

Palliative Care: Time for Action

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One of the main goals of medicine is to provide comfort and relief from pain and suffering. Unfortunately, a cure is not always possible particularly in this era of chronic diseases, and the role of physicians has become limited to controlling and palliating symptoms.

Palliative care is a relatively new specialty that evolved during the last five decades. The aim of this specialty was to provide end of life care for patients with advanced cancer and their families. It evolved as a result of growing public concern and dissatisfaction with the care of dying patients in the 1960's and 1970's.¹ At that time, oncologists were preoccupied with curative interventions and were not concerned much about end of life care.² Studies conducted at the time indicated that medical care provided to terminally ill patients did not exist or were suboptimal at best.^{3–5} Dame Cicely Saunders, widely recognized as the founder of palliative care, reported a similar experience.⁶ She founded the first modern hospice, St. Christopher's Hospice, in the UK in 1967.¹ The establishment of this hospice was a major turning point that inspired physicians all over the world to be trained in this new field and establish palliative care in their own countries.

Palliative medicine became a recognized medical subspecialty in Australia, New Zealand, the UK, Ireland, the USA, and several other countries.⁷ Training became structured with the establishment of fellowship training programs. Moreover, several palliative care professional associations have been established and many scientific journals, which specialize in this field, have been released. There have been calls to extend the philosophy and skills of palliative care physicians to include patients with non-malignant conditions such as end-stage renal disease, HIV/AIDS, progressive neurological diseases, cardiovascular, and respiratory diseases.⁸

The rationale was the similarity of the symptoms experienced by patients belonging to both categories.⁸ Indeed, access to palliative care services became a quality requirement for patients with end-stage renal disease and other chronic diseases.^{9,10}

The World Health Organization (WHO) defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual'.¹¹ The main focus of this specialty is to relieve pain and control symptoms and to improve the quality of care for patients, their families, and the healthcare system. It is holistic, patient-centered, comprehensive, and multidimensional so that it addresses not only the physical aspect, but also the psychological, social, and spiritual dimensions.

The best illustration of the multidimensional nature is the concept of 'total pain' described by Saunders.¹² The pain here is not merely physical but includes all of the other aspects mentioned above. Palliative care affirms life and regards dying as a normal process.¹¹ It offers a support system to help patients live as actively as possible until death.¹¹ It also provides a support system to help caregivers and families cope with the patient's illness and in bereavement.¹¹

Palliative care is usually provided by a multidisciplinary team, which includes physicians, nurses, psychologists, physiotherapists, clinical pharmacists, occupational therapists, dieticians, and social workers. In addition, pastoral care is also included according to the religious beliefs of the patient. The other important components of palliative care are effective communication and planning and coordination of care. Palliative care can

be introduced in several different settings: as a stand-alone service in a center or hospice, hospital-based, community-based, and home care.¹³

In 2014, the WHO adopted a resolution (WHA67.19) urging WHO member states to work to integrate palliative care into national healthcare systems, across all levels, with emphasis on primary, community, and home-based care.¹⁴ Furthermore, the resolution calls to ensure that palliative care is an integral component of all relevant global disease control and health system plans, including those relating to non-communicable diseases.¹⁴ It is noteworthy that ensuring the availability of palliative care services is an obligation of health care systems under international human rights law.¹⁵ Each year an estimated 40 million people are in need of palliative care, 78% of whom live in low- and middle-income countries.¹⁶ For children, 98% of those needing palliative care live in low- and middle-income countries.¹⁶ In high-income countries, it has been estimated that 69–82% of those who die are in need of palliative care.¹⁷ The demand is expected to be even greater in low- and middle-income countries due to less available resources to be spent on disease-modifying therapeutic options, thus, limiting the options to palliative treatment only. Also, as a result of increased life expectancy and aging, people are more prone to cancer and chronic diseases than they were in the past. Furthermore, the needs of the individual for medical care are usually greater at this critical stage of the life cycle during the end of life period when the person becomes most vulnerable.

The advantages of palliative care are enormous. Patients and their families have reported an improvement in quality of life.^{18–20} Distressing symptoms such as pain, depression, and spiritual distress have been better controlled.^{18–20} Additionally, patients and their families reported a higher level of satisfaction.²¹ Significant cost savings to health care systems have been reported when palliative care services were implemented, such as decreasing the number of hospital admissions, shortening the length of hospital stay, and decreasing the frequency of emergency room consultations.²¹

Despite the enthusiasm for palliative care, recent data showed that only 14% of people needing palliative care at the end of life received it.²² Three barriers were identified: lack of health policies in support of palliative care development, lack of

relevant training to healthcare workers, and poor accessibility of essential palliative care drugs.²³

Similar to other developing countries, Oman is encountering the challenge of a rising incidence of cancer due to an aging population and a higher prevalence of lifestyle-related risk factors. Despite the remarkable progress made in the health care services, palliative care services are still limited. Oman Cancer Association (OCA) (previously known as the National Association for Cancer Awareness) has been a key player and an essential partner in initiating and promoting palliative care.²⁴ The time has come now to strengthen the palliative care movement in Oman. This can only be achieved by exerting more efforts to convince policymakers about the enormous benefits of palliative care to the health care system as a whole. There should be attempts to integrate palliative at every level of care, especially at the primary health care level to include home and community-based care. The community, clinical, and administrative leaders should be engaged to help them to identify the great need for palliative care. Efforts are also required to overcome known barriers, and to identify and overcome unique challenges in Oman.²⁴ In particular, lack of governmental policies on palliative care and governmental regulations on access to opioids. Key to success is integrating palliative care training in all health institutions and partnerships between governmental and non-governmental organizations.

*“When you run so fast to get somewhere
You miss half the fun of getting there.
When you worry and hurry through your day,
It is like an unopened gift thrown away.
Life is not a race, so take it slower
Hear the music before your song is over.”*

(David L. Weatherford)

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