Present scenario of palliative care for cancer patients in India

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Short Communication

The total number of cancer cases in India is likely to go up from 979,786 cases in the year 2010 to 1,148,757 cases in the year 2020.3 In India, every hour more than 60 patients die from cancer. More than 80% of cancers in India present in advanced stages.1,2 This shows the need of palliative care and pain relief for the cancer patients in India.1,2

The cancer research and therapy has progressed leaps and bounds till date. Various options are now available apart from the conventional surgery, radiotherapy and chemotherapy.3,4 Several approaches like immunotherapy, thermal therapy, phototherapy, and gene therapy have been recently developed and tested.3 Emphasis on molecular targeted therapies has led to improvements in drug delivery systems. The use of several types of nanocarriers that have been synthesized for drug delivery include dendrimers, liposomes, solid lipid nanoparticles, polymersomes. Radiation, phototherapy, and siRNA delivery are advancing rapidly and studied widely.3 In spite of all these efforts, the five year survival rate for cancer patients is still 50%. Palliative care adds to the quality of life to those suffering with advanced, recurrent or metastatic cancer. The various domains of palliative care as outlined by National Consensus Project (NCP) for quality palliative care in the USA are structure and process of care; physical aspects of care; psychological and psychiatric aspects of care; social aspects of care; spiritual, religious and existential aspects of care; cultural aspects of care; care of the imminently dying patient and ethical and legal aspects of care.5

Palliative care has several terms and synonyms, and this could potentially lead to confusion in its proper understanding such as hospice, end of life care, and specialist palliative care. Hospice is derived from Latin word “hospitium”, which means host. Hospice focuses on creating a natural and comfortable end-of-life experience for those confronted with a terminal condition as was opened in India in 1952.6 However, the term 'palliative care' covers a wider perspective and is defined as an approach that improves the quality of life of patients and their families facing the problem 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.7 The concept of palliative care is expanding. There are various models of palliative care as stated by Mazanec et al.7: (a) 1st generation-reflects the need to choose between receiving curative treatment and transitioning to supportive care alone, (b) 2nd generation model is where aggressive treatment and palliative care coexist, and (c) 3rd generation model believes on “zero sum” assumption such that almost all efforts are oriented towards modifying disease process and palliative care increases as disease orientation decreases. The latest model as proposed by Mazanec et al.7 emphasizes that the palliative care should fluctuate depending on the patient and family needs.

In India, the earliest facilities to deliver palliative care within cancer centers were established in the late 1980s and the early 1990s in some places such as Ahmedabad, Bangalore, Mumbai, Trivandrum, and Delhi. In April 2008, Kerala became the first state in India to announce a palliative care policy. There are 138 hospice and palliative care organizations spread across India which seem to be quite less in number not only as compared to the developed nations, but it seems to be very meager when compared with the burden of people suffering from terminal or end stage disease. Moreover, with a population of over a billion, spread over a vast geo-political mosaic, the reach and reliability of palliative care programs may appear staggering and insurmountable.2,8

The various impediments in its growth as faced in India are (1) lack of awareness among medical personnel and general public, (2) opiophobia due its addictive nature, (3) lack of its easy availabil-
ity, and (4) lack of proper training and research in this field. Palliative care model created should not be an imitation from other countries but should be adapted to Indian economy, culture and traditions and should be based on care at home and empowering families. The co-existence of multiple systems of medicine (modern medicine, ayurveda, homeopathy, and naturopathy) should be used complementary. Financial condition of the patient should be taken into consideration while planning treatment. Steps have been taken in this regard like the twelfth 5-year plan makes a special provision that at least 10% of the budget needs to be earmarked for these services at level of cancer care services. For palliative care, there will be dedicated 4 beds at the district hospital. Doctors, nurses, and health workers will be trained in basic palliative care. One of the doctors in the District hospital needs to have a 2 weeks training in palliative care.

Another important step would be to set up an outpatient palliative care centre so that the burden on inpatient palliative care established in cancer hospitals can be reduced as has been recommended by the American Society of Clinical Oncology (ASCO). The ASCO recommends increased integration of Palliative Care into the oncology setting in order to achieve high-quality comprehensive cancer care by 2020. In an article entitled “Outpatient clinics are a new frontier for palliative care,” by Meier and Beresford describes this field as an essential link in the continuity of care with inpatient Palliative care services. By providing this link, Outpatient palliative care in oncology may prevent or shorten hospitalizations, improve quality of life (QOL) and mood, and prolong life.

References