

## IS MALAYSIA WHERE YOU WANT TO SPEND YOUR FINAL DAYS?

By Dr Ednin Hamzah, Chief Executive Officer, Hospis Malaysia

The past 2 years has seen humanity trying to come to terms with the Covid 19 pandemic. It has seen health systems struggle to adjust to new demands whilst trying to maintain existing operations. Malaysia, in line with most other countries has had its lows, where our health system was overwhelmed, resulting in an increased burden of morbidity and mortality both to Covid 19 as well as other diseases.

In 2020, there was 166,500 recorded deaths in Malaysia (*Dept of Statistics, Malaysia*). In 2022, for a similar number of people, this will be the last year of their life. Some will die due to cardiovascular disease, cancer, infectious disease and many others. What will their experience of end of life care be?

In 2010, the Economist Intelligence Unit published a Quality of Death Index for 40 countries. The Index scores countries across four categories: Basic End-of-Life Healthcare Environment; Availability of End-of-Life Care; Cost of End-of-Life Care; and Quality of End-of-Life Care. Malaysia was ranked 32<sup>nd</sup>.

In 2015, the EIU repeated the exercise. On this occasion, Malaysia was ranked 38 out of 80 countries. In this exercise, another category, community engagement was added. The United Kingdom and several other developed countries were ranked highest as they had invested in the various categories that were studied.

Palliative Care was introduced in Malaysia in the early 1990's through non-government organisations whilst

the first service under the Ministry of Health was started in Kota Kinabalu in 1995. Since then, palliative care has been recognised as a medical subspecialty and services set up in many government as well as private health institutions. In 2019, a National Palliative Care Strategy was launched.

In December 2021, another Quality of Death study was published in by Finkelstein *et al* (*Journal of Pain and Symptom Management*)\*. Countries were ranked and graded on the quality of End Of Life care taking patient and caregiver preferences into account but also relying on input from experts to provide their assessment of EOL performance on key indicators. Malaysia was ranked 62 out of 81 countries assessed and given a grade of F.

Whilst the United Kingdom again ranked highest, Taiwan, Korea and Hong Kong were placed in the top 10. And Singapore, Sri Lanka, Mongolia and Japan all made the top 30. Only Nepal and Bangladesh ranked lower than Malaysia amongst the Asian countries surveyed.

One can argue, the study has both advantages and weaknesses in its methodology but if the paper was studied in its entirety, could we truly argue with the general findings? Perhaps we could look at what the experts reported as factors that enabled high quality in end of life care and make our own deductions:

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## Key factors experts considered in the cross country comparison of the Quality of Death and Dying 2021 ranking\*:

1. Policy makers recognizing that EOL care is a human right, thereby making evidence-based and equity-oriented policies on and investments in palliative care at the national level.
2. Legislated entitlement to publicly financed universal health coverage that ensures free or low-cost access to palliative and EOL services, and recognizing the importance of care in the community, and the need for psycho-social care
3. Institutionalized regulatory mechanisms and government oversight to ensure quality standards.
4. Personalized, patient-centered, and integrated care delivery. This then enables well-facilitated communication with patients and families on end of life (EOL) care options. And through good palliative care delivery, patient autonomy is enabled to make EOL decisions.
5. Uninterrupted and adequate access to opioids and other essential medicines to alleviate serious health-related suffering at the EOL.
6. Mandatory competency-based palliative care education and training for clinicians and allied health professionals to generate highly skilled multidisciplinary healthcare teams.
7. Intersectional and multisectoral approaches that bridge boundaries between public and private entities, and social and health services.
8. Public education to promote awareness on and support civil society engagement on topics related to EOL.
9. Promotion of compassionate communities that complement formal EOL care services to improve quality of life of patients and their families. This includes training and support for lay caregivers.
10. Research opportunities and activities to generate necessary evidence for palliative care development.

Malaysia has made some developments in improving end of life care in recent years but many nations have made much greater progress.

As the needs for eldercare and the incidence of non-communicable disease rises, a greater number of Malaysians will require end of life care, not just in hospital but at home and aged care facilities. How do we prepare for this as a country?

Palliative Care and end of life care are not seen as a priority. At Hospis Malaysia we have seen patients being referred at an increasingly late stage over the past 5 years. Most healthcare workers do not receive education in palliative or end of life care. Realistic

discussions between patients, families and doctors hardly take place even as health deteriorates.

The Covid 19 pandemic has seen palliative care take a greater prominence in many countries as its contributions are more recognised and appreciated.

If today is the first day of the last year of your life, how would you plan your next 364 days? What matters most to you and how would you ensure that you would receive the care that you want? ■

\* The study and country reports may be viewed here: <https://www.duke-nus.edu.sg/lcpc/quality-of-death/about-this-effort>.

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## CAN PALLIATIVE CARE SUPPORT IN THE COMMUNITY HELP BRING SOME VALUE BACK TO DEATH (AND LIFE)?

*When I recently saw a doctor-colleague facing the impending death of his son-in-law from cancer, the transformation that happened in our society (about how it deals with the dying) over two generations became obvious to me. The most striking memory is the expression of the dying man's 15-year-old son, who was walking in the background choosing books and cramming them into bags. He was not part of the conversation; when he came close the conversation flagged. He was being given an unspoken message: "This is grown-up talk; kids are not part of it". He responded by pretending not to. He was being sent away to live with an uncle so that his father's illness and death would not disturb his studies....*

*A normal dying process was stretched out over weeks by interventions including an endotracheal tube and artificial ventilation of his lungs (but no pain relief). At the height of his suffering, he tried to pull out the tubes and cables, but his arms and legs were bound to the bed. His wife and father-in-law could visit him for only 5 minutes a couple of times a day, and each time had to watch the man dying a thousand deaths, his dignity and personhood violated in the worst possible way. Eventually, when the doctors suggested a tracheotomy and total parenteral nutrition, the family said no. The man died without seeing his son one last time, and the son was denied one last hug.*

*An excerpt from a writing by Dr M J Rajagopal<sup>1</sup>*



Death during Covid times has served to illuminate the value of a good death – for many, it was a medicalised and lonely experience, with loved ones unable to bid their last goodbyes, and come together to grieve.

The Lancet Commission<sup>1</sup> propositions that good palliative care can provide better outcomes for patients and carers at the end of life. Palliative care regards death and dying as part of the process of life. It recognizes that it is a relational and spiritual process and not just a medical one. While there is a need to address pain and other physical symptoms, there is also a need for more thought to be placed on the importance of families and communities as part of the eco-system of support and care for the dying.

In January 2022, a report was released by the Lancet Commission on the Value of Death<sup>1</sup>. The report highlights how dying has changed radically over the last several generations. With people living longer, death is now coming later, and dying is often prolonged. Potentially inappropriate treatment continues into the last hours of life. More and more people are dying in hospitals as opposed to with family back in their community.

Healthcare and individuals appear to struggle to accept mortality. Conversations about the imminence of death can be difficult. Doctors, patients, or family members may find it easier to avoid them altogether and continue treatment, often leading to inappropriate treatment even when diagnosed with an illness which is irreversible, and especially at the end of life.

*As a carer in Australia shared: "I... did not know you could care for somebody at home but she was dying and not dying fast enough for the hospital system and they kept sending her home and taking her back in and then sending her home again. And it was very distressing. ....I decided that we could do better and brought her home...I managed to care for Mum until she died at home which was a great experience for everybody, her family and me."*

The full report can be read here: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)02314-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02314-X/fulltext).

1. The Lancet Commission on the Value of Death: bringing death back into life: Libby Sallnow et al.

## PALLIATIVE CARE LEADERSHIP AND LEARNING FROM THOSE WHO HAVE WALKED THE PATH

The concept of whole person care and addressing “total pain” was coined by Dame Cicely Saunders in the late 1960s, bringing about the modern hospice and palliative care movement. When patients with serious progressive illnesses and their families experience the kind of whole person care palliative care offers, it almost seems simplistic. It isn’t about the latest advances in surgical interventions, nor is it about newly discovered drugs. It is about working with the patient to uncover what is causing him physical pain and other discomfort, and what may be causing him emotional pain and mental anguish. What is causing him to lose his meaning to live. It is about understanding the person, and addressing what is causing him distress. This requires the care to be delivered by a multi-disciplinary team to address the various facets of his suffering. And when adequately addressed, much of the distress and anguish the patient and family face can be reduced or go away, enabling them to focus on living, and living as well as possible. I am sure for all of us – this is really not a bad deal.

Yet after more than 50 years, it is an area of healthcare which is still trying to continuously establish itself. And in many countries, advocates and practitioners are still finding it challenging to include palliative care into mainstream medicine. Why?

While there has been remarkable development of clinical skills and education, there is strong suggestion that the specialty lacks leaders. Leaders who can create a vision and influence others to buy into the vision. Leadership in healthcare requires the ability to drive excellence in evidence-based clinical practice, leadership in research to grow and mature the evidence; leadership in advocacy to guide changes in health care delivery and access; and leadership in education to assure skills development.

For palliative care, because of its interdisciplinary approach, an added dimension may be required – some term it collaborative interdisciplinary leadership. A key ingredient in palliative care leadership is building relationships with patients, families, healthcare colleagues including referring clinicians, and communities to understand what is important to them. Leaders consult, listen and think critically and negotiate conflicts. And in so doing build trust to enable them to empower colleagues, and collectively work towards the shared vision.

As a relatively new specialty with emphasis on patient-centred care, perhaps what differentiates it from the other specialties is the need for its leaders to continue to innovate and experiment with new ideas and novel processes to enable greater engagement with all its stakeholders. The success stories from these innovations are demonstrated by more patient populations being supported and more community partnerships developed.

Perhaps a good way to understand what it takes to be a palliative care leader, is to look at some of the palliative care leaders around the world, and what they did enroute to achieving their vision.



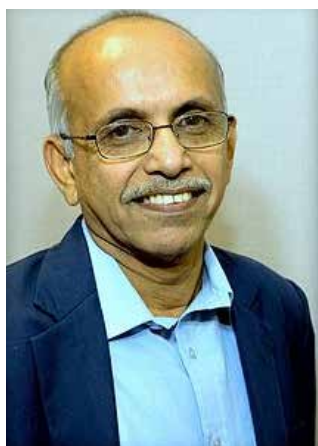
**Dame Cicely Saunders**

**Dame Cicely Saunders** - who in 1967, brought together a large number of patients with terminal illnesses from various wards in hospitals scattered across London, and established St Christopher’s Hospice in London, with a vision of combining teaching and clinical research. She pushed the boundaries with the management of physical pain with the use of regular doses of morphine during a time when the regular use of opioids even amongst the medical fraternity was perceived to lead to addiction.

She was able to demonstrate that apart from physical pain, most patients with serious incurable illnesses also suffered emotional, social and spiritual pain, and developed the concept of “total pain”. To this day, palliative care practitioners practise this holistic manner of assessing the patient and his family’s well-being.



Even in the early days, Dame Cicely and her colleagues, while busy working through how to manage the various aspects of pain, recognized the need to design and manage the hospice as a “home from home” where the physical environment was important. It was a place where patients could garden, write, talk, and get their hair done. A place where their loved ones would look forward to visit and spend valuable time together.



**Dr M. R. Rajagopal**



**Dr. K. Sureshkumar**

**Dr Rajagopal and Dr Sureshkumar** founded the Pain and Palliative Care Society (PPCS) in Kerala in 1993 as a way to build a sustainable model of service in a resource-constrained environment. They adopted a strategy of maximising the use of existing government facilities, and organising voluntary service and empowering close relatives of their patients to participate in palliative care. The remaining resource gap then bridged by society

In a world where 80% of its population cannot receive adequate medication for pain relief because of political, regulatory and social barriers due primarily to UN’s International Drug Control Conventions, the founding doctors of PPCS dedicated decades to advocate for better access to controlled medicines such as morphine which is affordable and effective but highly stigmatized. Their advocacy contributed to law reform in India—a critical step in reducing needless suffering and allowing millions in a developing country like India to access uninterrupted availability of oral morphine for pain relief.

In 2001, to enable a better reach of the service to more in need, the Neighbourhood Network in Palliative Care (NNPC) was founded as an extension of PPCS. With the

support of the clinical teams from PPCS, community-owned NNPC units were set up in rural areas.

The initiative mobilized the entire community and developed novel training programs for volunteers to perform simple nursing procedures, keeping the pharmacy and visiting and talking to patients at home. Family members were empowered to ensure continuity of treatment. Training courses were conducted for family physicians, anaesthetists, cancer specialists and medical students to increase awareness about palliative care approaches to care.

Today the NNPC model continues to draw much attention and inspires other communities, even in high-resourced countries like the UK, where compassionate community projects have mushroomed to support people living with serious progressive illnesses to live well in their preferred place of care – often back in their own communities.



**Professor Cynthia Goh**

**Prof Cynthia Goh** was one of the palliative care pioneers who built the palliative care ecosystem in Singapore. And in her capacity as Chairperson of the Asia Pacific Hospice & Palliative Care Network, she continued her passion in her work by partnering with numerous countries in the Asia Pacific to promote and build better access to palliative care.

Together with a handful of like-minded individuals, she transformed Singaporeans’ early misperceptions about hospices being purely places where people go to die. She consulted colleagues in the UK (including Dame Cicely) where hospice and palliative care was already an established medical specialty to provide good pain

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## PALLIATIVE CARE AWARENESS MONTH

*April 2022*

# AIMING TO LEAVE NO ONE BEHIND

A recent update by the World Hospice and Palliative Care Alliance (WHPCA) in collaboration with the World Health Organization (WHO), estimates that over 56.8 million people require palliative care each year<sup>1</sup>, up from an estimate of 40 million in 2014. By 2060, the need for palliative care at the end of life is expected to double<sup>1</sup>!

Despite improvements in the development of palliative care services leading to more patients now receiving palliative care than six years ago, we are still witnessing that only 12% of the needs across the world are being met. This means that millions of children and adults with palliative care needs are still suffering and in pain. And this can be attributed to the inequities in the provision of palliative care globally – both between countries and within countries. In many low and middle income countries (LMICs), palliative care services are either under-developed or non-existent and access to essential palliative medicines, including opioids remains a problem. And while the need for cancer palliative care has been progressively acknowledged worldwide, there is still a lack of understanding, even amongst healthcare workers that patients with chronic conditions may also require palliative care support. And these include patients with organ failure, cardiovascular diseases, neurodegenerative disorders, drug-resistant TB, diseases of older people, and most recently long-Covid.

In Malaysia, The Ministry of Health (MOH) in 2019 estimated that more than 220,000 people in the country each year require palliative care as a result of serious health-related suffering<sup>2</sup>. And currently less than 10% have access to it. The MOH also mapped out the availability of palliative care services in the country<sup>2</sup>. It identified palliative care services in 7 MOH hospitals located in urban areas while a group of NGO hospices serve the community in similar urban locations, suggesting that such services are currently not available in small towns and rural settings. Moreover, within the 10% who currently have access to palliative care in the country, the majority were patients with cancer, once again suggesting that despite the availability of the service, the needs of many patients with non-cancer conditions have not been identified, and their suffering not addressed.

There is therefore much to be done to highlight the plight of those with serious illnesses, who may, (or may not) be seeking active treatment, whose physical and emotional suffering may (or may not) have been identified, and who currently still do not have access to palliative care!

Palliative care aims to improve the quality of life of patients and their families by identifying and addressing the physical and emotional suffering of people living with a serious progressive illness.

Palliative Care Awareness Month (PCAM) held in April every year, is Hospis Malaysia's initiative in broadening Malaysians understanding of palliative care, and highlighting the serious gap in access to this very crucial component of healthcare.



**LEAVE NO ONE BEHIND**  
**EQUITY IN ACCESS TO PALLIATIVE CARE**

This year's theme "Leave no one behind - Equity in Access to Palliative Care", seeks to remind us that it is a basic human right to have access to good healthcare from cradle to grave, and within that, the right to good palliative care as part of the continuum of care. Anyone with a serious progressive illness regardless of age, gender, race, or social class has the right to care that enables them to live well, free of avoidable suffering and with dignity despite the illness.

In our attempt to advance this, we join our global colleagues to call on the government to to:



*Integrate palliative care in Universal Health Coverage reforms, and recognize the need for greater development of palliative care*



*Train, equip and support health workers to improve their ability to identify the population's need for palliative care, and to improve their ability to deliver good palliative care*



*Have balanced policies to ensure access to essential medications for palliative care and pain treatment*



*Support palliative care development, especially in the community, with greater funding*

This April, in conjunction with Palliative Care Awareness Month (PCAM) 2022,

- 1. We call on the community to join us in this call to advocate for equity in access to palliative care by signing the pledge at [www.palliativecare.my](http://www.palliativecare.my).**
- 2. We encourage you to start having conversations about what matters to you if you were diagnosed with a serious progressive illness, and you are aware that your time is limited.**

- Many find death a difficult topic to discuss. It brings up a mix of feelings - anxiety, fear, awkwardness, sadness. Many skirt the issue and prefer to ignore the inevitable.
- We would like to encourage inter-generations to speak up early about what matters to them if they were diagnosed with a serious illness.
- Sharing what matters to you with your loved ones early can help them support you in your choices, so that your loved ones can focus on helping you live well, and not be burdened by difficult decisions.

For more information about Hospis Malaysia's Palliative Care Awareness Month, please email us at [pr@hospismalaysia.org](mailto:pr@hospismalaysia.org). ■

#### HOW TO START A "WHAT MATTERS" CONVERSATION:

These conversations can be part of a normal conversation, and can happen at home, at a café, or when on holiday.

Focus on what's important to you – what matters if you had limited time, what may make you happy, what your hopes may be, who you would like to make healthcare decisions for you when you no longer can make them for yourself. Some indications of what matters could be – spending time with loved ones, reinforcing relationships with family, continue to have dignity, would you want to be on life support even when there is no hope of recovery.





## “I SAW HOW PALLIATIVE CARE CAN CHANGE A PERSON’S LIFE.”

After a decade in internal medicine, Dr. Liew Kean Yew found a further path - palliative care. Currently training to be a palliative care specialist, he shares how his 6-month training with Hospis Malaysia has further expanded his world.

### 1. What led to your decision to specialise in palliative care?

I was seeing a patient with chronic obstructive pulmonary disease annually. His visits became so frequent, he was returning every few days. After so many years in Internal Medicine, I found that I wasn't equipped enough to make patients more comfortable. Until a visit from a palliative care consultant from Hospital Selayang. I saw that when care was given to address the patient's discomfort and his symptoms were managed well, the patient didn't feel a need to come by anymore. That was when I realised the importance of palliative care.

### 2. Why Hospis Malaysia for the 6-month stint?

Hospis Malaysia is one of the organisations stipulated in our training programme. As one of the most established hospices around, it's almost by default that we're assigned to train here.

### 3. How have your 6 months at Hospis Malaysia matched up to your expectations?

I undergo a rotation half-yearly. So I usually don't have any expectations. But my predecessors described their time with Hospis Malaysia as “mind-blowing”. Having spent 6 months here, I too was “blown away” by what I experienced and witnessed first-hand.

At Hospis Malaysia, I learned of a bigger world in palliative care. Their links with the international palliative care community have given me the opportunity to attend international online conferences. That's important as there's a need to measure ourselves against the world.

### 4. Was there a structure to the training at Hospis Malaysia?

The structure included assessments with supervisors, tutorials, house visits and feedback. To start, we had to plan and write out a personal learning plan with our supervisors. Then we would discuss our learning needs with them. My goal was to improve my skills in the psychological, social and spiritual aspects of palliative care.



Dr. Liew Kean Yew

We were also required to go for home visits with the nurses. Every morning, the nurses, my supervisors and I would meet to talk about the patients we saw the day before. We'd present the cases to ensure we were all aligned in the management of each patient.

We would also have at least 2 days of teaching sessions weekly with our supervisors that included case-based or clinical reflections and communication skill training as well as online international talks. Every session was fruitful. The meetings served as a learning experience for all of us. Our supervisors would also give us goal-directed feedback. The personalised time and constructive feedback when discussing our learnings were the highlights of my training here.

### 5. What are the aspects of suffering you have witnessed in the course of your training? How were they addressed?

I saw people living with life-limiting illness experience a range of suffering, from physical symptoms and psychological issues to spiritual and social woes. For example, a person living with cancer would have pain. That means he's suffering from the physical aspect of it. He could then lose his job and source of income as



his illness renders him unable to cope. In turn, he'd be worried - how am I going to pay for treatment, could I be treated or cured? All these anxieties might send him further into depression. Sometimes, people just lose their meaning in life. When they see that there's no curative treatment to their disease, it threatens the spirituality in them. These 4 aspects are interlinked.

When we first see a patient, we'd look at him from all 4 aspects and see what his needs and preferences are. Some would want to address the physical aspect. Some from a social point of view. For instance, they'd feel that they're getting weaker yet they're embarrassed to ask their family for help. We'd then facilitate from that angle and discuss with the family. For the psychological aspect, we use certain techniques - eg: dignity therapy when we talk about things that are meaningful to them - like career achievements. When they talk about their achievements, it gives them back their dignity. Some may be anxious about their disease and sometimes it's just about sharing information with them. After they know where their illness or treatment is going, they'll feel calmer.

## **6. What areas of the work in palliative care do you see most challenging?**

The lack of understanding for the need for palliative care. The biggest misconception is that palliative care deals with those who can no longer be treated. When patients are referred to me, a lot of them see me as "death". This is so far from the truth.

Even healthcare personnel and some specialists lack understanding of what we do. This has led to late referrals. In the UK and Australia, the palliative care team gets involved in the care very early so that they can focus on communication and uncovering the needs of the patient directly with him. This helps to reduce distress for the patient and family. And in the later phases, we focus on providing comfort care, and honouring the patient's preferences. Here, unfortunately patients are referred to palliative care very late. By the time we see the patient, he's often already very ill and the family is very distressed. Either a lot needs to be done in a very short time or very little can be done except to keep him comfortable.

## **7. You have spent time in hospitals and in the community. Any difference between the two?**

In the hospital, patients feel the need to conform to rules. For example, they have to wear the hospital attire like a uniform. They become one of them in the ward. And they lose their identity. At home, they wear

whatever they like. When they're comfortable in their own clothes and can be surrounded by their loved ones, they don't feel like they're just another patient. They're someone's father, wife, son etc. This gives their lives meaning.

There's a "power gap" when they see me in hospital. They come to the busy hospital environment which is my territory and they'd rather not ask too much. When we go to the community, we're going into their territory. It's my turn to "conform" to their "rules". I may be the doctor but the moment I go into their homes, I have to respect a certain set of values that they carry. Also, since it's just them with no other patients around, they open up to us more. Also most want to be at home, resources permitting. And when we visit, we can spend time getting to know them. In hospital, it takes us a lot longer to gain that trust.

## **8. In your opinion, how important it is for a palliative care trainee to spend time in the community?**

Very important! There's no better way than to be there to see, listen and feel it for yourself. It's also through the house visits that I learned about techniques to deal with the psychological, social and spiritual aspects of patients.

## **9. Palliative care can sometimes be misperceived as just good nursing care. Would you like to share any case with us that will help our readers dispel this misperception?**

There was a gentleman in his 50s with colon cancer. When we visited him, he thought he would pass on in a matter of days. Fast forward 6 months later, he's still sitting down with me, talking and laughing away.

Palliative care isn't about dying. It's about living. In those 6 months, we helped him managed his pain and his spirituality. Spirituality isn't always about religion. To some, their job is their meaning of life. He couldn't continue his career as a lawyer because of his illness and he felt like he'd lost all meaning in life. In our visits, we also talked about how he could occupy himself. Eventually our conversations got him to open up his world. He started a blog about his legal experience, which he found to be very meaningful. And soon, it led to consultation work, as peers from other firms started to look him up.

This is where I want to stress that palliative care isn't about good nursing care. It's about symptoms management and most importantly, helping the patient restore his dignity and meaning to his life. ■

## PALLIATIVE CARE IS JUST ABOUT HELPING PEOPLE RELIEVE PAIN AND OTHER PHYSICAL SYMPTOMS. MYTH OR FACT?

***Pak Din was a man who knew what he wanted at the end of life. But as his daughter and caregiver, Norwati discovered in their journey together, there was so much more to just the physical support that helped them achieve what he wanted.***

A former police officer who led an independent life after retirement and the passing of his wife to cancer, Pak Din loved life and knew how to make the most of it. So when he was referred to Hospis Malaysia after being told that his cancer had spread, he chose not to be put on life support should the time come. That was when the family started his end-of-life journey with Hospis Malaysia's support.

"We just wanted him to be comfortable and not in pain," Norwati recalled. But she gradually saw that the physical aspect of his illness wasn't what troubled Pak Din the most. It was expressing his wishes and sharing his thoughts with his loved ones that he found most difficult to do. "My father didn't want to burden the family, despite us being there with him the whole time. Instead, he felt more comfortable sharing his concerns about his pain with Stephanie, our palliative care nurse," Norwati explained.

The family realised that it was the additional psychosocial support that they were not able to offer. "Maybe because we were family," Norwati remarked. Sometimes, the people closest to us are the ones we find hardest to open up to. "That's why we were glad that my father had someone he could turn to," she continued. To her family, Hospis Malaysia was more than just about medical support and pain



Norwati and husband

management. Stephanie also provided Pak Din with psychological support, prepping him for what was to come. "She was always there to listen to him - his fears, hopes, dreams and about what will happen to his family after he's gone." Because he found a warm and willing ear in the nurse, he was also able to talk about his other thoughts and feelings with her. "Stephanie would tell us that my father was always telling her how lucky he was to have his family around him," Norwati said.

The aim of palliative care is to help people with any complex or progressive illness have the best possible quality of life. It involves a combination of care and support that looks after all the important aspects of a person's well-being, whether it's their physical, psychological, social or spiritual needs. It also aims to support the family and ensure that they are prepared for the journey the patient is going through. Palliative care is about helping the patient and family live with the illness with as much comfort, dignity and peace of mind, for as long as possible. ■

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relief and social and emotional support to patients in need. With the good work at the grassroots level, policy makers recognized the importance of providing good care for people at the end of life.

Through her capacity as the founder of the palliative care department at the National Cancer Centre and a service at the Singapore General Hospital, she enabled palliative care to be accepted into mainstream medicine and with that, the ability to attract talented doctors to sustain services. She was also instrumental in working with the Lien Foundation to establish the Lien Centre for Palliative Care at the Duke-NUS Medical School to further education, training and research in this field.

Today palliative care in Singapore has developed into an eco-system of government-funded hospital and community-based services integrated into the nation's healthcare system. And the SingHealth Duke-NUS Supportive and Palliative Care Centre (SDSPCC) was formed in 2020 to bring together health professionals of different expertise dedicated to improve the quality of palliative care and foster collaboration with its community partners to achieve coordinated care.

This was a vision Prof Goh had for Singapore, and it became a reality before her passing in February 2022. ■

# Thank you!

Grateful to all our donors for helping make a difference! Your support in helping Hospis Malaysia raise palliative care awareness and funds makes it possible for us to continue improving palliative care access to our community.



YB Tuan Tan Kok Wai, Chairman of MP Office, Cheras for supporting Hospis Malaysia.



The Chinese Chamber of Commerce & Industry of Kuala Lumpur & Selangor for choosing Hospis Malaysia as one of their recipients.



Mrs Gana Jegadeva, and brothers Visaghan & Pranava Shanta Mohan for organizing "The Ripple Charitable Fundraiser" for Hospis Malaysia" for its 3rd consecutive year.



Syarikat Ong Sdn Bhd for choosing us to be one of its Charity Exhibitors.



ADV Fusionex Sdn Bhd for sponsoring medical supplies to support our patientcare services.



Translab Sdn Bhd for sponsoring Flowflex™ SARS-CoV-2 Antigen Rapid Test kits.



Magnum Group for selecting us as its charity beneficiary for its 3rd annual Community Support Program.



Harlow's MGI Sdn Bhd for supporting us as one of the recipients for its Charity Day 2021.

**We would like to also thank all our individual and corporate donors who have supported us in many ways!**





# 21st Annual Charity Treasure Hunt

KL - PENANG  
18 & 19 JUNE 2022



**RM220/PERSON\***

**Early Bird - RM190/person\*** (Ends 30th April 2022)

\*Fee is inclusive of 1 night (twin sharing) at Bayview Hotel Georgetown Penang, buffet dinner and breakfast the next day.

**REGISTRATION ENDS 31 MAY 2022**

**Corporate Sponsors are welcome with complimentary team entitlement.  
Contact us to find out more!**

For more info, email to [pr@hospismalaysia.org](mailto:pr@hospismalaysia.org)  
OR WhatsApp us at 013-983 1682

