Review Article

What must Iran do for Palliative care? A systematized review

Marziyeh Hadian, Alireza Jabbari¹, Elaheh Mazaheri²

Abstract:

Palliative care has been proposed as a multidisciplinary method for providing patients with care. The present study proposes to discuss the necessary principles required for any country to successfully implement a palliative medicine program. The present study was a systematic review conducted in January 2019, and the articles related to palliative care requirements on the databases of Web of Science, PubMed, Scopus, Science Direct, Ovid, ProQuest, Wiley, and Google Scholar from January 1, 2009, to January 20, 2019, were searched. Strategy for searching and selecting the articles was Preferred Reporting Items for Systematic Reviews and Meta-Analyses Guidelines. The findings showed that the World Health Organization has introduced for main phases for increasing these types of services including: defining and developing a national policy, training and educating healthcare employees and general public, as well as pain relief. In general, two scenarios are described in the development of palliative medicine: bottom-up and top-down approaches. In conclusion, although there seem to be progressing activities regarding the issue of making palliative medicine accessible, there are still many obstacles including lack of adequate knowledge and political support, social and cultural problems, inadequate training and education of physicians and nurses, fixed and biased attitude in medical professions, and low priority of palliative medicine among policymakers. Therefore, it could be said that implementing palliative medicine programs requires an overall change in culture, public and individual education, political support, and appropriate policies.

Keywords:

Palliative care, patient care, systematized review, Iran

Department of Health Care Management, Health Management and Economics Research Center, Student Research Committee, School of Management and Medical Information Sciences, Isfahan University of Medical Sciences, Isfahan, Iran, ¹Health Services Management, Health Management and Economics Research Center, Isfahan University of Medical Sciences, Isfahan, Iran, ²Health Information Technology Research Center, Student Research Committee, Department of Medical Library and Information Sciences, School of Management and Medical Information Sciences, Isfahan University of Medical Sciences, Isfahan, Iran

Address for correspondence:
Ms. Elaheh Mazaheri, Health Information Technology Research Center, Student Research Committee, Department of Medical Library and Information Sciences, School of Management and Medical Information Sciences, Isfahan University of Medical Sciences, Isfahan, Iran.
E-mail: mazaheri.elaheh@gmail.com

Received: 10-02-2020
Accepted: 12-05-2020
Published: 30-10-2020

Introduction

Application of advanced techniques for improving patient health is of utmost importance. However, these techniques are incomplete unless various ideas are considered, especially when patient's chances for recovery are slim. Technological advances in the medicine must be in accordance with human's compassion toward patients with deadly diseases and people they care for. In this regard, palliative care has been proposed as a multidisciplinary method for providing patients with care until their last moments of life and continuing this trend as far as possible.[1] Palliative medicine focuses on relieving pain, treating symptoms of patients, and providing further support for patients and their families during each phase of the disease.[2] Palliative medicine is a leading field in health which requires a multidisciplinary approach, including medical, social, and mental care. During palliative care, physicians can consider the requirements and demands of patients and their families, during the patient's final moments of life.[3] However, this is not to say that palliative medicine alone can replace other methods completely, rather it provides the basis of good medical care. In this approach, the patient is viewed as a complete individual among family members to explore the realms of social, cultural, spiritual, and mental aspects. This approach has a significant effect on professional medical cares.[4] The high volume of baggage that comes along

with deadly diseases such as cancer, HIV, and other diseases including sickle cell disease along with the accompanying physical and mental pain all highlights the importance of developing palliative medicine in developing countries.[5]

The sedative attribute of palliative medicine during the final moments of life is still up for debate, especially considering how it involves moral issues, regarding definitions of a good life and death. Bordering on issues such as euthanasia or physician-assisted suicide also calls for serious discussions.[6] Furthermore, it seems that policymaking regarding palliative medicine, such as laws for getting patient's informed consent, is a rather complicated task during the final stages of a patient's life.[3] From this aspect, many developing countries have not considered palliative medicine individually and think of it as part of general healthcare. There is also the issue of insufficient training of healthcare professionals and general public, regarding palliative medicine.[5] Various models have been proposed for palliative medicine in developing countries. Some of these models were initially created for answering the requirements demanded by cancer patients and were later used for patients suffering from AIDS and other diseases.[7] To make the most benefit of palliative medicine, countries must create the necessary circumstances and environment and can assure their success by observing essential principles. Thus, the present study proposes to discuss the necessary principles required for any country to successfully implement and execute a palliative medicine program.

Research Methods

The present study was a systematized review of publications relating to palliative care requirements. The study performed based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and Critical Appraisal Skills Program (CASP).[8]

Search Strategy

This study was conducted during January 2019 to review English and Persian language-published papers in the field of palliative care requirements. For this purpose, we studied databases including ISI Web of Science, PubMed, Scopus, Science Direct, Ovid, ProQuest, Wiley, and Google Scholar from January 1, 2009, to January 20, 2019. The search keywords included "palliative care," "palliative treatment," "end of life care," "end of life treatment," and "requirement." Using OR and AND, keywords were combined and written in the search box of databases. All synonyms of the keywords were searched with using MESH strategies.

Selection of Articles and Document

Independent reviewers (EM and MH) screened abstracts and titles for eligibility. When the reviewers felt that the abstract or title was potentially useful, full copies of the article were retrieved and considered for eligibility by both reviewers. If discrepancies occurred between reviewers, the reasons were identified and a final decision was made based on the third reviewer (AJ) agreement. Two authors assessed the methodological quality and grade of evidence of included studies with the CASP tools.[9] The CASP tools use a systematic approach to appraise different study designs from the following domains: study validity, methodology quality, presentation of results, and external validity, and each of the items from the checklists was judged with yes (low risk of bias, score 1), no (high risk of bias), or cannot tell (unclear or unknown risk of bias, score 0). Total scores were used to grade the methodological quality of each study assessed.[9]

Inclusion and Exclusion Criteria

We searched (1) papers that mentioned to palliative care requirements and based on evaluation of CASP criteria in terms of methodology were corrected; (2) articles are in English or Persian language; (3) articles have a perfect structure; (4) internal articles have been printed in scientific and research journals; and (5) published papers in 2009 and after.

Study Quality Assessment

Quality assessment of the included studies was done using the CASP tools. The score of quantitative studies ranged from 2 to 9. Majority of quantitative studies did not provide any ethical statement, study design, sampling, and reflexivity related to the research process. In these studies, seven articles were used appropriate methods. And also, the majority of them did not consider important confounding factors accounted.

Finding

Database search
The initial electronic database search of the literature resulted in a total of 2509 articles. At the next step, duplicate articles were eliminated and the number decreased to 1980 articles. Using systematic screening, we reviewed the titles to find those related to palliative care requirements and selected 651 articles. In the next step, abstracts of the articles were studied and 28 articles were selected to be fully reviewed. After that, all of the selected articles were completely read, and on the basis of the inclusion criteria, only 16 articles were selected. Figure 1 shows the strategy for searching and
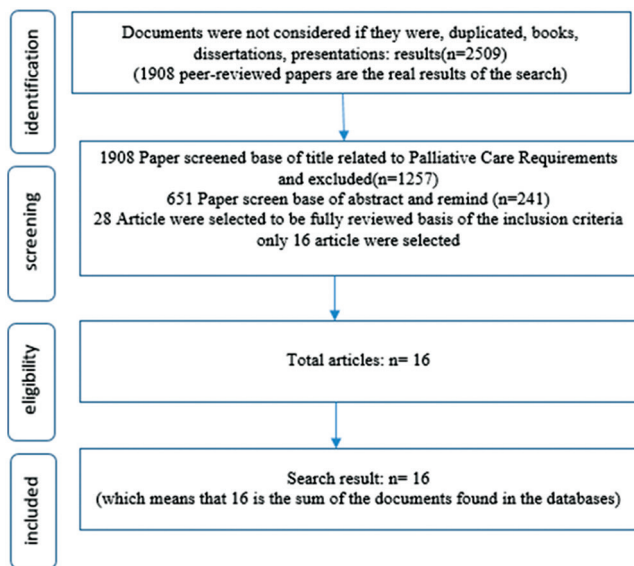
Figure 1: Strategy searching and selecting the articles in accordance with the PRISMA Guidelines

selecting the articles in accordance with the PRISMA guidelines.

Creating Palliative Care Services

According to the World Health Organization (WHO), palliative medicine is defined as an approach for improving patients' (and patient's families) quality of life when faced with life-threatening diseases through prevention, pain relief, early diagnosis and accurate evaluations, pain treatment, and other physical, mental, and spiritual methods.[1] The WHO and the European Council of Palliative Medicine have formulated a series of guidelines and recommendations for merging palliative care with national healthcare systems. They concluded that each individual in need of palliative medicine must have easy access to palliative care services, and service providers must, as far as rationality permits, act in consistency with patient requirements and preferences, despite patient's culture, ethnicity, or other preferences. General healthcare policies must consider patients' rights to have access to high-quality palliative medicine, despite type of patient's disease and financial support or nonofficial healthcare providers.[10] For example, in Atlantic, access to palliative medicine is a fundamental right of the public by government policies. Access, as part of all models of palliative medicine services, implies on the concept of equity and justice and is not determined according to the geographical location.[11]

The WHO has introduced for main phases for increasing these types of services including:
1. Defining and developing a national policy: Palliative care services have not yet been recognized in governmental programs. Supporting palliative medicine as an essential part of the healthcare system can be a major step on part of the government toward assuring the allocation of certain budgets for providing services to patients with chronic diseases
2. Training and educating healthcare employees and general public: Having a thorough understanding of palliative medicine and how to perform palliative care procedures is significantly essential for policymakers, healthcare employees, and families
3. Pain relief: Offering educational and training courses on palliative medicine to healthcare employees and observing changes in laws, which consist with this type of medical care, is following an increasing trend in many countries. Therefore, it is essential to have a defined policy for ensuring the provision of drugs for palliative care and other symptoms in a country.[1,7]

A major setback in implementing palliative medicine in developing countries mentioned in the references section is the government's lack of commitment toward the philosophy of palliative care in countries.[1] In general, two scenarios are described in the development of palliative medicine: bottom-up and top-down approaches. The bottom-up approach was determined by a group of highly energetic activists, who recognize local requirements and start their proceedings to improve the situation. The top-down approach occurs when the Ministry of Health intervenes, promotes, and legislates in early stages, provides a national policy, and ultimately merges palliative medicine in national healthcare system.[12] A report investigating national laws, policies, and programs of seven European countries regarding palliative medicine mentioned that European countries are especially significant in dealing with palliative care policies, considering their cultural differences and historical effects. The right to palliative medicine has only been implemented in Belgium, France, and Germany, whereas all countries have defined the related policies and have created the circumstances for offering these services to patients and granting necessary permits. There are, however, differences in issues including leaving palliative care coverage, advanced prescriptions, national budget, palliative care training, research, policies regarding use of narcotic drugs, and volunteerism.[10] A study of Georgia reviled the main challenges of implementing palliative care as:
- Lack of adequate information among general public, potential beneficiaries, and decision-makers
- Lack of knowledge and skills in healthcare professions
- Lack of financial resources.[13]

Comprehensive care in many different setting, including palliative care, is needed. Although palliative care is attracting a lot of attention, especially in developing countries, there are numerous factors which can decrease the effectiveness of palliative medicine. Among these

factors are policies regarding delayed dissemination of narcotic drugs, lack of skilled human resources, and lack of investiture in this field of medicine.[14] Widespread palliative care services require a cultural change toward accepting and promoting skills of medical practitioners, patients, and families. The patients do not only hope for longer life but also yearn for peace, truthful information, care of family problems, and compassion.[15] The international palliative medicine society has proclaimed key statements including Cape Town Statement (2002), Korean Statement, and Budapest Commitments (2007). This settlement calls governments to:

1. Create and implement policies for palliative medicine
2. Act justly in regard to access to services, without discrimination
3. Procure payable life-saving drugs, including narcotics
4. Provide palliative care services at all levels of care (levels 1, 2, and 3 of service provision)
5. Merge palliative care training and education with the whole learning chain, ranging from unofficial healthcare providers to healthcare professions.[16]

Providing palliative medicine in hospitals is a challenging task considering how hospital care procedures mainly focus on extending life time. Empowering hospital nurses to act as delegates for end of life and palliative care services and spread knowledge and skills of palliative medicine can increase quality of services provided for dying patients in a hospital.[8] A convenient hospital providing palliative medicine must make patients the focal point of attention, not the actual disease itself. The purpose of making hospitals' civil is to provide care services for patients and promote their overall health which is known as complete health. Ergo, civility is a must for a center providing palliative care services.[9] Considering the significant amount of mental anxiety accompanying the final days of life, consideration of various moral issues, written information, and written consent of patients before providing palliative medicine is necessary. When faced with the difficulty of truthfully stating a probable verdict to a patient, healthcare professionals must consider patient's mental breakdown. There are two main issues which must be considered for palliative care patients: morality in presenting information to patients entering the stage of palliative care and requirements needed for registering information profiles of patients.[3]

The most important principles guiding all aspects of end-of-life care include:

1. Being patient/family-centered: Service providers must act with sensitivity toward beliefs and personal, cultural, and mental values of patients and their families
2. Morality: Respecting individuality, patient's confidential rights, and moral doctrines usual in their culture, being honest with patients, and acting in accordance with standards
3. Improving life and end-of-life quality: Assuring that patients and their families are satisfied with quality of life
4. Accessibility: Appropriate services must be accessible at or near patients living courters
5. Effectiveness: Services must be evidence based and related to a set of standards, norms, and acting guidelines and must be comprehensive meaning they must respond to all physical, spiritual, and social requirements of patients and must be provided by trained professionals and coordinated using communicational media
6. Providing collaborative services
7. Sufficiency of resources and cost-effective provision.[17]

There seem to be numerous solutions to providing constructive palliative care services. All of these methods require sympathy, being sensitive to patient differences, and communication skills for establishing connections with all patients and their families. There is also the need to be sensitive toward beliefs and local traditions. Indeed, these goals are quite complicated, but not impossible. There is hope for the future of palliative medicine in international levels.[15]

Conclusion

Although there seem to be progressing activities regarding the issue of making palliative medicine accessible, there are still many obstacles in the way of implementing the essential elements of patient's right to palliative cares: availability, accessibility, acceptability, and quality. These drawbacks include lack of adequate knowledge and political support, social and cultural problems, inadequate training and education of physicians and nurses regarding pain control, fixed and biased attitude in medical professions, and low priority of palliative medicine among policymakers, health managers, and healthcare educators.[16] Therefore, it could be said that implementing palliative medicine programs requires an overall change in culture, public and individual education, political support, and appropriate policies.

Conflicts of interest
There are no conflicts of interest.

References

1. Santos Garcia JB, Rodrigues RF, Lima SF. Structuring a palliative care service in Brazil: Experience report. Rev Bras Anestesiol 2014;64:286-91.
2. Hauser J, Sileo M, Araneta N, Kirk R, Martinez J, Finn K, *et al*. Navigation and palliative care. Cancer 2011;117 15 Suppl: 3585-91.
3. Plu I, Moutel G, Purssell-Franc I. Ethical issues arising from the requirement to provide written information in palliative care. Palliat Med 2007;21:55, 57.
4. Twaddle ML. The impact of a home-based palliative care program in an accountable care organization. J Palliat Med 2016;19:1-4.
5. Ddungu H. Palliative care: What approaches are suitable in developing countries? Br J Haematol 2011;154:728-35.
6. Juth N, Lindblad A, Lynöe N, Sjöstrand M, Helgesson G. European Association for Palliative Care (EAPC) framework for palliative sedation: An ethical discussion. BMC Palliat Care 2010;9:20.
7. Lucas S. Palliative Care: Issues and Challenges. World Health Organization; 2002. Available from: http://www.who.int/3by5/en/palliativecare_en.pdf. [Last accessed on 2010 May 18].
8. Witkamp FE, Lv Z, Maas PJ, Hv D, Rijt CC, Heide A. Improving the quality of palliative and terminal care in the hospital by a network of palliative care nurse champions: The study protocol of the PalTeC-H project. BMC Health Serv Res 2013;13:115.
9. Schneider N, Lueckmann SL, Kuehne F, Klindtworth K, Behmann M. Developing targets for public health initiatives to improve palliative care. BMC Public Health 2010;10:222.
10. Beek KV, Woitha K, Ahmed N, Menten J, Jaspers B, Engels Y, *et al*. Comparison of legislation, regulations and national health strategies for palliative care in seven European countries (Results from the Europall Research Group): A descriptive study. BMC Health Serv Res 2013;13:275.
11. Sagin A, Kirkpatrick JN, Pisani BA, Fahlberg B, Sundlof AL, O'Connor NR. Emerging collaboration between palliative care specialists and mechanical circulatory support teams: A qualitative study. J Pain Symptom Manag 2016;52(4):4-9.
12. Knaul FM, Richard A. Provision of palliative care in low- and middle-income countries: Overcoming obstacles for effective treatment delivery. J Clin Oncol 2015;62:1615.
13. Rukhadze T, Kezeli T, Lekashvili T, Kordzaia D. Georgian national palliative care strategic plan – Achievements, challenges and perspectives in implementation palliative care in Georgia. EPMA J 2014;5 Suppl 1:A106.
14. Marrelli TM. Hospice and Palliative Care Handbook: Quality, Compliance, and Rembursment. 3rd ed. Indianapolis, IN: Sigma Theta Tau; 2018. p. 20-5.
15. Cassileth BR. Palliative care: Progress, needs, and challenges. Cassileth J Health Policy Res 2012;1:10.
16. Gwyther L, Brennan F, Harding R. Advancing palliative care as a human right. J Pain Symptom Manag 2009;38(5):767-74.
17. A Provincial Framework for End-of-Life Care. British Columbia: Ministry of Health; May, 2006.