lack of Discourse |
| INKA\_063\_0115-AT | editing | La notion de soutien dans le cadre d'une équipe belge de soins palliatifs à domicile | The notion of support in a home-based Belgian palliative care team | The notion of Support in a Home-Based Belgian Palliative Care Team |
| INKA\_064\_0141-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_064\_0143-AB | editing | La douleur d’origine cancéreuse est très fréquente en clinique. Elle peut révéler une maladie néoplasique et témoigne de son évolution. Elle se manifeste de multiples façons en mêlant l’excès de nociception, l’intégrité des voies de transmission et l’interprétation du signal. La douleur retentit non seulement sur la personne malade mais aussi sur son entourage. Elle peut être spécifique de certains cancers, de la personne qui en souffre, de son environnement ainsi que des manœuvres diagnostiques ou thérapeutiques. La douleur constitue donc un élément de vulnérabilité et de fragilité du patient qui peut être encore majoré en présence de difficultés de communication. Les objectifs du traitement de la douleur cancéreuse obéissent à des principes stricts d’évaluation et de mesure qui s’inscrivent dans une démarche éthique de qualité des soins. L’ensemble des moyens thérapeutiques à visée symptomatique ou étiologique sera mis en œuvre de manière conjointe et personnalisée afin de préserver ou de restaurer la qualité de vie du patient. | Cancer pain is frequent in clinical practice. Pain may reveal the existence of neoplastic disease. It can be the witness of its progression. Nociceptive excess, integrity of transmission and signal interpretation may influence the various manifestations of pain.Not only does pain interfere on patients life but also on their relatives. Pain may be specific of some cancers, of the suffering person, of its environment and of diagnostic and therapeutic manœuvres.Pain thus constitutes an indicator of patient’s vulnerability and frailty which may become worse in the presence of communication impairment.Treatment objectives of cancer pain follow strict evaluation measures and ethic principles of quality of care. Symptomatic and etiologic treatments should work together to maintain or restore patient’s quality of life. | Cancer pain is frequent in clinical practice. Pain may reveal the existence of a neoplastic disease, and can reveal its progression. Nociceptive excess, integrity of transmission and signal interpretation may influence the various manifestations of pain. Not only does pain interfere with patients’ life but also with their relatives’. Pain may be specific to some cancers, to the suffering person, to its environment and to diagnostic and therapeutic tools. Pain is an aspect of the patient’s vulnerability and frailty, which may become worse when communication is impaired. The goals of cancer pain treatment follow strict evaluation measures and ethic principles of quality of care. Symptomatic and etiologic treatments should work together to maintain or restore the patient’s quality of life. |
| INKA\_064\_0143-AT | editing | La douleur du patient atteint de cancer : du diagnostic de la récidive au traitement adapté | Pain in cancer patient | Pain in Cancer Patients |
| INKA\_064\_0149-AT | editing | Intérêt des techniques d'anesthésie loco-régionales dans un service d'accompagnement et de soins palliatifs | Usefulness of loco-regional anesthesia techniques in a palliative care and end-of-life unit | Usefulness of Locoregional Anesthesia Techniques in a Palliative care and Support Unit |
| INKA\_064\_0163-AT | editing | Deuil normal, deuil pathologique et prévention en milieu clinique | Normal bereavement, pathological bereavement, and prevention in clinical practice | Normal Grief, Pathological Grief, and Prevention in Clinical Practice |
| INKA\_064\_0163-ST | editing | "Forum" | Forum | Forum |
| INKA\_064\_0167-ST | editing |   | Forum | Forum |
| INKA\_071\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_071\_0003-AT | editing | La gestion du deuil des soignants confrontés quotidiennement à la mort : recherche dans une unité de soins palliatifs | How carers who are daily confronted with death deal with loss and mourning: research in a palliative care unit | Medical Staff and Grief: Research in a Palliative Care Unit |
| INKA\_071\_0013-AT | editing | La dépression dans les maladies fatales | Depression in fatal disease | Depression in Fatal Diseases |
| INKA\_071\_0019-AT | editing | La transdisciplinarité : une condition préalable à la pratique des soins palliatifs | Transdisciplinarity: a prerequisite for palliative care practice | Transdisciplinarity: A Prerequisite for Palliative Care Practice |
| INKA\_071\_0023-AB | editing | Face aux symptômes provoqués par une obstruction intestinale cancéreuse irréversible, une intervention chirurgicale présente un risque non négligeable de mortalité et de morbidité. L’administration d’octréotide en association avec d’autres mesures médicamenteuses conventionnelles peut alors constituer une alternative favorable et efficace pendant plusieurs semaines. La description de 4 situations cliniques suggère aussi que la mise en place d’une sonde naso-gastrique d’aspiration n’est pas inéluctable et que les douleurs et l’inconfort général sont maîtrisables jusqu’au décès qui est survenu en moyenne 57 jours après le diagnostic de l’obstruction. De plus, la disponibilité d’analogues de la somatostatine à plus longue demi-vie pourrait permettre le maintien à domicile des patients qui devraient être autrement hospitalisés. | In the case of an irreversible malignant intestinal obstruction, surgery carries important mortality and morbidity risks. The administration of octreotide together with other conventional drugs represents a favourable alternative that is effective for many weeks. Description of 4 clinical cases suggests that insertion of a naso-gastric tube may then be avoided most of the time. In addition, pain and general discomfort appear manageable until death which occurred 51 to 64 days after diagnosis of obstruction. Finally, somatostatine analogues with longer half-life could help maintain patients at home rather than in hospitals. | In the case of an irreversible malignant intestinal obstruction, surgery carries important mortality and morbidity risks. The administration of octreotide together with other conventional drugs represents a favorable and effective alternative for a number of weeks. Description of 4 clinical cases suggests that insertion of a naso-gastric tube may be avoided, and that pain and general discomfort can be managed until death, which occurred on average 57 days after the diagnosis of obstruction. Finally, somatostatine analogues with longer half-life could help keep patients at home rather than in hospitals. |
| INKA\_071\_0023-AT | editing | Le rôle exceptionnel de l'octréotide dans le traitement symptomatique de l'occlusion intestinale tumorale irréversible : à propos de quelques observations cliniques en médecine palliative | The exceptional role of octreotide in the symptomatic treatment of malignant irreversible intestinal obstruction: about of few clinical observa-tions in palliative medicine | The Exceptional Role of Octreotide in the Symptomatic Treatment of Malignant Irreversible Intestinal Obstruction: Some Clinical Observations in Palliative Medicine |
| INKA\_071\_0027-ST | editing | "Forum" | Forum | Forum |
| INKA\_072\_0033-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_072\_0035-AT | editing | Comment la personne atteinte d'une maladie cancéreuse vit-elle la confiance ? | How do persons living with cancer experience trust | Cancer and Trust |
| INKA\_072\_0045-AB | editing | Des manifestations cutanées d’Herpès Simplex Virus (HSV) de localisation postérieure, sont étudiées systématiquement dans un service de soins palliatifs. Six femmes et trois hommes âgés de 60 à 80 ans souffrant tous d’un cancer métastasé sont décrits. HSV-2 était confirmé par immunofluorescence dans 7 prélèvements sur 10. Sous traitement, 2 patients ont cicatrisé et 7 patients ont été rapidement soulagés mais sont décédés de leur cancer avant guérison de l’herpès. Cette forme d’herpès doit être détectée et traitée précocement. Son aspect parfois atypique ou associé à des escarres incite à confirmer le diagnostic. | Posterior sites of cutaneous Herpes Simplex virus (HVS) are systematically studies in a palliative care unit. Six women and three men aged 60 to 80 years and suffering from metastatic cancer are described. HSV-2 was confirmed by immunofluorescence in 7 of 10 samples. When treated was administered, the lesions healed in 2 patients and were markedly alleviated in 7 who died of their cancer before the lesions cleared. This form of HSV should be detected and treated early. Atypical presentation resembling pressure ulcers requires laboratory confirmation of the diagnosis. | Posterior instances of cutaneous Herpes Simplex virus (HVS) are systematically studies in a palliative care unit. Six women and three men aged 60 to 80 and suffering from metastatic cancer are described. HSV-2 was confirmed by immunofluorescence in 7 out of 10 samples. When treatment was administered, the lesions healed for 2 patients, and were markedly alleviated in 7 who died of their cancer before the lesions cleared. This form of HSV should be detected and treated early. Its presentation, sometimes atypical or resembling pressure ulcers requires laboratory confirmation of the diagnosis. |
| INKA\_072\_0045-AT | editing | Lésions d'escarres ou d'herpès : expérience en soins palliatifs | Herpetic lesions or pressure ulcers: experience in palliative care | Herpetic Lesions or Pressure Ulcers: Experience in Palliative Care |
| INKA\_072\_0049-AT | editing | Cancer chez la personne âgée : démarche oncogériatrique et dépistage des patients fragiles pour une prise en charge optimale | Cancer in the elderly: oncogeriatric approach and screening of frail individuals to enhance the quality of care | Cancer in the Elderly: Oncogeriatric Approach and Screening of Frail Individuals to Enhance the Quality of Care |
| INKA\_073\_0061-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_073\_0063-AB | editing | La prévalence de la douleur chez la personne âgée vivant à domicile ou dans les établissements médico-sociaux (EMS) est très grande et ceci malgré les moyens médicaux qui sont bien connus et dont l’efficacité est prouvée. Depuis plusieurs années, l’association « Ensemble contre la douleur » mêne des campagnes, dont l’une d’elles, « Vers un milieu de vie sans douleur » porte sur la prise en considération et le soulagement de toutes les formes de douleur dans les EMS. En suivant le protocole de cette association, nous avons mené une campagne dans notre EMS du 21 mars 2003 au 21 mars 2006, soit une période de 3 ans, qui porte d’une part sur une approche clinique de la douleur et d’autre part sur la consommation d’antalgiques et de neuroleptiques. L’évaluation de la douleur a été réalisée grâce aux questionnaires d’hétéro évaluation, par le personnel soignant, chaque fois que des modifications du comportement d’un résident ont été observées. Puis le score de l’évaluation a été analysé avec les médecins traitants et le traitement antalgique adapté en conséquence. Chaque semaine, la consommation des antalgiques de tous les résidents a été relevée. En fin d’années nous avons établi la consommation annuelle des neuroleptiques. Le dynamisme du personnel soignant, engendré par cette campagne contre la douleur, donne des résultats tangibles. La consommation des antalgiques a nettement augmenté. Le nombre de résidents traités efficacement contre la douleur a passé de 32% à près de 70%. La consommation des neuroleptiques a diminué de 27 à 37% selon les années. La prise en compte des signes cliniques de la douleur, par le personnel soignant, dans le cadre des activités auprès des résidents rend possible une meilleure prise en charge de la douleur. | Prevalence of pain in elderly persons living at home or in nursing facilities is very high, despite well-known and effective medical therapies. For several years, the association « Together against pain » leads campaigns, one of which, « Towards a pain-free life-space » targets awareness and management of pain in nursing homes. Following this association’s protocol, we led a campaign in our facility from March 21rst 2003 to March 21rst 2006, for a period of three years, targeting a clinical approach to pain, and the use of analgesic and neuroleptic medication. Hetero-evaluation questionnaires were used for pain evaluation by health care providers every time behavior change was noted in a resident. Scores were evaluated with primary care physicians and analgesia adapted accordingly. Analgesic use was evaluated every week for each resident. At the end of the year, we determined the yearly use. The health care team’s motivation, generated through this campaign, yielded tangible results. Analgesic use increased markedly. The number of residents effectively treated went from 32% to almost 70%. Neuroleptic use decreased from 27 to 37% depending on baseline year. Awareness of clinical signs of pain within activities with residents foster improvement in pain management. | Prevalence of pain in elderly people living at home or in nursing care facilities is very high, despite well-known and effective medical therapies. For several years, the association “Together against pain” has led campaigns, one of which (“Towards a pain-free life”) targets awareness and management of pain in nursing homes. Following this association’s protocol, we led a campaign in our facility from March 21, 2003 to March 21, 2006, for a period of three years, targeting a clinical approach to pain, and the use of analgesic and neuroleptic medication. Hetero-evaluation questionnaires were used for pain evaluation by health care providers every time behavior change was noted in a resident. Scores were evaluated with primary care physicians, and analgesia was adapted accordingly. Analgesic use was evaluated every week for each resident. At the end of the year, we determined the yearly use. The health care team’s motivation, generated through this campaign, yielded tangible results. Analgesic use increased markedly. The number of residents effectively treated went from 32% to almost 70%. Neuroleptic use decreased from 27% to 37% depending on baseline year. Awareness of clinical signs of pain in the context of the activities with residents fosters improvement in pain management. |
| INKA\_073\_0063-AT | editing | « Vers un milieu de vie sans douleur ».  | «Towards a pain-free life-space» Mobilization of one health care team to relieve and combat pain of elderley persons living in nursing homefacilities | “Towards a Pain-free Life”: Relieving Pain in Elderly Residents of a Nursing Home |
| INKA\_073\_0069-AT | editing | Représentations associées aux soins palliatifs chez des internes : impact des pratiques et de l'opinion vis-à-vis de l'euthanasie | Representations associated with palliative care among residents- impact of practices and opinions regarding euthanasia | Representations of Palliative Care Among Residents: Impact of Practices and Opinions on Euthanasia |
| INKA\_073\_0075-AT | editing | Effet antalgique des bisphosphonates en médecine palliative : mythes et réalités | Analgesic effect of bisphosphonates in palliative medicine:myths and realities | Analgesic Effect of Bisphosphonates in Palliative Medicine: Myths and Reality  |
| INKA\_073\_0079-AT | editing | L'espace spirituel et l'art-thérapie en soins palliatifs | Spiritual space and art therapy in palliative care | Spirituality and Art Therapy in Palliative Care |
| INKA\_073\_0079-ST | editing | "Forum" | Forum | Forum |
| INKA\_074\_0093-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_074\_0095-AT | editing | Place des neuroleptiques atypiques dans la prise en charge du delirium et des nausées chez le patient palliatif | The place of atypical neuroleptics in the management of delirium and nausea in the palliative patient | The Role of Atypical Neuroleptics in the Management of Delirium and Nausea in the Palliative Patient |
| INKA\_074\_0105-AT | editing | Qualité de vie en soins palliatifs : discours et représentations des patients | Quality of life in palliative care: patients’ discourse and representations | Quality of Life in Palliative Care: Patients’ Discourses and Representations |
| INKA\_074\_0111-AT | editing | Une expérience de réflexologie dans une unité de soins palliatifs | An experience of reflexology in a palliative care unit | Reflexology in a Palliative Care Unit |
| INKA\_074\_0119-ST | editing | "Forum" | Forum | Forum |
| INKA\_081\_0001-AT | editing | Editorial | Editorial | Editorial |
| INKA\_082\_0049-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_082\_0051-AT | editing | Vécus, pratiques et représentations associés aux soins palliatifs : une étude auprès d'infirmie(è)r(e)s | Living experience, practices and representations associated with palliative care: a study among nurses | Experiences, Practices and Representations Associated with Palliative Care: A Study Among Nurses |
| INKA\_082\_0061-AT | editing | Quelle est la légitimité des approches psycho-corporelles dans les unités de soins palliatifs ? | What legitimacy for mind-body approaches in palliative care units? | Legitimacy of Mind-Body Approaches in Palliative Care Units |
| INKA\_082\_0067-AT | editing | Gestion par une unité de soins palliatifs d'une situation conflictuelle autour d'un patient | Management of a conflict situation surrounding a patient by a palliative care unit | Palliative Care Unit Management of a Conflict Surrounding a Patient  |
| INKA\_082\_0071-ST | editing | "Forum" | Forum | Forum |
| INKA\_082\_0079-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_083\_0081-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_083\_0083-AT | editing | Problèmes éthiques soulevés par la prise en charge thérapeutique des patients âgés déments atteints de cancer | Ethical issues in caring for elderly dementia patients with cancer | Ethical Issues in Caring for Elderly Dementia Patients with Cancer |
| INKA\_083\_0099-ST | editing | "Forum" | Forum | Forum |
| INKA\_083\_0103-ST | editing |   | Forum | Forum |
| INKA\_083\_0126-AT | editing | Nous avons reçu | New publications  | New publications  |
| INKA\_084\_0129-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_084\_0163-AT | editing | Nous avons reçu | New publications  | New publications  |
| INKA\_091\_0001-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_091\_0003-AB | editing | Le cours de soins palliatifs de huit heures destiné aux étudiants de 4e année de médecine a été complètement revu. Il intègre de nouvelles méthodes pédagogiques telles que l’apprentissage par problème, l’apprentissage en petits groupes et l’apprentissage par voie informatique *(e-learning)*. Les objectifs d’apprentissage recherchés visent à élargir voire modifier les attitudes à adopter face à des patients en fin de vie. Un cadre d’évaluation, sur la base d’un questionnaire, a été développé pour évaluer les domaines suivants : a) le vécu de l’étudiant en rapport avec le cours (questions fermées et semi-ouvertes, « focus » groupe) ; b) le changement au niveau des attitudes (questionnaire de 10 items de type Likert) ; c) les changements dans l’auto-perception des compétences (questionnaire de 7 items de type Likert) ; d) les modifications au niveau des connaissances. Les étudiants ont rempli le questionnaire « avant » et « directement après » le cours. Entre 45 et 74 étudiants sur 104 ont participé aux différents modules du cours. En comparaison à l’année précédente, la participation au cours a augmenté (de 21 à 45 étudiants). Quatre items, permettent de relever une amélioration significative de l’attitude. Le changement dans l’auto-perception des compétences se retrouve dans tous les items. Seul un item met en évidence les modifications sur le plan des connaissances (définition de la dyspnée). Par ailleurs, les résultats montrent que les soins palliatifs actifs peuvent être gratifiants du point de vue des étudiants. Le cours a permis de contribuer à un changement d’attitudes des étudiants envers les patients en fin de vie. Il n’est pas surprenant que le domaine des connaissances ne se soit pas amélioré au vu du faible taux de participation aux modules *e-learning*. Le cadre d’évaluation mis en place ainsi que les résultats obtenus permettront de préparer et d’évaluer d’autres cours. | In 2007, the 8-hour palliative care course in the 4th year of the University of Lausanne’s undergraduate medical curriculum was revised to incorporate interactive learning methods, small-group problem-based learning and some limited computer-based learning (e-learning). Clearer learning objectives (focusing on changes in attitudes towards caring for the dying) were formulated. The goal of this study was to develop an appropriate evaluation framework and assess the impact of this course. An evaluation framework was developed that evaluated the following domains : a) the student’s experience with the course and its various elements (closed and open-ended questions, focus group) ; b) changes in attitudes (a 10-item survey) ; c) changes in self-perceived competency levels (7-item survey) ; and d) knowledge. Students completed the surveys pre- and immediately post-course. Forty-five to 74 out of 104 students participated in the course sessions. This was improved from the previous years’ 21 to 45 students. There were significant improvements in 4 of the attitudinal items. Self-perceived competency levels improved across all items from generally very low to medium-range. Students improved their knowledge in only one item ; assessment of dyspnea. Students viewed palliative care more as active care and thought of it as more professionally satisfying after the course. Overall, the course was evaluated very positively by the students. The course was able to positively improve student’s attitudes towards caring for dying persons. It made them feel more comfortable. Since the knowledge domain was largely addressed through the e-learning modules (because of time limitations) and few students accessed these, there was surprisingly no improvements in that domain. This evaluation framework appears useful to evaluate other similar courses. The results will assist in further development of the course. | In 2007, an eight-hour palliative care course (part of the fourth year undergraduate medical curriculum) at the University of Lausanne was revised to incorporate interactive learning methods, small-group problem-based learning, and some limited computer-based learning (e-learning). Clearer learning objectives (focusing on changes in attitudes towards terminal patients) were formulated. This study developed an appropriate evaluation framework (based on a questionnaire) to assess the impact of this course, by measuring: a) the student’s experience of the course and its various elements (closed and open-ended questions, focus group); b) changes in attitudes (a 10-item Likert scale); c) changes in self-perceived competency levels (7-item Likert scale); and d) knowledge. Students completed the surveys before and immediately after the course. Between 45 and 74 students out of 104 participated in the various modules of the course. This was an improvement from previous years’ numbers (between 21 and 45). There were significant improvements in four of the attitudinal items. Self-perceived competency levels improved across all items, from generally very low to medium. Only one item showed changes in students’ knowledge: the definition of dyspnea. Generally, students viewed palliative care as more active care and considered it more professionally satisfying after the course. Overall, the course received very positive feedback by the students. The course was able to positively improve student’s attitudes towards caring for terminal patients. It made them feel more comfortable. Since the knowledge domain was largely addressed through the e-learning modules (because of time limitations) and few students accessed these, there was unsurprisingly no improvement in that domain. This evaluation framework appears useful to evaluate similar courses. The results will assist the course’s further development. |
| INKA\_091\_0027-ST | editing | "Forum" | Forum | Forum |
| INKA\_091\_0031-ST | editing |   | Forum | Forum |
| INKA\_091\_0035-ST | editing |   | Forum | Forum |
| INKA\_091\_0036-ST | editing |   | Forum | Forum |
| INKA\_091\_0047-AT | editing | Nous avons reçu | New publications  | New publications  |
| INKA\_092\_0053-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_092\_0055-AT | editing | De l'enquête au soutien des parents endeuillés | Grieving families – from exploration to support | Grieving Families: From Research to Support |
| INKA\_092\_0061-AT | editing | A propos de la mise en place des soins de support en cancérologie : pistes de réflexions et propositions | On setting up a support care unit in oncology : reflection and a proposal | Implementation of a Support Care Unit in Oncology: Reflection and a Proposal |
| INKA\_093\_0097-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_093\_0099-AT | editing | Bronchopneumopathie chronique obstructive : quelle place pour les soins palliatifs ? | Chronic Obstructive Pulmonary Disease : what place for palliative care ? | Chronic Obstructive Pulmonary Disease: what place for palliative care? |
| INKA\_093\_0141-AT | editing | Soins pour la famille ou avec la famille ? | Care of the family or with the family ? | Caring for the Family or with the Family? |
| INKA\_093\_0147-AB | editing | Le temps n’a pas la même valeur selon le degré de la maladie. Le sens des choses non plus. La notion de soins d’esthétique passe ainsi, en soins palliatifs, de la futilité à une forme particulière de la relation humaine entre l’esthéticienne et le malade qui devient un échange ou se côtoient une forme de perception d’éternité et un effet miroir. | Time has a different value with the degree of the illness. As does the meaning of things. The notion of aesthetic care would thus, within palliative care, move from futility to a particular perception of human relation between the beauty specialist and the patient who becomes an exchange where a form of perception of eternity, and mirror effects, walk alongside. | Time has a different meaning depending on the degree of the illness, as do things. Thus, the notion of cosmetic treatments in palliative care shifts from futility to a particular form of the human relationship between the beauty therapist and the patient: in this exchange, perceptions of eternity and mirror effects go hand in hand. |
| INKA\_093\_0147-AT | editing | Esthétique et temps en soins palliatifs | Aesthetic and time in palliative care | Beauty and Time in Palliative Care |
| INKA\_093\_0147-ST | editing | "Forum" | Forum | Forum |
| INKA\_093\_0153-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_094\_0157-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_094\_0165-AB | editing | L’idée même de la fin de vie laisse certains patients figés dans leur corps et leur psychisme. L’hypnose par son approche spécifique et par l’apprentissage de la transe permet aux personnes de reprendre contact avec leur corps et leurs émotions. En apprenant à changer son regard, la personne opère un décalage qui permet de débloquer une situation figée. Un traumatisme, la maladie grave, la douleur, peuvent ainsi être pensés différemment, on observe alors un lâcher prise sur d’anciennes peurs et d’anciennes façons de penser. Le corps est vécu différemment, il est bien vivant jusqu’au bout... | The very idea of the end of life leaves some patients rigid in their bodies and psyche. Hypnosis, through its specific approach and by teaching trance, allows people to reconnect with their bodies and emotions. By learning to change the angle of vision, the person can operate a shift, enabling her to unblock a frozen situation. Traumatism, serious illness, and pain can thus be thought through differently, leading to a letting go of former fears and ways of thinking. The body is experienced differently, as alive to the end... | The very idea of death leaves some patients stupefied in their bodies and minds. Hypnosis, through its specific approach and by teaching a state of trance, allows people to reconnect with their bodies and emotions. By learning to change perspective, the person can operate a shift and unlock a blocked situation. Trauma, severe illness, and pain can be considered differently, letting go of former fears and ways of thinking. The body is experienced differently, and is alive until the end. |
| INKA\_094\_0165-AT | editing | Hypnose et lâcher prise en soins palliatifs : à propos d'une situation clinique | Hypnosis and letting go in palliative care : a clinical case discussion | Hypnosis and Letting Go in Palliative Care: A Clinical Case  |
| INKA\_094\_0169-ST | editing | "Forum" | Forum | Forum |
| INKA\_094\_0173-ST | editing |   | Forum | Forum |
| INKA\_101\_0003-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_101\_0005-AB | editing | Sans doute l’une des plus profondes et des plus durables révolutions ayant marqué l’histoire humaine, la transition démographique caractérisant notre époque entraîne une redéfinition complète de notre rapport au temps et à la mort. Associée à la mort et à la dégénérescence, la vieillesse apparaît désormais comme une tare, comme un fléau contre lequel il faut absolument lutter. Traçant un parallèle entre les statuts des personnes âgées et les avancées biomédicales liées à la lutte anti-âge, cet article analyse les conséquences sociales et éthiques de la volonté de vaincre scientifiquement la mort, de vivre sans vieillir et d’étendre indéfiniment la durée de vie. | The demographic transition that characterizes our era is undoubtedly one of the most profound and sustained revolution marking human history. As such, it redefines our relationship with time and death. Associated with death and degeneration, old age now seems like a medical defect or a curse against which one must struggle. Drawing a parallel between the status of older people and the biomedical advances’ linked to the fight against ageing, this article will investigate the social and ethical consequences of this desire to scientifically conquer death, to live without ageing and to extend life indefinitely. | The demographic transition that characterizes our era is undoubtedly one of the most profound and sustained revolutions in human history. As such, it redefines our relationship with time and death. Associated with death and degeneration, old age now seems like a medical defect or a curse against which one must fight. Drawing a parallel between the status of elderly people and biomedical advances in the fight against ageing, this article will investigate the social and ethical consequences of this desire to conquer death scientifically, to live without aging, and to extend life indefinitely. |
| INKA\_101\_0024-AB | editing | Pour répondre aux enjeux d’une fin de vie digne en maison de retraite médicalisée, la santé publique participe à justifier et à promouvoir le développement de « bonnes pratiques » en soins palliatifs de base. Toutefois, la diffusion d’une telle démarche n’est pas donnée d’emblée, elle s’inscrit, se construit, se transforme et se trouve légitimée à travers des relations sociales et des rapports sociaux, fondés sur des intérêts et des objectifs parfois contradictoires. Pour interroger ce processus, cet article traite de l’introduction d’outils d’évaluation de la douleur et de symptômes liés à la fin de vie au sein de maison de retraite médicalisée et dans le cadre d’une politique de santé. À partir d’une enquête ethnographique, l’accent est mis sur les manières dont les différents acteurs (médecins, infirmières, aides-soignantes, institutions) accueillent, se réapproprient et tentent de concrétiser au quotidien cette problématique. Cet article explore ainsi quelques enjeux sociaux, politiques et moraux liés à cette démarche d’évaluation pour montrer comment elle déborde de la sphère des compétences strictement médicales et soignantes. | To maintain dignity at the end-of-life in nursing homes, public health justifies and promotes the development of « good practices » in basic palliative care. However, the diffusion of such process is complex ; it is in line with, it builds and transforms itself and it is legitimated through social relations, based on sometimes contradictory interests and objectives. In order to question the process, this article deals with the introduction of the pain and symptoms assessment linked to the end of life in nursing homes within a health politics framework. From an ethnographic investigation, the emphasis is put on the ways different actors (physicians, nurses, nursing auxiliary, institutions) receive, reappropriate and try to make this issue a daily reality. This article explores some social, political and moral issues linked to the evaluation process in order to highlight how it goes beyond the sphere of strictly medical and nursing skills. | To maintain the dignity of nursing home patients at the end of their lives, public health justifies and promotes the development of “good practices” in basic palliative care. However, the diffusion of this process is complex; it is part of, and it is constructed, transformed and legitimated through, social relations, based on sometimes contradictory interests and objectives. In order to examine this process, this article deals with the introduction in nursing homes of tools for the assessment of pain and symptoms linked to the end of life, in a health policy framework. Based on an ethnographic investigation, the emphasis is put on the ways different actors (physicians, nurses, nursing auxiliaries, institutions) receive, appropriate and translate this issue into practice on a daily basis. This article explores some social, political and moral issues linked to the evaluation process in order to highlight how it goes beyond the sphere of strictly medical and nursing skills. |
| INKA\_101\_0030-AB | editing | Sur la base de données ethnographiques rendant compte d’échanges quotidiens entre une équipe mobile de soins palliatifs et différents services de « première ligne » d’un hôpital, cet article considère les relations d’intermédicalité entre ces cultures médicales divergentes. Dans un premier temps, les obstacles qui émergent lors de tentatives d’intégration du nouveau modèle proposé par les soins palliatifs seront discutés. En effet, celui-ci introduit une conception nouvelle de la trajectoire de la maladie incurable traduisant des valeurs fondamentales telles que prendre du temps et s’adapter aux besoins du patient tout en soulageant efficacement les symptômes liés à l’incurabilité et à la fin de vie. Les données recueillies dans cette enquête montrent que, tout en se confrontant à l’ordre hospitalier, les soins palliatifs participent dans une certaine mesure au renouvellement de pratiques institutionnelles. Dans un deuxième temps, ces confrontations et transformations seront lues à la lumière d’enjeux de pouvoir sous-jacents influençant le processus de reconnaissance des soins palliatifs dans le champ médical. En tant que nouvelle spécialité « à contre-courant », une forte adaptation est requise laissant poindre le risque d’assimilation de l’équipe mobile à l’institution hospitalière. | Based on ethnographic data describing daily interactions between a palliative mobile team and various « first line » units in the hospital setting, this paper considers relations of inter-medicality between these divergent medical cultures. Emerging tensions while attempting to integrate the new model proposed by palliative care in the hospital setting will first be discussed. It actually introduces a new conception of incurable illness trajectory with core palliative values such as taking time and adapting to the patient’s needs while efficiently relieving the symptom due to incurability and end of life. Data show that palliative care while being confronted to hospital organization, participate to some extent, to renew institutional practices. Such confrontations and transformations will then be linked to the underlying power struggle influencing the recognition of palliative care within the medical field. As a new divergent specialty, strong adaptation is required foreseeing the risk of the mobile team’s assimilation to the hospital institution. | Based on ethnographic data on the daily interactions between a palliative mobile team and various first-line units in the hospital setting, this paper considers relationships of intermedicality between divergent medical cultures. Firstly, we will discuss the tensions that emerge while attempting to integrate the new model proposed by palliative care in the hospital setting. This model introduces a new conception of the trajectory of incurable illnesses, with core values such as taking time and adapting to the patient’s needs—while effectively relieving the symptoms linked to the incurability of illnesses and the proximity of death. Data show that palliative care, while being confronted to hospital organization, contributes to some extent to a renewal of institutional practices. Such confrontations and transformations will be interpreted in light of the power struggle underlying the recognition of palliative care within the medical field. As a new “alternative” specialty, it requires a great deal of adaptation, suggesting the risk of assimilation to the hospital institution for the mobile team. |
| INKA\_101\_0037-AB | editing | Dans le contexte social d’incertitude de la fin de vie, le passage d’une médecine curative à des soins palliatifs nécessite toujours des choix et des décisions ; questionner les enjeux et les implications de cette frontière mouvante revient à interroger les interactions qui la définissent. De quelle manière les exigences biomédicales, humaines et relationnelles des soins palliatifs et de la médecine curative sont-elles en convergence ou en opposition ? Comment penser les soins palliatifs au sein de la médecine en général ? En esquissant quelques pistes de réflexion, cet article interroge la difficulté des soins palliatifs à concilier l’inconciliable, à innover par rapport à la médecine, tout en cherchant à asseoir sa légitimité. | Facing the social uncertainty of the end of life, the medical transition from a curative to a palliative medicine implies some critical decisions : to grasp the issues of such moving boundary, one needs to analyse the interactions that determine its definition. Are the biomedical, human and relational requirements of palliative care and of curative medicine converging or do they contradict each other ? How can one define palliative care within medicine in general ? This article addresses and offers some tentative answers to the challenge of palliative care in its attempt to reconcile the irreconcilable : to innovate in front of medicine while legitimising itself. | Facing the social uncertainty of the end of life, the medical transition from a curative to a palliative medicine implies some critical decisions: to grasp the issues of this shifting boundary, the interactions that determine it must be analyzed. How are the biomedical, human and relational requirements of palliative care and of curative medicine converging or contradicting each other? What is the place of palliative care within medicine in general? This article offers some reflections on palliative care’s difficulty in reconciling the irreconcilable: to bring innovation to medicine, while trying to assert its legitimacy. |
| INKA\_102\_0045-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_103\_0103-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_103\_0121-ST | editing | "Forum" | Forum | Forum |
| INKA\_104\_0147-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_104\_0175-ST | editing | "Notes de lecture" | Reviews | Reviews |
| INKA\_111\_0003-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_113\_0269-AB | editing | En soins palliatifs, la crise d’identité est un concept fondamental pour comprendre la détresse d’un patient. La pathologie mortelle rompt douloureusement la perception d’une continuité de l’existence. Le patient se découvre étranger à lui-même, ce qui peut l’amener à demander une aide psychologique pour se relier à soi. L’objectif de cette étude est d’explorer l’identité des patients accompagnés psychologiquement et les caractéristiques de leurs suivis. Méthode : quatorze psychologues intervenant en soins palliatifs dans une région française remplissent pour chaque suivi un livret d’analyse. Résultats : les 100 premiers patients sont suivis à l’aide de 284 entretiens débutant généralement six semaines avant leur décès. Ils sont en majorité des hommes dans la soixantaine et les psychologues des femmes trentenaires. Discussion : l’âge relativement jeune des patients laisse présumer un rôle de l’âge dans le besoin d’entretien. Ce profil des patients et des psychologues instaure dans les suivis une altérité des sexes et des générations. Cette étude se poursuit par une analyse du contenu des entretiens, notamment des liens entre détresse, crise d’identité et mécanismes de défense. Elle associe, en 2011, un second groupe de psychologues réuni par le collège des psychologues de la Société française d’accompagnement et de soins palliatifs. | In palliative care, the identity crisis is a fundamental concept in order to understand patient’s distress. A fatal disease painfully breaks the perception of life’s continuity. The patient finds himself a stranger to himself, which can lead him seek psychological to find a connection to himself again. The purpose of this study is to explore the identity of patients in counseling and the characteristics of their follow-ups. Method : 14 psychologists involved in palliative care in a French region completed a booklet of analysis for each patient. Results : the first 100 patients are tracked through 284 interviews starting often 6 weeks before their deaths. They are mostly men in their sixties and psychologists are women in their thirties. Discussion : the relatively young age of patients suggest a role of age in the need for interviews. This profile of patients and psychologists introduced an otherness of sexes and generations. This study continues with a content analysis of interviews, including links between distress, crisis of identity and defense mechanisms. In 2011, a second group of psychologists brought together by the College of psychologists of the French society for accompaniment and palliative care was associated with the study. | In palliative care, the identity crisis is a fundamental concept in order to understand a patient’s distress. A fatal illness painfully breaks the perception of life’s continuity. Patients become strangers to themselves, which can lead them to seek psychological help in order to rediscover their connection with themselves. The purpose of this study is to explore the identity of patients in counseling and the characteristics of their therapy. Method: 14 psychologists involved in palliative care in a French region completed an analysis report for each patient. Results: the first 100 patients are treated in 284 sessions, starting generally six weeks before their death. They are mostly men in their sixties, and the psychologists are women in their thirties. Discussion: the relatively young age of patients suggest the influence of age in the need for counseling sessions. This profile of patients and psychologists introduced sexual and generational otherness in the therapy. The study continues with content analysis of the interviews, including links between distress, identity crisis and defense mechanisms. In 2011, a second group of psychologists (brought together by the College of Psychologists of the French Society for Palliative Care and Support) joined the study. |
| INKA\_113\_0269-AT | editing | Entretiens psychologiques en soins palliatifs | Psychological interviews in palliative care : patient characteristics, specific follow-up | Psychological Interviews in Palliative Care: Patient Characteristics and Specific Follow-Up |
| INKA\_113\_0277-AT | editing | Les proches impliqués dans une assistance au suicide | Family members involved in assisted suicide | Family Members Involved in Assisted Suicide |
| INKA\_113\_0287-AT | editing | Un an de soins palliatifs au Burkina Faso | One year of palliative care in Burkina Faso | One Year of Palliative Care in Burkina Faso |
| INKA\_113\_0293-AT | editing | Un groupe de parole en soins palliatifs : le groupe comme une peau | A sharing group in palliative care : the group as a skin | A Support Group in Palliative Care: The Group as Skin |
| INKA\_113\_0299-AT | editing | Concept de soins palliatifs en EMS | A palliative care concept in medico-social facilities | A Palliative Care Concept in Nursing Care Facilities |
| INKA\_114\_0311-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_114\_0313-AT | editing | Soins infirmiers et spiritualité : d'une démarche systématique à l'accueil d'une expérience | Nursing and spirituality | Nursing and Spirituality |
| INKA\_114\_0327-AB | editing | A travers notre expérience aux côtés de patients atteints de cancers, nous avons été exposés à une question clinique fondamentale : l’expérience subjective du lien entre les patients et un être aimé. Quelle peut être la teneur des pertes passées lorsqu’un individu, autrefois témoin du cancer chez un proche, s’incarne brutalement acteur dans l’occurrence de cette même pathologie ? Ce « petit bout de savoir en plus » induit par cette place de témoin préalable est ici interrogé dans ce potentiel pathogène souvent annoncé. Il se trouve que ces liens, ainsi revisités, étayent le sujet dans la position de « deuilleur ». Nous serons, nous-mêmes, témoins d’un vécu d’« inquiétante étranget頻 que peut constituer le basculement d’une place de spectateur à celle d’acteur qui précipite le sujet sur la scène dramatique incarnée par son corps blessé. Afin d’étudier ce paysage psychique, nous étayerons notre réflexion à partir de la rencontre avec Mme R. | Through our experience near patients suffering from cancers, we have been exposed to a fundamental clinical question : the subjective experience of patients’ link with love objects. What might be the tone of the patients’ former losses when an individual who witnessed cancer in a loved one suddenly becomes an actor in the occurrence of the same disease ? This «little piece of additional knowledge » brought by this previous witness role is explored here in an often announced pathogenic potential. As it happens, the links thus revisited strengthen the subject in the position of «mourner ». We will, ourselves, witness an experience of «worrying strangeness », which can constitute the shift from spectator to actor, throwing the subject onto the dramatic scene incarnated by his wounded body. To study this psychic landscape, we shall support our reflection by our investigation with Mrs R. | Through our experience with patients suffering from cancer, we have been exposed to a fundamental clinical question: the subjective experience of patients’ bond with love objects. What is the content of former losses, when an individual who has witnessed cancer in a loved one is suddenly inflicted with the same disease? This “little piece of additional knowledge” caused by previous experience is explored in its often clear pathogenic potential. These associations, thus revisited, support the subject in the position of “mourner.” We will witness the “uncanny” experience that can be caused by the shift from spectator to actor, throwing the subject onto the stage of their injured body. To study this psychological landscape, we will support our reflection through our work with Mrs R. |
| INKA\_114\_0327-AT | editing | « Comment dire Je dans un corps qui devient fou ? » | How meet as subject in a body which becomes crazy ? | How Can the Subject Exist in a Body That Is Becoming Crazy? |
| INKA\_114\_0333-ST | editing | "Forum" | Forum | Forum |
| INKA\_114\_0339-ST | editing |   | Forum | Forum |
| INKA\_114\_0345-AT | editing | Notes de lecture | Reviews | Reviews |
| INKA\_121\_0003-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_121\_0005-AB | editing | Les équipes de soins palliatifs sont régulièrement confrontées à la problématique de la nutrition artificielle chez les patients en fin de vie. Nous avons réalisé une étude prospective monocentrique descriptive afin d’évaluer la conformité des prescriptions de nutrition parentérale dans l’Unité de soins palliatifs du Centre Oscar Lambret au regard des recommandations de la Fédération nationale des Centres de lutte contre le cancer (FNCLCC). Dix-neuf patients ont été inclus sur 135 entrées pendant neuf mois. Pour chacun, nous avons recueilli les renseignements cliniques, les paramètres de la nutrition parentérale, et réalisé un suivi clinique et nutritionnel à quinze jours, un mois et deux mois. Dix-sept patients sont décédés moins de trois mois après l’introduction de la nutrition parentérale, et le suivi n’a pu être mené à son terme devant l’altération massive de l’état général de la plupart des patients. Les prescriptions de nutrition parentérale n’étaient donc pas conformes aux Standards, Options et Recommandations (SOR). Il s’agit cependant d’une décision complexe, qui ne peut se limiter à des recommandations et qui doit être intégrée dans une prise en charge globale et individualisée. Cette étude nous a permis de proposer quelques axes d’amélioration afin d’aider l’équipe de l’unité dans sa démarche. | Palliative care teams are regularly faced with the issue of artificial nutrition for terminaly ill patients. We set-up a prospective monocentric descriptive study to evaluate the conformity of parenteral nutrition prescriptions in the Oscar Lambret Center palliative care unit, with the recommendations of the FNCLCC (Fédération Nationale des Centres de Lutte contre le Cancer). During nine months, nineteen patients were included among 135 hospitalizations. For each one we collected the clinical data, the parenteral nutrition parameters, and we managed a clinical and nutritional follow-up at fifteen days, one month and two months. Seventeen patients died less than three months after the start beginning of parenteral nutrition, and follow-up could not be completed due to the rapidly declining health condition of most of the patients. Prescriptions of parenteral nutrition were not in accordance with the recommendations. These are, however rather complex decisions, which cannot limit themselves to strict recommendations and must be part of a global and invidualized patient care approach. This study allowed us to advise the hospital care unit on some improvements to the management of palliative care patients. | Palliative care teams are regularly faced with the issue of artificial nutrition for terminally ill patients. We set up a prospective monocentric descriptive study to evaluate the conformity of parenteral nutrition prescriptions in the palliative care unit of the Oscar Lambret Center with the recommendations of the FNCLCC (Fédération Nationale des Centres de Lutte contre le Cancer). For nine months, nineteen patients were included among 135 hospitalizations. For each one we collected clinical data and parenteral nutrition parameters, and we conducted a clinical and nutritional follow-up at fifteen days, one month and two months. Seventeen patients died less than three months after beginning parenteral nutrition, and follow-up could not be completed due to the rapidly declining health condition of most of the patients. Prescriptions of parenteral nutrition were not in accordance with the Standards, Options and Recommendations. It is however a complex decision, which cannot be limited to strict recommendations and must be part of a global and individualized approach to patient care. This study allowed us to advise the hospital care unit on some improvements to the management of palliative care patients. |
| INKA\_121\_0005-AT | editing | Expérience clinique et réflexions sur la prescription de nutrition parentérale en unité de soins palliatifs dans un centre de lutte contre le cancer | Clinical experiences and thoughts about parenteral nutrition in a palliative care unit of anticancer center | Clinical Experiences and Reflections about Parenteral Nutrition in the Palliative Care Unit of an Anticancer Center |
| INKA\_121\_0013-AT | editing | Connaissance de la loi relative aux droits des malades et la fin de vie dans un CHU : enquête auprès des personnels | Knowledge of the law on patients’ rights at the end of live in a teaching hospital : a health professionals’ survey | Law on Terminal Patients’ Rights in a Teaching Hospital: A Survey of Health Professionals |
| INKA\_121\_0019-AB | editing | L’approche multidisciplinaire est bien valorisée en médecine palliative ainsi que le recours aux thérapeutiques complémentaires. Face à la survenue de nausées et vomissements réfractaires aux médicaments dans un contexte clinique atypique, le recours à l’hypnose médicale a permis un soulagement efficace des symptômes. De surcroît, un bon confort de vie a pu être obtenu jusqu’au décès d’un patient fortement marqué par les expériences précédemment subies en cours de traitement opioïde et le souvenir d’un père mourant de manière douloureuse. | Multidisciplinary approach is widely accepted in palliative medicine together with complimentary therapeutics. In a situation of refractory nausea and vomiting, medical hypnosis was able to efficiently relieve these symptoms in an atypical clinical situation. In addition, adequate comfort was obtained until death for a patient deeply influenced by his prior poor experience with opioids and the memory of a dying father in great pain. | The multidisciplinary approach is widely accepted in palliative medicine together with alternative therapies. In a situation of refractory nausea and vomiting, medical hypnosis was able to efficiently relieve these symptoms in an atypical clinical situation. In addition, adequate comfort could be provided until death for a patient deeply influenced by his poor prior experiences with opioids and the memory of a father who died in pain. |
| INKA\_121\_0019-AT | editing | Symptôme réfractaire, interdisciplinarité et médecine complémentaire | Refractory symptom, interdisciplinarity and complementary medicine | Refractory Symptoms, Interdisciplinarity and Alternative Medicine |
| INKA\_121\_0027-AB | editing | La littérature dans son ensemble aborde souvent l’idée du « vivre ensemble ». Celle-ci n’occulte pas les tensions existantes entre l’individu et le collectif. En soins palliatifs, l’exigence d’approches complémentaires pour une prise en charge globale de la personne et de ses proches est incontournable. Cet article propose d’explorer l’individu dans ses dimensions personnelles et professionnelles et son rapport au collectif. Quelques exemples exposent les enjeux de tensions du travailler et vivre ensemble. | The literature often approaches the idea of « living together ». This however, does not solve tensions existing between individual and collective dimensions of life. In palliative care, the requirement of additional approaches for a global care of the person and his close relations is inescapable. This article offers to explore the individual in its personal and professional dimensions and its report to the collective. Some examples expose the stakes in tensions of to work and to live together. | Literature often approaches the idea of “living together.” This however does not solve the tensions between the individual and collective dimensions of life. In palliative care, the need for alternative approaches for the holistic care of the person and their family is inescapable. This article proposes to explore the individual in their personal and professional dimensions and their relationship to collectivity. Some examples illustrate the issues at stake in working and living together. |
| INKA\_121\_0027-AT | editing | Tension entre individu et collectif : quel équilibre ? | Tension between individual and collectivity : which balance ? | Tension between Individual and Collectivity: Which Balance? |
| INKA\_121\_0027-ST | editing | "Forum" | Forum | Forum |
| INKA\_121\_0033-AB | editing | Préserver l’autonomie pour préserver l’Altérité, considérer le patient comme sujet et éviter l’obstination déraisonnable ou l’abandon de soin. L’autonomie est affaiblie par le fait des troubles cognitifs qui influencent les capacités opérationnelles et décisionnelles. Le consentement du patient se recherche en l’observant, en interrogeant son histoire au travers d’une procédure collégiale qui inclut les désirs du patient, dans une démarche de soins. La responsabilité offre au soignant la possibilité de répondre et d’ajuster la relation soignant-soigné pour suppléer à la perte de l’autonomie en fin de vie d’une personne amoindrie par des troubles cognitifs. La philosophie renforce la réflexion, propose des réponses. La sollicitude ouvre des perspectives soignantes susceptibles de préserver les valeurs du soin. | Preserving autonomy as much as possible in order to preserve Otherness, considering the patient as subject rather than object, and avoiding decisional drifting such as unreasonable obstinacy, accelerating death, or abandoning care. Autonomy is reduced as an effect of cognitive impairment which influence on operational and decisional capacities. A patient’s consent or assent is to be sought by observing her and questioning her story through a collegial process that must include the patient’s wishes and desires, in a care approach requiring time and traceability. Responsibility offers health care providers a possibility of responding and adjusting the provider-patient relationship to complement the loss of autonomy at the end of life for a person who is weakened by cognitive impairment. Philosophy reinforces reflexion, proposes answers. Solicitude opens care provider perspectives likely to preserve the values of care. | Preserving autonomy as much as possible in order to preserve Otherness and considering the patient as subject rather than object—avoiding unreasonable obstinacy or withdrawal of treatment. Autonomy is reduced as an effect of cognitive impairment, which influences the ability to act and make decisions. A patient’s consent is obtained by observing them, by considering their story through a collegial process that must include the patient’s wishes and desires in the approach to treatment. Responsibility offers health care providers a possibility of responding and adjusting the provider-patient relationship to compensate for the loss of autonomy of a person in a terminal stage who is affected by cognitive impairment. Philosophy reinforces reflection and proposes answers. Solicitude allows medical providers to preserve the values of care. |
| INKA\_121\_0033-AT | editing | La vulnérabilité appelle la responsabilité, la sollicitude sauve de la solitude | Vulnerability calls for responsibility, solicitude saves from solitude | Vulnerability Calls for Responsibility; Solicitude Saves from Loneliness |
| INKA\_121\_0033-ST | editing |   | Forum | Forum |
| INKA\_122\_0043-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_122\_0045-AB | editing | Cet article vise à présenter les résultats d’une recherche qualitative originale réalisée auprès d’ergothérapeutes québécoises (Canada) travaillant en soutien à domicile auprès d’une clientèle en phase palliative ou terminale. L’objectif de la recherche était de décrire les pratiques actuelle et idéale de ces professionnelles selon leurs perspectives. L’exercice des métaphores a été utilisé. L’analyse des données révèle que les ergothérapeutes conçoivent leur pratique en manque d’intégration en raison, entre autres, de l’ambiguïté du rôle ou d’une pauvre collaboration interdisciplinaire. Leur souci d’efficacité ne pourra être résolu que par l’accès à un plus grand nombre de ressources, à du soutien et à de la formation portant à la fois sur l’approche spécifique auprès des personnes en soins palliatifs et sur le travail dynamique en équipe. | This article aims to present the results of an original qualitative research conducted with occupational therapists from Quebec (Canada) working in support at home with a palliative or terminal clientele. The objective of this research was to describe the current and ideal practices of these professionals from their perspectives. The exercise of the metaphors was used. The analysis of the data revealed that the occupational therapists perceive their practice as lacking in integration because, for example, of the ambiguity of their role, or poor interdisciplinary collaboration. Their concern for efficacy can be solved only through access to a greater number of resources, to support and to training both on the specific approach in palliative care and dynamic teamwork. | This article aims to present the results of an original qualitative research conducted with occupational therapists from Quebec (Canada) working at home with terminal clients (or in palliative care). The objective of this study was to describe the current and ideal practices of these professionals from their perspectives. Metaphors were used. The analysis of the data revealed that occupational therapists perceive their practice as lacking in integration because (among other reasons) of the ambiguity of their role or poor interdisciplinary collaboration. Their concern for efficacy can be solved only through access to a greater number of resources, support, and training both in the specific approaches to patients in palliative care and to dynamic teamwork. |
| INKA\_122\_0045-AT | editing | Une pratique morcelée qui invite à l'intégration des services | A piecemeal approach which invites integration | A Piecemeal Approach Calling for Service Integration |
| INKA\_122\_0051-AB | editing | Ce travail expose le cas d’une malade atteinte de cancer du sein compliqué de métastases rachidiennes responsables de douleurs rebelles qui a bénéficié de la quasi-totalité de traitements antalgiques actuellement disponibles. Cette observation permet de faire une courte mise au point à visée didactique des différentes techniques et médicaments antalgiques à la disposition de cliniciens en soins palliatifs : PCA oxycodone, TENS, kétamine, samarium, analgésie rachidienne par cathéter intrathécal avec administration de morphine puis de ziconotide et enfin méthadone. | A woman with a breast cancer and spinal bone metastasis was treated for intractable pain. She received almost all the available analgesic treatments.This case report allows for a short didactical review of available treatments available to health professionals in palliative care : patient controlled analgesia, transcutaneous electrical nerve stimulation, ketamine, samarium, intrathécal analgesia either with morphine or ziconotide, and methadone. | A woman with breast cancer and spinal cord metastasis was treated for intractable pain. She received almost all available analgesic treatments. This case study allows for a short didactical review of treatments available to health professionals in palliative care: patient-controlled analgesia (oxycodone), transcutaneous electrical nerve stimulation, ketamine, samarium, intrathecal analgesia with morphine then ziconotide, and methadone. |
| INKA\_122\_0051-AT | editing | Douleurs rebelles en soins palliatifs : différents traitements possibles à partir d'un cas clinique | Intractable pain in palliative care : case study and possible therapies | Intractable Pain in Palliative Care: A Case Study and Possible Therapies |
| INKA\_122\_0063-AB | editing | L’idée d’effectuer le stage du diplôme universitaire de soins palliatifs ailleurs est née de l’envie de faire un stage centré sur l’accompagnement dans un contexte moins favorisé que celui des pays occidentaux. Le stage au Caire a permis de mettre en évidence les contraintes d’un tel projet réunies sous l’acronyme TABLE : Temps, Autorisations, Budget, Lieu, Etranger. Sans prétendre être exhaustifs, les auteurs évoquent un certain nombre de pistes pour chaque item et font référence à l’expérience vécue. Les enseignements sont nombreux mais l’expérience la plus marquante est de se retrouver à l’étranger, de perdre ses repères professionnels, faire l’apprentissage de l’isolement, de l’impérieuse nécessité de solliciter, d’accepter non de donner mais de recevoir. L’autre constat est celui du chemin à parcourir : le système de santé égyptien est perfectible, les soins palliatifs sont encore balbutiants en Egypte. Peu d’équipes sont labellisées mais elles travaillent à développer une culture des soins palliatifs par la formation des infirmières, par la diffusion de référentiels sur la douleur, par la promotion de la prise en charge psychosociale et la lutte contre les idées reçues. | The idea of a work experience placement abroad for an university palliative course arose from the need for experience focused on care in a context different from that of favored Western countries. The Cairo internship lead to the description of such a project’s constraints, under the French acronym TABLE : Time, Approval, Budget, Place and Foreigner (Temps, Autorisations, Budget, Lieu, Etranger). The authors recall some questions required for each point and refer to their experience. The most important experience was to discover oneself as a foreigner, losing professional habits, training for loneliness and learning the imperious requirement to seek, to agree not to give but to receive. The other observation is the path required for such an experience : the Egyptian health system is perfectible, and palliative care is just beginning in Egypt. Only few identified teams exist but they work hard to develop a palliative care culture, training nurses, sharing high standards regarding pain, promoting psychosocial support for patients and their family, and fighting against accepted ideas. | The idea of conducting the work experience component of the university degree in palliative care overseas arose from the need for experiencing support in a less privileged context than Western countries. The constraints of the Cairo project can be described with the French acronym TABLE: *Temps, Autorisations, Budget, Lieu, Etranger* (“Time, Approval, Budget, Place and Foreignness”). The authors briefly outline some considerations for each point and refer to their experience. The most important learning opportunity was the fact of finding oneself as a foreigner, losing professional reference points, learning isolation and the absolute need to seek—to agree not to give but to receive. The other observation concerns the process for such an experience: the Egyptian health system can be perfected, and palliative care is just beginning in Egypt. Only a few identified teams exist but they are working to develop a palliative care culture by training nurses, sharing frameworks regarding pain, promoting psychosocial support for patients and their family, and fighting against preconceived ideas. |
| INKA\_122\_0063-AT | editing | Un projet sur la TABLE : un stage du diplôme universitaire de soins palliatifs en Egypte. De la théorie à la pratique | From project to practice. Palliative care abroad : A work experience placement in Cairo for a university palliative course | From Project to Practice: A Palliative Care Work Experience Placement in Cairo  |
| INKA\_122\_0063-ST | editing | "Forum" | Forum | Forum |
| INKA\_122\_0073-AB | editing | La psychomotricité est une profession paramédicale ressource dans le domaine des soins corporels. Elle est régie par un décret de compétence qui définit le cadre d’exercice. L’approche psychomotrice des soins trouve sa place dans la démarche palliative. Elle peut enrichir la réflexion, la pratique et la qualité du prendre soin au quotidien. Elle s’articule en équipe avec le travail des autres professionnels de santé. | Psychomotricity is a paramedical profession considered to be a resource in the domain of bodily care. It is regulated by a decree of expertise, which sets out the frame of practice. The approach of health care by the psychomotrician has a place in the palliative care field. It can enhance reflection, practices and the quality of care on a day-to-day basis. It is carried out within a team with the participation of the other health care professionals. | Psychomotricity is a paramedical profession considered to be a resource in the domain of physical therapy. It is regulated by standards of expertise which set out its domain of practice. The psychomotor approach to health care has a place in the palliative care domain. It can enhance reflection, practices and the quality of care on a day-to-day basis. It is carried out in partnership with other health care professionals. |
| INKA\_122\_0073-AT | editing | Une approche spécifique de la psychomotricité en situation palliative | A specific approach to psychomotricity in palliative situations | A Specific Approach to Psychomotricity in Palliative Situations |
| INKA\_122\_0073-ST | editing |   | Forum | Forum |
| INKA\_123\_0083-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_123\_0085-AB | editing | Un grand nombre de personnes en fin de vie décèdent aux urgences dans des conditions insatisfaisantes, sur des brancards, dans les couloirs, sans accompagnement adapté. Dans le cadre de la présente étude, un protocole spécifique d’accompagnement des patients admis aux urgences avec un diagnostic « soins palliatifs » a été élaboré, mis en place et testé sur une période de douze mois. La nature et la qualité de la prise en charge ont été évaluées par des questionnaires anonymes destinés aux personnels soignants référents, à l’équipe mobile de soins palliatifs et aux familles. | At the end of their life, many persons will die in the emergency department under unsatisfactory conditions : on stretchers, in the corridors, without appropriate accompaniment. In the present study, a specific protocol designed for patients admitted in the emergency department with a diagnosis « palliative care » was developed and tested over a period of twelve months. The nature and quality of care were assessed with an anonymous questionnaire that was completed by the emergency staff, the palliative care mobile team and the patients’ families. | Many terminal patients die in the emergency department under unsatisfactory conditions: on stretchers, in the corridors, without appropriate support. In the present study we developed, implemented and tested, over a period of twelve months, a specific protocol designed for patients admitted to the emergency department with a “palliative care” diagnosis. The nature and quality of care were assessed with an anonymous questionnaire that was completed by the emergency staff, the mobile palliative care team and patients’ families. |
| INKA\_123\_0085-AT | editing | Accompagnement de la fin de vie aux urgences | Accompanying the end of life in emergency department | Supporting the End of Life in the Emergency Department |
| INKA\_123\_0091-AB | editing | Une décennie vient de s’écouler depuis la parution, en France, de la loi du 4 mars 2002, relative aux droits des malades et à la qualité du système de santé, posant l’information à donner aux malades comme un droit inaliénable. Cependant, malgré la prudente précaution, inscrite dans cette même loi, de respecter la volonté d’ignorance du malade, nous ne pouvons que constater que le corps médical a tendance à s’orienter vers une annonce systématique du caractère létal de la maladie qui les touche. L’objet de cet article est d’en relever les effets délétères et de réintroduire une réflexion éthique concernant l’annonce du pronostic létal, lorsque celle-ci tend à se systématiser, en dépit des malades eux-mêmes, notamment dans leur sollicitation en vue d’obtenir la rédaction de leurs directives anticipées. | A decade has just passed since the publication in France of the law of March 4th, 2002, about the rights of the patients and about the quality of the health system, putting the information to be given to the patients as an inalienable right. However, in spite of the careful precaution contained in the same law to respect the will of ignorance of the patient, we can now notice that the medical profession tends to turn to a systematic announcement of the lethal character of the disease which affects the patient. The object of this article is to raise up the deleterious effect of such announcement and to reintroduce an ethical thought concerning the telling of the lethal prognosis, when it tends to be systematized in spite of the patients themselves, in particular with the aim to obtain the writing of anticipated directives. | It has been ten years since the publication in France of the law of March 4, 2002 about patients’ rights and the quality of the health system, which established patients’ inalienable right to information. Although the law makes the sensible recommendation to respect patients’ desire for ignorance, we observe that the medical profession tends to systematically announce the fatal nature of the disease affecting the patient. The goal of this article is to observe the negative effects and the ethical implications of this announcement, which tends to become systematic in spite of the patients—in particular as they are pushed to write their advance care directives. |
| INKA\_123\_0091-AT | editing | Pronostic létal : les risques de l'annonce | Lethal prognosis, the risks of telling | Lethal Prognosis: The Risks of Telling |
| INKA\_123\_0097-AB | editing | La fin de vie comprend un certain déroulement, une temporalité qui permet l’accompagnement de celui qui part. Cet accompagnement peut être l’occasion pour lui comme à tout autre moment de sa vie, d’une ultime évolution. La vie le quitte, la mort le prend, c’est le temps de l’agonie (le combat). Les soignants s’accompagnent également mutuellement dans ce travail, et la tâche de mise en mots de leur vécu participe au tissage et au récit d’une histoire commune. | The end of life includes a certain process, a temporality which enables the dying person to be accompanied. This accompaniment may be the opportunity for an ultimate evolution, similar to other changes that have occurred during lifetime. Life is leaving him, death takes him, it is time for agony (combat). Health professional support each other in this task and by verbalizing their experience contribute to weave and tell a common story. | The end of life includes a certain process, a temporality which enables the dying person to be supported. This support may be a last opportunity for evolution for the individual, similar to other changes that have occurred in their lifetime. As life abandons them and death overtakes them, it is time for agony (fighting). Health professional support each other in this task, and by verbalizing their experience contribute to weaving and telling a common story. |
| INKA\_123\_0097-AT | editing | L'envol des montgolfières ou l'accompagnement d'une ultime évolution... | The flight of the hot-air balloons | The Flight of the Hot-Air Balloons |
| INKA\_123\_0103-AB | editing | Le dispositif « soins palliatifs » questionne le soignant comme le malade. L’enjeu est d’aider la personne malade à vivre le mieux possible jusqu’à la mort. Une des conditions est de favoriser l’expression de ce qu’elle vit. Ce texte présente un outil inspiré de la psychologie humaniste qui a pour but d’encourager la formulation de l’expérience vécue en utilisant comme support l’arbre. En s’identifiant à l’arbre, la personne peut évoquer sa situation en langage analogique et parler autour de la mort en lien avec son parcours de vie. Après une brève présentation de « l’Epreuve des Trois Arbres » et des modalités d’analyse, deux cas sont présentés. Ils permettent de discuter de la validité du discours subjectif analogique pour évoquer la mort et des ouvertures qui s’exposent alors pour la personne en fin de vie. | The network « palliative care » questions both health professionals and patients with the challenge to help the sick person to live as well as possible until death. One of the conditions is to favour the expression of what the person is experiencing. This paper introduces a humanistic psychology tool with the purpose to encourage the formulation of the past life by using the tree as a support. Identified to the tree, the person may then relate its situation by using analogical language and speak about death in relation to its life course. After a presentation of the « Test of the three trees » and of the analysis procedure, two cases are presented. These cases allow to discuss the validity of the subjective analogical speech that is used to talk about death and about openings occurring at the end of life. | Palliative care questions both health professionals and patients with the challenge to help the sick person to live as well as possible until death. One of the conditions is to encourage the expression of what the person is experiencing. This paper introduces a humanistic psychology tool with the purpose to encourage the verbalization of experience by using the metaphor of the tree. Identifying with the tree, the person may then relate their situation in terms of analogy, and talk about death in relation to their life trajectory. After a presentation of the “Test of the three trees” and the analysis procedure, two cases are presented. These cases illustrate the validity of the subjective analogical discourse used to talk about death and about the opportunities occurring at the end of one’s life. |
| INKA\_123\_0103-AT | editing | Vivre en fin de vie | Living the end of life | Living at the End of One’s Life |
| INKA\_123\_0103-ST | editing | "Forum" | Forum | Forum |
| INKA\_124\_0123-ST | editing | "Editorial" | Editorial | Editorial |
| INKA\_124\_0125-AB | editing | Cette étude examine le rôle de la culture dans l’expression verbale de la douleur chez 47 patients français et 34 patients syriens atteints de leucémie. L’intensité (EVA) et les dimensions sensorielle et affective (QDSA) de leur douleur étaient recueillies. Les descripteurs sensoriels et émotionnels choisis par les Syriens ont un contenu sémantique plus fort que ceux utilisés par les Français. L’origine culturelle du patient, en modifiant la qualité sémantique de l’expression verbale de la douleur, doit être prise en considération dans les pratiques de soins. | This study examines the role of culture in the perception and the verbal expression of pain among syrian and french blood-related cancer patients. The level of intensity (AVS scale) and the different aspects (Saint-Antoine SAPQ Pain Questionnaire) of their pain were studied. The sensory and emotional descriptors chosen by the Syrian patients have a stronger semantic content in comparison to those used by the French. The patient’s cultural background which affects the perception and verbal expression of pain should be considered in the care practice. | This study examines the role of culture in the perception and the verbal expression of pain among Syrian and French cancer patients. The level of intensity (AVS scale) and the different aspects (Saint-Antoine Pain Questionnaire) of their pain were studied. The sensory and emotional descriptors chosen by Syrian patients have a stronger semantic content in comparison to those used by the French. The patient’s cultural background affects the perception and verbal expression of pain, and as such should be considered in treatment. |
| INKA\_124\_0125-AT | editing | L'influence de la culture dans l'expression verbale de la douleur : étude comparative entre des patients cancéreux français et syriens | The influence of culture on the verbal expression of comparative study between French and Syrian cancer patients pain | The Influence of Culture on the Verbal Expression of Pain: Comparative Study between French and Syrian Cancer Patients |
| INKA\_124\_0141-AB | editing | Les patients en soins palliatifs souffrent souvent de cruralgies d’origine néoplasique mal calmées par les traite ments habituels. Le bloc iliofascial (BIF) est une solution efficace, sans danger, bien tolérée et permettant le retour à domicile. Le BIF est une technique d’analgésie locorégionale très simple à réaliser. A l’image de son utilisation par des praticiens non anesthésistes réanimateurs en médecine d’urgence préhospitalière, son emploi mériterait d’être étendu aux médecins prenant en charge des malades en soins palliatifs. Un cas clinique illustre ce propos. | Palliative care patients are often affected by neoplastic cruralgia with little response to usual medication. Iliofascial block (IFB) is an effective and safe solution, which is well tolerated and can enable patients to return home. IFB is easy to administer. It is used by non anesthetists in prehospital emergency services. Similarly, its use could be spread to physicians in palliative care contexts.We illustrate this with a clinical case. | Palliative care patients are often affected by neoplastic cruralgia with little response to usual medication. Iliofascial block (IFB) is an effective and safe solution, which is well tolerated and can enable patients to return home. IFB is easy to administer. It is used by non-anesthesiologists in pre-hospital emergency services. Similarly, its use could be extended to physicians in palliative care contexts. We illustrate this with a clinical case. |
| INKA\_124\_0141-AT | editing | Intérêt du bloc iliofascial (BIF) en soins palliatifs | Interest of fascia iliaca compartement block for palliative care patients | Relevance of the Fascia Iliaca Compartment Block for Palliative Care Patients |
| INKA\_124\_0145-AB | editing | Notre contribution vise à rendre compte d’un dispositif d’intervention mis en œuvre auprès de patients en soins palliatifs. L’idée générale est de proposer aux patients des informations au sujet des recherches sur l’expérience de mort imminente (EMI), de créer un espace de discussion et la possibilité d’un travail personnel. Ce dispositif peut constituer le support à démarche réflexive pour le patient. Ce dispositif semble pertinent pour travailler sur les manifestations anxio-dépressives des patients. Ce type de dispositif doit s’accompagner d’une posture éthique et déontologique forte afin de garantir les droits du patient. | The aim of our contribution is to report on an intervention device implemented with palliative patients. The general idea is to provide patients with information about research on near death experience (NDE), of create an interlocutory space and to provide the possibility for a personal work. This intervention can become a support to a reflexive work for the patient. This device seems to minimize the expression of anxiety and depressive manifestations. This type of device must be accompanied by a strong ethics position to guarantee patients’ rights. | The aim of our contribution is to report on an intervention tool with patients in palliative care. The general idea is to provide patients with information about research on near death experiences (NDE), creating a space for dialogue and providing the possibility for work on oneself. This intervention can offer reflective support to the patient. This device can be useful in minimizing the expression of anxiety and depressive manifestations. This type of device must be accompanied by a strong ethical position to guarantee patients’ rights. |
| INKA\_124\_0145-AT | editing | L'utilisation d'un mythe contemporain comme potentiel thérapeutique | The use of a contemporary myth as therapeutic potential | A Contemporary Myth’s Therapeutic Potential |
| INKA\_132\_0133-AB | editing | En soins palliatifs, le médecin interne construit son identité professionnelle tout en étant exposé quotidiennement à la souffrance et à la mort. Le stress qui en résulte peut parfois amener au *burn-out*, voire à la dépression. Un questionnaire a été distribué aux médecins internes en début et en fin de rotation de deux à six mois en médecine palliative. L’objectif consistait à mesurer l’évolution des connaissances, des sentiments et des comportements ainsi que le recours à des substances toxiques. Huit questionnaires sur onze ont été retournés, soit un taux de réponse de 73%. Les résultats montrent que les médecins internes ne consomment pas de toxiques et qu’ils privilégient l’expression de leurs émotions à leurs proches en début de rotation et les débriefings entre collègues à la fin. On observe une diminution moyenne de l’appréhension de 26% et un doublement du niveau de connaissances. Les objectifs fixés ont été atteints pour 87,5% d’entre eux. Lors de leur immersion en milieu de soins palliatifs, les médecins internes parviennent à gérer leurs émotions en les exprimant plutôt que d’utiliser des comportements d’évitement. Ils donnent de l’importance à l’acquisition de connaissances biomédicales et insistent sur la communication et le partage interdisciplinaire. L’expérience professionnelle acquise pendant cette rotation mériterait donc d’être étendue dans la période prégraduée de la formation afin de contribuer à une meilleure préparation des médecins à la vie active. | In palliative care, residents are building up their professional identity while being daily exposed to suffering and death. The resulting stress can lead to burnout and depression.A questionnaire was distributed to residents at the beginning and at the end of a 2 to 6 months palliative care rotation. The aim was to measure the evolution of knowledge, emotions and behaviour as well as the use of toxic substances.8 out of 11 questionnaires were returned for a response rate of 73%. Results show that residents do not take toxic substances but prefer to express their emotions with relatives at the beginning of their rotation and use team debriefing at the end. Apprehension level decreased to 26% and level of knowledge in palliative care doubled. 87% of residents reached their learning objectives.During immersion in palliative care, residents are able to cope with their emotions by expressing them rather than using avoidance behaviours. They give importance to improve on biomedical knowledge, on communication and on interdisciplinary sharing. The professional experience gained during this rotation should be extended within the pre-graduate period in order to contribute to a better preparation of residents to active life. | In palliative care, residents are building their professional identity while being exposed daily to suffering and death. The resulting stress can lead to burnout and depression. A questionnaire was distributed to residents at the beginning and at the end of a 2—6 months rotation in palliative care. The aim was to measure the evolution of knowledge, emotions and behavior as well as the use of toxic substances. 8 out of 11 questionnaires were returned, with a response rate of 73%. Results show that residents do not take toxic substances but prefer to express their emotions with relatives at the beginning of their rotation, and through team debriefing at the end. Anxiety levels decreased to 26%, and the level of palliative care knowledge doubled. 87.5% of residents reached their learning objectives. During immersion in palliative care, residents are able to cope with their emotions by expressing them rather than using avoidance behaviors. They value the acquisition of biomedical knowledge, communication, and interdisciplinary sharing. The professional experience gained during this rotation should be extended in the undergraduate period in order to better prepare residents to the profession. |
| INKA\_132\_0133-AT | editing | Impact psychologique et comportemental du travail en unité de soins palliatifs sur les médecins internes | Psychological and behavioural impact on residents working in palliative care units | Psychological and Behavioral Impact on Residents Working in Palliative Care Units |
| INKA\_132\_0143-AB | editing | La solitude en fin de vie est un sujet peu étudié. Avec cette étude, l’objectif est de déterminer si des patients en soins palliatifs souffrent de solitude, d’en définir la prévalence et s’il existe par exemple une association entre isolement, solitude et état anxio-dépressif. Les outils utilisés sont les échelles de solitude de l’Université de Laval (ESUL) et d’anxiété et de dépression de Hamilton (HADS). Nous avons pu interroger dix sujets d’une moyenne d’âge de 66,9 ans. La moyenne du score de l’ESUL, dont l’étendue va de 20 à 80, est de 31 pour les patients en soins palliatifs et de 31,5 pour la population âgée de référence. Il n’existe pas de différence significative entre ces deux populations en comparant leur moyenne et écart-type. C’est la borne supérieure de l’intervalle de confiance de la moyenne de la population de référence, soit 33, qui a été retenue comme valeur seuil afin de déterminer si les sujets sont seuls. Nous avons observé trois valeurs au-dessus de 33 pour une prévalence de solitude de 30%. Les prévalences de l’anxiété et de la dépression dans notre collectif sont de 40%. La recherche d’une corrélation entre l’ESUL et l’échelle d’Hamilton s’est avérée négative. Toutefois, il existe une tendance nette à ce que les deux sujets qui sont à la fois anxieux et dépressifs présentent les scores maximums de solitude, respectivement 46 et 49 à l’ESUL. | Loneliness at the end of life has not been extensively studied. Objectives of this study were to determine if patients in palliative care suffer of loneliness, to specify its prevalence and to look for an association between isolation, loneliness, anxiety and depression. Tools used are the scale of loneliness of the Laval’s University (ESUL) and the Hamilton hospital anxiety and depression scale (HADS). Ten subjects, mean age of 66,9 years, were interviewed. Mean ESUL score, range 20 to 80, was 31 for the patients in palliative care and 31,5 for the reference population and there was no significant difference between both populations. The upper limit of the confidence interval of the reference population, ie 33, was taken as the threshold for loneliness.We observed three values above 33 for a loneliness prevalence of 30% in the subjects studied, whereas the prevalence of anxiety and depression was 40%. There was no correlation between ESUL and HADS but a clear trend for two subjects who were at the same time anxious and depressed to show the maximum score of loneliness, respectively ESUL 46 and 49. | Loneliness at the end of life has not been extensively studied. This study aims to determine whether patients in palliative care suffer from loneliness, to specify its prevalence, and to determine the association between isolation, loneliness, anxiety and depression, if any. The tools used are Laval’s University Loneliness Scale (ESUL) and the Hospital Anxiety and Depression Scale (HADS). Ten subjects, with a mean age of 66.9 years, were interviewed. The mean ESUL score (range 20—80) was 31 for the patients in palliative care and 31.5 for the reference population, and there was no significant difference between them. The upper limit of the confidence interval of the reference population (33) was taken as the threshold for loneliness. We observed three values above 33 for a loneliness prevalence of 30% in the subjects studied, whereas the prevalence of anxiety and depression was 40%. There was no correlation between ESUL and HADS but a clear trend for two subjects who were both anxious and depressed and who showed the maximum loneliness scores, respectively 46 and 49 on the ESUL. |
| INKA\_132\_0143-AT | editing | L'isolement en soins palliatifs | Isolation in palliative care | Isolation in Palliative Care |
| INKA\_132\_0157-AB | editing | Lors d’une précédente contribution nous avons présenté un dispositif d’intervention mis en œuvre auprès de patients en soins palliatifs. Ce dispositif vise à proposer aux patients des informations au sujet des recherches sur l’expérience de mort imminente (EMI). Nous présentons ici les réflexions associées à l’usage du mythe comme potentiel thérapeutique et les contours et enjeux du dispositif proposé aux patients. | In a previous contribution we presented an intervention device implemented with palliative patients. The goal of this intervention is to provide patients with information about research on near death experience (NDE). We present here some thoughts associated to the use of myth as a therapeutic potential, and the outlines and stakes associated to this kind of intervention. | In a previous contribution we presented an intervention device implemented with palliative patients. The goal of this intervention is to provide patients with information about research on near death experiences (NDE). We present here some reflections associated with the use of myth as therapeutic potential, and the outline and issues associated to this kind of intervention. |
| INKA\_132\_0157-AT | editing | L'utilisation d'un mythe contemporain comme potentiel thérapeutique : commentaires et réflexions | The use of a contemporary myth as therapeutic potential : comments and thought | A Contemporary Myth’s Therapeutic Potential: Comments and Thoughts |
| INKA\_133\_0175-AB | editing | Un séjour en unité spécialisée de soins palliatifs doit être optimal pour que les patients puissent bénéficier des soins adaptés à leur situation. L’influence de facteurs socio-économiques sur la durée de séjour est peu connue. Du 1er décembre 2011 au 31 mai 2012, les données démographiques, médicales et socio-économiques des patients hospitalisés au service de médecine palliative des Hôpitaux universitaires de Genève ont été recueillies et liées à la durée et l’issue du séjour par un modelé de Cox. Pendant la période d’observation, 181 patients ont été hospitalisés. Trois quarts souffraient de cancer. Le séjour médian était de 14 jours et 75% des patients sont décédés. Les patients de moins de 65 ans et ceux de nationalité suisse demeuraient plus longtemps à l’hôpital. L’âge et la nationalité ont influencé la durée de séjour. Des facteurs socio-économiques ont pu jouer un rôle pendant l’hospitalisation. Leur identification pourrait être utile dans les décisions que les soignants sont amenés à prendre. | Length of stay in palliative care units should be optimal for patients to benefit from the specialised care adapted to their situation. Little is known on how socio-economic factors may influence the length of stay in palliative care. Between 1 December 2011 and 31 May 2012, demographic, medical and socio-economic data of patients hospitalised in the division of palliative care of Geneva University Hospitals were recorded. Data were then linked to the length and outcome of stay, using a Cox proportional hazards model. During the observation period, 181 patients were admitted. Three quarters had cancer. Median stay was 14 days, 75% of the patients died. Patients younger than 65 years and Swiss nationals had longer stays. Age and nationality were associated with the length of stay. Socio-economic variables can play a role in hospitalisation duration and could help care givers in their decisions. | The length of stay in a palliative care unit should be optimal for patients to benefit from the specialized care adapted to their situation. Little is known on how socio-economic factors may influence the length of stay in palliative care. Between December 1, 2011 and May 31, 2012, we recorded demographic, medical and socio-economic data of patients hospitalized in the palliative care division of Geneva’s University Hospital. Data were then linked to the length and outcome of stay, using a Cox proportional hazards model. During the observation period, 181 patients were admitted. Three quarters had cancer. The median stay was 14 days, and 75% of the patients died. Patients younger than 65 and Swiss nationals had longer stays. Age and nationality were associated with the length of stay. Socio-economic variables can play a role in the length of hospitalization and could assist medical staff in their decisions. |
| INKA\_133\_0175-AT | editing | La durée de séjour en soins palliatifs | Lenghth of stay in palliative care | Length of Stay in Palliative Care |
| INKA\_133\_0181-AB | editing | Cet article décrit la prise en soin d’Ana, au sein l’Unité de Soins palliatifs (USP) de l’Hôpital Fribourgeois (HFR), où l’équipe infirmière a fait le choix d’honorer le caractère unique des personnes, en ancrant sa pratique aux valeurs de la philosophie de l’Humain devenant. La thématique se centre sur ce que vit la personne recevant une sédation palliative pour symptôme réfractaire et elle est directement corrélée à la notion de dignité, telle que décrite par le Dr Parse. | This article describes the care of Ana in the Palliative Care Unit of the Hôpital Fribourgeois where the nursing team made the choice to honor the unique character of persons, by anchoring its practice to the values of the Human to become philosophy. The theme is centered on what is experiencing the person receiving palliative sedation for refractory symptoms and it is directly correlated to the notion of dignity, as described by Dr. Parse. | This article describes the treatment of Ana in the Palliative Care Unit of the HFR Fribourg Hospital, where the nursing team has made the choice to honor people’s uniqueness by anchoring its practice in the values of the human becoming philosophy. The theme is the experience of the person receiving palliative sedation for refractory symptoms and it is directly correlated to the notion of dignity, as described by Dr Parse. |
| INKA\_133\_0185-AB | editing | Tout autant qu’elle demeure l’expérience la plus certaine de notre vie, la mort, notre mort, ne pourrait être représentable en elle-même. Nous ne pourrions alors que la mettre de côté (Freud S., 1915). Et quand bien même elle prendrait forme dans le corps de cet autre, dépendant de soins palliatifs, nous pourrions encore en faire un objet, objet mourant. (Higgins R.W., 2003). Le domicile, dans le désir qu’expriment nombre de ces patients de retour ou de maintien en celui-ci, pourrait représenter une médiation potentielle. Ainsi la rencontre demeurerait possible, pour les professionnels, comme les proches. Mais alors comment pourrions-nous entendre cette demande de maintien à domicile, alors que, là, la mise en œuvre de soins pourrait relever tantôt de l’aide, tantôt de l’intrusion. (Ennuyer B.2006) La présente recherche vise à appréhender le sens qui pourrait survenir par et pour le domicile, dans cette expérience de la mort, au travers des différentes rencontres cliniques que nous avons pu faire. Une distinction s’impose alors entre le domicile et le foyer, dont notre étude vise à poser finalement les jalons. | As much as it remains the most certain experience to occur in life, death, our death, cannot be represented in itself. We could just put it aside (Freud S, 1915). Even if death would materialize in the body of someone dependent on palliative care, we could still see it as an object, a dying object (Higgins RW, 2003). Home, in the desire expressed by many patients to return or stay there, could represent a potential mediation. Then would the meeting become possible for health professionals and for the proxies. But, how could we listen to the demand to stay at home whereas there, care could on one hand be taken as help and on the other as an intrusion (Ennuyer B, 2006). The present research aims to under­stand the meaning brought by home, and for the home, in the death experience through our many clinical interactions. A clear distinction between house and home then becomes obvious and this is what our study is all about. | As much as it remains the most certain experience to occur in life, our death cannot be represented in itself. We can only set it aside (Freud 1915). Even when death becomes embodied in the Other in palliative care, we can still see it as an object, a dying object (Higgins 2003). Home (as many patients express a desire to return or stay there) could represent a potential mediation, so that health professionals and families can find a common space. This request is more problematic when home care can be taken as help as well as an intrusion (Ennuyer 2006). The present research aims to under­stand the significance conveyed and assumed by the home in the death experience, through our many clinical interactions. A clear distinction between house and home emerges clearly, which our study outlines. |
| INKA\_133\_0185-AT | editing | Mourir chez soi, sens et enjeu du domicile dans la pratique des soins palliatifs | To die at home, meaning and stakes of home in the practice of palliative care | Dying at Home: Meaning and Issues of Home in the Practice of Palliative Care |
| INKA\_134\_0227-AB | editing | L’activité des équipes mobiles de soins palliatifs soulève la question du maintien d’un idéal d’accompagnement palliatif, au sein d’un cadre qu’elles ne peuvent maîtriser et dont les référentiels sont bien souvent différents. Elles représentent ainsi par excellence un lieu de questionnement éthique de la pratique palliative, au carrefour entre un certain idéal, véhiculant des normes qui lui sont propres, et les contraintes de la réalité de terrain. Cette réflexion de portée générale explorera successivement les modalités relationnelles entre services référents et équipes mobiles, les motifs de résistance à leur intervention, avant de conclure sur les points de vigilance à maintenir par les équipes mobiles de soins palliatifs. | The activity of mobile palliative care units raises the question of sustaining an ideal of palliative care, within a frame they cannot control and whose referential is often very different. They represent par excellence a space for an ethical questioning of palliative practice itself, at the crossroad between a certain ideal conveying its own standards and the constraints of the ground reality. This general thought will successively explore the relational terms between the referring services and the mobile units, the reasons to resist mobile units’ intervention, before drawing a conclusion on the main aspects palliative care units must pay attention. | The activity of mobile palliative care units raises the question of sustaining a palliative care ideal within a framework they cannot understand and whose reference points are often very different. As such, they are an ideal opportunity for the ethical questioning of palliative practice itself, at the crossroad between an ideal (with its own standards) and the constraints of practice. This general reflection will successively explore the relationship between referral services and mobile units and the reasons to resist mobile units’ intervention, before concluding with the main aspects to which palliative care units must pay attention. |