



Importance of Palliative Care

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The role of palliative care is getting more attention, acceptance, and priority in recent years when it comes to advanced cancer and in other chronic diseases. Palliative care is a specialized medical care for people living with serious illness—this type of care focuses on providing relief from the symptoms and stress of the illness. The goal is to improve the quality of life for both patient and the family.

The palliative care team includes specially trained physicians, nurses, and other specialists who work together with patients and other physicians to treat the patient and provide an extra layer of support. It is based on the needs of the patient rather than the prognosis.

Palliative care is appropriate at any age and any stage of a serious illness and can be provided along with curative treatment. The World Health Organization addressed the issue of palliative care in a 2020 article, addressing that suffering involves taking care of issues beyond physical symptoms.

Palliative care uses a team approach to support patients and their caregivers: it addresses both the practical needs as well as bereavement counseling. It offers a support system to help patients live as actively as possible until death. Palliative care is explicitly recognized under the human right to health.

The WHO recommended that it should be provided through patient-centered and integrated health services that pay special attention to the specific needs and preferences of the individual. The majority of adults in need of palliative care have chronic diseases like CVA, Cardiovascular disease, Cancer, Chronic respiratory disease, AIDS, Diabetes mellitus, Multiple sclerosis, Parkinson's disease, Dementia, etc.

Each year, an estimated 40 million people worldwide are in need of palliative care, and 78% of them live in low-and

middle-income countries.

In 2014, the first ever global resolution on palliative care called upon member states to improve access to palliative care as a core component of the health system. They recommended integrating palliative care into all relevant global disease control and health system plans, developing guidelines and tools on integrated palliative care across disease groups and levels of care, and addressing the ethical issues related to the provision of comprehensibility of care. Another aspect is promoting increased access of palliative care for children. In Bangladesh—where a significant amount of diagnosis of malignancy is at an advanced stage—the role of palliative care is very important.

The first clinical study on palliative care was published in the New England Journal of Medicine from Massachusetts General Hospital in 2010. They randomly assigned newly diagnosed metastatic non-small cell lung cancer patients to receive early palliative care (integrated with standard oncology care) or standard oncology care alone. The quality of life and mood was assessed at baseline and at 12 weeks using the functional assessment of cancer therapy lung FACT-L scale in hospital anxiety depression scale. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care was collected from electronic medical records. Among patients with metastatic non-small cell lung cancer, early palliative care led to significant improvement in quality of life and mood.

Surprisingly, there was an increase in median survival in the palliative care group. The palliative care group also got an early referral to hospice and had less aggressive care at the end-of-life, avoiding ventilator support and intensive care use (medical care is usually futile at that stage of illness). This published report got national attention, and the integration of palliative care took root. Medicare and other major medical

insurances were interested in taking part in this movement, as it showed the improvement in the quality of life and survival, and there was a proven decrease in the cost of medical care.

The American Society of Clinical Oncology recommended the early integration of palliative care in the management of advanced malignancy.

In Bangladesh, where patients are without medical insurance, the cost of treatment of any chronic illness—including cancer—comes directly out of the pockets of patients or families. So many times, we have seen people selling the last bit of land or spending the last bit of savings to seek higher level of medical care. Physicians in Bangladesh face the situation where families bring an advanced cancer patient to a major city and can only afford to stay there for a very short period of time. Most of the time, it does not really make a difference in the patient's condition, and the patient may end up dying in an unknown place—sometimes even alone in the ICU. However, if you ask people about their dying wishes, the majority will want to die in their own homes, surrounded by family and prayers.

Patients living through advanced illnesses not only have a multitude of physical symptoms but also have psychological and spiritual issues. "Why me?" is an universal question many patients ask themselves, sometimes interpreting their illness as God's punishment for something they have done in the past. The spiritual burden this puts on patients is exactly why spiritual support is vital—patients must be aware that their illness is not due to their fault. Both physical and spiritual comfort is very important component of a good death.

Four common themes have been identified for a good death which includes:

1. The Person should have the feeling of completion of life
2. Treatment preferences
3. Dignity
4. Proximity to family

Feeling of completion of life including hopes for achievements can be dealt with spiritual and psychological care/support and acceptance of situation. Treatment preferences include giving patient

the choices and a sense of control over treatment options and the belief that available treatments were used. Dignity consists of being respected as individuals, and maintaining independence as much as situation allows. Proximity to family allows family support, patients wishes not to be a burden on family, acceptance of the situation by the family and starting preparations of death.

All of these can be accomplished by starting multiple conversations early and including family and patient, and the treatment care team.

Even with good intentions, the oncologist and the team might not have time to discuss these points in detail most of the time. A palliative care team can help tremendously in these situations and provide help with symptom management and other psychological and emotional issues that are as important.

So an organized palliative care team component is essential, and it provides an extra layer of care for the patient in addition to standard oncology care.

Our goal should be to introduce, organize, and train palliative care teams throughout Bangladesh to help understand the illness, and goal of care, prevent unnecessary costs and avoid futile medical care in a life-threatening illness situation.

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