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Mini Review

Barriers and Opportunities for Palliative Care Development in Pakistan

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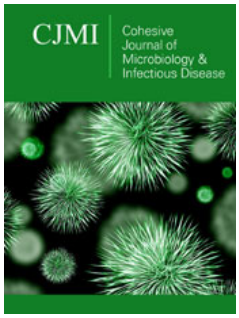

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Introduction

The World Health Organization (WHO) defines the palliative care as an approach that improves quality of life of patients facing problems associated with life-threatening illness [1]. It addresses the needs of the patients with cancer, stroke, end-stage renal failure, dementia, congestive heart failure and chronic respiratory diseases. Many other conditions may also require palliative care, including, chronic liver disease, multiple sclerosis, rheumatoid arthritis, neurological disease, Parkinson's disease, dementia, congenital anomalies, and drug-resistant tuberculosis. The main two frequent and serious symptoms are pain and breathing difficulty by patients who need of palliative care. For instance, 80% patients with cancer or AIDS, 67% cardiovascular disease patients and chronic obstructive pulmonary disease patients will experience moderate to severe pain during end of their lives.

Palliative care provides relief from pain, integrates psychological and spiritual aspects to enhance quality of life with usage of a team approach. An estimated each year 40 million people worldwide in need of palliative care, while 78% of them live in low-middle income countries. Only 14% of people currently receive palliative care access globally. Palliative care treats the patient as a whole and not restricted to a particular organ failure or specialty. Three domains of palliative care: outpatient clinics, hospital-based and home care reduces the length of patient's hospital stay, improves their satisfaction with lesser emergency department visits during last few months of life. Palliative care has gained a considerable attention during the last few decades. Increasing demands by the countries owing the increased number of elderly populations with chronic illnesses require health care professionals in palliative care with competence. Palliative care needs will continue to grow globally as ageing population poses a rising burden of communicable and non-communicable diseases. Early stages delivery of palliative care will reduce unnecessary burden of admission in hospitals and health services. There is an immense scope of palliative care considering in Pakistan, need to be establish structure recognized specialty. Our country has only a handful of palliative medicine consultants; in fact, it's barely existing [2].

There are only few pain relief clinics in Pakistan; however, a comprehensive approach is yet to be developed as some hospitals recently started such services. This crucial field is sorely neglected as the ratio for palliative care services in Pakistan population is 1:90 million showing a woeful picture [3]. Palliative care improves patient's quality of life, making death peaceful and dignified with as painless as possible. As a developing and poverty-stricken country this might not always possible due to an uncommitted government with lack of drugs. It is too well remembered that death experience is an integral aspect of life. A misconception prevails that palliative care sometimes confused with the euthanasia, but in fact these are two very opposite different things. Euthanasia is a practice of actively ending a patient's life to minimize suffering, while palliative care strives to make easier living and the ending with

peace. It also includes non-medical care for dying person, caters patient emotional needs, providing religious facilities if required, addressing the family's concerns, and making that period of life as easy as possible.

Opioids are essential in palliative care for managing pain. The most important requirement is morphine, used to minimize pain to help the dying person with least possible suffering. Opioids can alleviate other common distressing symptoms including breathlessness. Controlling these symptoms at an early stage is ethical duty to relieve suffering and respect a person's dignity. In 2018 the International Narcotics Control Board found that 79 per cent of the world's population, people in low- and middle-income countries mainly, consumed only 13 per cent of the total amount of morphine used in the management of pain and suffering.4 Allowing morphine into the mainstream of palliative care in a manner to be controlled dispense to prevent it from falling in the wrong hands. Morphine is a crucial narcotic as an addictive substance; extract derived from opium plant is not legally available in hospitals of Pakistan. It is a high time to provide morphine in palliative care hospitals for pain relief. Neighboring country Afghanistan is the world's largest producer of opium, harvest accounts for 80 percent supply of the world. Pakistan should import opium, the most abundant useful commodity to provide majority of the palliative care centers all around the globe to improve economy as well.

Through public health approach, young adults can be engaged to extend the palliative care reach in the communities [4,5]. Most surgical programs provide only limited formal education and skills related to the end-of-life care. A review paper had identified the deficiencies in palliative care education in postgraduate surgical education suggested different approaches for existing residency training [6]. The situation in Pakistan is alarming where this concept is yet to be recognized. With limited resources and increasing demand integration of palliative medicine continues to be a challenge for the existing postgraduate curriculum. A study from Pakistan on the status of palliative medicine showed a huge challenge for the accreditation bodies and medical educationists [7]. Moreover, by providing education on end-of-life care in the country nursing school curriculum, future nurses would be prepared to provide dying patients and their families with quality care. However, there is not any dedicated and funded capacity-building strategy exists in Pakistan to support palliative education for these nurses and nursing care providers. Furthermore, evidence-informed palliative practice critical role of knowledge suggests good outcomes from this education. Yet this infrequently identified as instructional methods with identified goals of care conversations with highest educational priority were perceived as effective.

A narrative approach pilot program demonstrates the 3-Act Model is teachable and highly appreciated by learners. This online curriculum is the first narrative-based approach reported high satisfactions with objective skills improvement [8]. A thematic analysis found trainees were least confident with the teaching in counseling about emotional impact of emergencies and organ donation [9]. Expert communication skills are essential across the domains of care. However, only few health care providers receive this kind of formal communication training in Pakistan [10]. COVID 19 has brought a complex array of clinical and ethical challenges for the healthcare community globally. A case was managed by a team of experienced clinicians where the patient

wishes conflicted with his family. This significance lessons learned range to legal, social and policy level [11]. Adequate national policies and programs with resources should be made on palliative care are urgently needed in Pakistan to improve access. Lack of awareness of its benefits among health care professionals, policymakers, and public social-cultural beliefs about dying and death are main barriers in the country [12]. Lack of supportive training in health care workers and poor accessibility to palliative medicine are major barriers in palliative care. Health care workers in pain management department are reluctant to opioid analgesia in the fear of respiratory distress and inducing dependence with increased substance abuse due to less training. End life recognition is an unfamiliar concept in Pakistan. They think hospice care as a life giving instead of better quality of remaining life of patients with less than six months life expectancy due to specific disease.

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