



## Case Report

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# New Emerging Fields in Palliative Care

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## Introduction

Palliative care is a crucial part of integrated, people-centered health services. Relieving serious health-related suffering, be it physical, psychological, social, or spiritual, is a global ethical responsibility. Thus, whether the cause of suffering is cardiovascular disease, cancer, major organ failure, drug-resistant tuberculosis, severe burns, end-stage chronic illness, acute trauma, extreme birth prematurity or extreme frailty of old age, palliative care may be needed and has to be available at all levels of care [1,2].

The World Health Organization defines palliative care as an approach which improves the quality of life of patients and their families facing 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 [1,2].

While palliative care has historically been associated with cancer and therefore, over the decades evolved to cater to the needs of cancer patients and their families, there is growing body of international evidence and literature advocating the need for palliative care for non-cancer conditions like dementia, stroke, cardiac failure, chronic hepatic failure, chronic kidney disease and other chronic life limiting conditions associated with distressing symptoms and caregiver burden. Sandra McKinnon describes her experience of what happens to people dying of non-cancer diagnosis and states in her article that even though the illness may eventually lead to death, people will live, on average, much longer with any medical diagnosis other than cancer [3]. She justifies the need of palliative care services for non-cancer patients stating that each of these illnesses is characterized by exacerbations and remissions with an eventual terminal phase requiring support for patients and families. The support required by people dying from

any of the medical conditions is not different from the support needed by someone dying from cancer [3]. In a review of 14 studies Luddington L et al also summarized that some patients dying of non-cancer conditions have needs comparable with those dying of cancer [4].

In 2010, the major contributions to diseases requiring palliative care in India were from non-communicable diseases that accounted for 53% of all deaths. Among them, cancers constituted only 6%, whereas cardiovascular diseases contributed to 24% followed by respiratory diseases (11%), injuries (10%) and diabetes (2%) [5]. The right to a pain free and dignified life cannot be denied to people suffering from conditions considered less serious than cancer. Especially when the numbers of such chronic non-communicable diseases are on an increasing trend in India. Nearly 3.6 crore cases of coronary heart disease and 3.1 crore cases of diabetes was estimated for the year 2005 and was expected to have risen to nearly 6.1 crore and 4.6 crore cases respectively in 2015. Hypertension prevalence among adults  $\geq 20$  years was 159.46 per thousand. In addition to these non-communicable diseases, wide availability of anti-retro viral therapy has made HIV to be a chronic condition requiring palliative care; around 2.7 million people are living with HIV and about 1.89 million suffer from pain requiring palliative care [6]. The need for palliative care is further increased in India because of rising life expectancy and increasing proportion of elderly in the population [6]. It is known that only less than 2% of those who need it have access to any type of palliative care in India [7] given that the total number who need palliative care is estimated to be 6 million people a year [8].

The guiding principles as rightly suggested by the Expert Group for the Proposal of Strategies for Palliative Care in India is

to deliver palliative care at all levels of the health delivery systems, from primary to tertiary levels [6]. The Global Atlas has described Palliative care to be provided at three different levels: i) through a 'palliative care approach' adopted by all healthcare professionals, provided they are educated and skilled through appropriate training ii) 'general palliative care' provided by primary care professionals and those treating patients with life-threatening diseases, with a good basic knowledge of palliative care, and iii) 'specialist palliative care' provided by specialized teams for patients with complex problems [9].

To improve the scenario and for successfully implementing the first of the three strategies given by Global Atlas i.e., 'palliative care approach' for all healthcare professionals, all doctors and nurses have to be trained in skills of delivering palliative care services. If such training is given, the second strategy of 'general palliative care' can also happen. This can happen only when it is introduced as a must-know area into the graduate curriculum for medical and nursing courses. In the Proposal of Strategies for Palliative Care

in India, the recommendations for tertiary care centers focus on providing palliative care to mainly cancer patients in the Tertiary Cancer Centers (TCC) Scheme [3]. But tertiary care centers can be a good point of access to all non-cancer patients requiring palliative care and if the treating physicians and nurses are oriented and skilled to provide palliative care, the outcomes of treatment can improve. The care can be part of the continuum that the patients would receive also in the community. So, when planning for the palliative care services in the country through integration into the public health, the oft neglected non-cancer diseases should remain in focus of our policy makers and the large network of tertiary hospitals should also be in the service delivery of palliative care.

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### **Conflict of interest**

None.