

Early Cancer Palliative Care (PC) Integration into Daily Clinical Practice by Nurses: A Critical Review.

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Abstract: This review discourses early palliative care integration in daily clinical practices by nurses in Nigerian context. Access to palliative care services is one of the major problems families face in getting this care outside of a hospital setting. Patients continue to lose their lives to life threatening and limiting diseases like cancer because, few of them receive palliative or hospice care. Cancer mortality in Nigeria stood at males-30,400 and females-38,000 deaths in 2012. In the country presently, there are few comprehensive palliative care programs. The quality of life for the cancer patients and the family is reduced when there are no palliative care services especially in situation where patients report at the terminal stage of the disease.

Presently there is no evidence and data on cancer palliative care integration in Nigeria. Out of 72 articles examined from five electronic databases (Science Direct, EBSCO host, Pub Med, and Cochrane) only five of the articles provided information and data on early integration of palliative care into clinical care of cancer patients in developed countries. Therefore, there is need for early integration of palliative care into the care of cancer patients to give them a meaningful and quality life at the end of life.

Keywords: Cancer, daily clinical practices, early integration, palliative care.

I. Introduction

Globally, cancer is considered a terminal and terrible ailment [1]. Most persons see the diagnosis of cancer as a death sentence, all though one-third of cancers can be prevented and another third are treatable, so long as they are diagnosed timely; and in the most of incurable patients, quality of life can be better by palliative care [2]. The author maintained that, approach to death of most people is influenced by spiritual philosophies. Death, from cancer, is viewed by a lot of people as a doing of God that cannot be altered [2]. Most patients especially in developing countries desire to turn to traditional doctors first. Even though these therapists do not comprehend the exact origin of cancer management, they talk efficiently with their patients and impart in them some degree of hopefulness [2]. These patients apply the prevailing services in orthodox clinics as a last option. This practice of seeking traditional treatment after cancer diagnosis causes deferment in appearance at the hospital; subsequently, a great percentage of cancer patients are seen in the advanced phases of the disease.

The term cancer is a collective term relating to a large cluster of disease characterized by unrestrained tumor and spread of irregular cells [3]. This cluster of disease rises from diverse tissues and structures, it varies seriously from one another in form and growth [3]. It also follows very diverse ways of development in the hosts, and reacts differently to the range of treatments applied to them. Cancer is a disease that disturbs many body structures at the same time. Cancer is described as not being one disease, and that the term is broad and is made up of "more than 200 diseases" which have similar features [3]. The author contends that their growth cannot be regulated; they are spread to other parts of the body. The management of cancer is therefore not based on type of malignancy but, the extent of its growth and their sensitivity to treatment modalities [3]. Although many cancers can be treated or controlled, cancer is one of the diseases that patients fear most. A diagnosis of cancer produces mental and emotional reactions and is a threat to social association and role responsibilities. The family and friends of persons who have cancer are also affected by the diagnosis.

In Africa, cancer new cases stood at over 700 000 and almost 600 000 deaths in 2007 [4]. Most African countries nevertheless, have no contact to effective screening, early diagnosis, treatment or palliative care; those with cancer and other life-threatening illnesses experience an agonizing and distressing death [4]. WHO's assessment of the necessity for palliative care is 1% of a country's entire population, approximately 9.67 million persons are in need of palliative care throughout Africa [1]. Notwithstanding, vast majority of Africans with advanced and life-limiting diseases right to access socially suitable, whole palliative care is inadequate, and at worst not available [4]. Based on the above facts, palliative care has an active role to play so as to help in monitoring and managing terminal cancer cases in other to give patient comfort and minimized care burden on families.

II. The Concept of Palliative Care

Modern hospice and palliative care commenced in England in the late 1950s, and Dame Cicely Saunders was recognized as the initiator of the growth of modern hospice care within UK and the world as a whole [5]. In the year 1987, the United Kingdom became the first country in the world to see palliative medicine as a specialty [5]. Cicely Saunders dedicated the rest of her life to develop modern approach to the care of the dying, as a nurse and later, physician, she has passion about the problem of pain in cancer patients before their death [6]. Dame Saunders developed a program of care of patients dying of cancer based on control of pain, family or community environment and an engagement with the dying patients which is rooted deeply on spirituality [7].

Many individuals, organizations and bodies including the WHO have come up with different definitions of palliative care. Macpherson defined palliative care as “to mitigate the suffering of the patient, not to affect a cure” [8]. Boltz described palliative care “as expert curative care of patients with severe disorders, and it emphasizes providing patients with relief from symptoms, discomfort and worry of serious illness, irrespective of the diagnosis” [9]. WHO revised the meaning of palliative care (PC) to be “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” [10].

Nursing care and palliative care is an act or service which is not very popular and a lot of people may see it as non-profitable because, people assume that palliative care as it is focus on the comfort care where death is eminent. As a result of this knowledge, nurses themselves see palliative care as not beneficial. The care given to patients even at the point of death within most cultures is always being appreciated by the clients’ family members. The mere facts that, their loved ones were well cared for with love and comforts at end stage always go down well in the history of that family. “The art of caring receives less attention as a result of being abstract in nature” [11]. Palliative care and nursing are “natural partners in clinical practice” [11]. This is because, nurses are the main focus when it comes to caring for the patient especially where physical, psychosocial and even spiritual care are involved. They are the ones to monitor effect and response of medication recommended by the physicians, patients’ general reaction to daily care etc. [11], if they are not knowledgeable and skillful in their caring process, they may end up as unskilled nurses and carry the blame for any negative outcome.

Florence Nightingale (1820-1910) the first nurse theorist professed the art of caring as she took care of the wounded soldiers at the Crimean war [12]. Nightingale went into the army hospitals where death toll was on the increase, soldiers were dying more from diseases due to poor sanitary condition than the wound they sustained in the battle front [12]. Nightingale focused on the nutrition and the comfort aspect of the soldiers which led to massive improvement of their health and reduction in death toll [12]. This caring behavior is what is required by palliative care nurses so as to be able to assess and give adequate intervention to patients diagnosed of cancer. Florence Nightingale laid the foundation for modern nursing profession. Therefore, it is pertinent that all nurses combine knowledge and compassion without being sentimental or hoping for gain when giving palliative care to cancer patients.

Palliative care is associated with the end-stage of life and whenever palliative care is mentioned, it means curative care is to be discontinued [13]. This review has different perspectives as it is trying to look at palliative care being introduced right from the point where cancer is diagnosed till death of the patient. And, even up to bereavement making sure that the family members are also made comfortable throughout the period. On March 2010, the American president Obama signed into law the “affordable act” [14]. The act among other package has it that medical aid services to implement a three-year project that will enable patients to received curative treatment as well as palliative/hospice care at the same time. The Americans has seen the benefit of integrating palliative care with curative management that, it reduces cost as compared to using only curative care. The project reduced cost of giving care (palliative care) at home and also the quality of life of these patients will improved [14]. The health care reform Act, stressed on cost effectiveness which can be borrowed employed in all care setting especially in developing countries like Nigeria.

The World Health Assembly approved the resolution to integrate hospice and palliative care services into national health services [15]. The body acknowledge these important health services as a fundamental part of health systems globally and therefore call on national governments to make sure they be given the responsiveness they deserve. This is the first time that the World Health Assembly has deliberated a resolution on palliative care. It endorses that all countries need to take palliative care earnestly [15]. The main recommendations to all member states of WHO as seen in the resolution are to integrate palliative care into healthcare systems. Making sure that palliative care is incorporated into the introductory and continuing education and training for all health care personnel and make sure that appropriate medications, as well as strong pain medications, are accessible to patients [15].

The role of nurses does not include the field of counseling, spiritual/pastoral care or social works, but they can play a significant part in facilitating or helping the patient to address these issues. An active approach

of assisting the patient is to connect them with either a local NGO or faith based group. Nonprofessional may be able to provide quality relief of suffering to the patient [16]. The way nurses facilitate the contribution of nonprofessional can have a significant impact on the quality of life and death of the patient. For example, permitting a support or prayer group to be at the patient's bedside, or allowing a support group to use clinic facilities.

III. Early Integration of Palliative Care into Daily Clinical Practice

Palliative care ought not to be understood as a relocation of care out of the natural care setting [17]. Palliative care according to the authors can be effectively integrated much earlier into the course of patients with progressive, life-threatening disease devoid of any undesirable outcome on patients and families. The usual opinion, that patients will give up confidence and "stop fighting" their sickness, is incorrect and frequently averts or postpones good end-of-life care up to just a few weeks or days before death [17]. This short period of intervention may mean that patients and families feel pain unjustly for months. Palliative care highlights patient discomfort and indicates controlling, lay emphasis on communication with patients and their relatives, and institutes harmonization of care. Agreed the incidence of cancer and the great necessity to control symptoms of this habitually progressive disease, scholars have projected that palliative care ought to be incorporated into usual cancer management [18, 19].

Fallon & Hanks opined that although palliative care is often equate to end-of-life care, the focus is on quality of life of patients and families who has been diagnosed of having life threatening disease[20]. They further stressed that; patient with cancer can have advantage of palliative care facility from the time diagnosis is confirmed throughout treatment of the disease up to the end-of life. Early integration of palliative care along cancer treatment will not only improve the quality of life, but, the care may lead to a cure [21]. In the same vein, early integration of palliative care in the course of treatment of cancer patient from diagnosis bring about a better outcome [22]. Numerous clinical researches have revealed the benefits of timely intervention with PC in patients with progressive cancer. Furthermore, in the old care model, palliative care is introduced only when life-prolonging or therapeutic action is no longer ordered [22]. In the combined or integrated model, both palliative care and life-prolonging care are delivered all through the progression of illness.

The purpose of palliative care lies in the lessening of distress and enhancement in the quality of life for patients and their families. Palliative care is managed either by working in partnership with professionals comprised in a multidisciplinary palliative care team (doctors, nurses, social workers, chaplains, counsellors, and psychologists or psychiatrists) or within the range of a broad care method coordinated by a health expert (frequently a nurse) [23]. Early palliative care can be provided in a scope of sites as well as community, hospitals, and inpatient clinics[23]. Early palliative care begins at diagnosis of cancer and continues even when death is eminent [23]. They opined that this should be carried along-side standard curative treatment. A requirement for patients' willingness for palliative care in such an early condition is comprehensible and compassionate communication of health care professionals [23; 24].

In a retrospect study conducted, the main objective of which was to assess in the consequence of palliative intervention on survival in non-small-cell-lung cancer (NSCLC) and other cancers [25]. The study revealed alterations in the progresses in survival period as a result of early intervention in NSCLC, gastric cancer and colorectal cancers [25]. The survival time according to the authors "increased by 10.5 months (P ¼ 0.010) in patients with NSCLC, 5.1 months (P ¼ 0.310) in patients with gastric cancer and 4.4 months (P ¼ 0.039) in patients with colorectal cancer with early palliative intervention" [25]. A noteworthy change was realised in the survival time in NSCLC and colorectal cancers[25]. This result proposes that early palliative intervention increases the survival time of cancers other than NSCLC [25]. With the result of this study, it was recommended that patient diagnosed with cancer should be referred early to palliative care services while still receiving chemotherapy and other cancer treatment [25].

In another study, 151 patients who were recently identified with non-small cell lung cancer (NSCLC) were randomly allocated to early palliative care and normal oncology care or to normal oncology care only [26]. The palliative care intervention comprised of a standard assessment (using consistent assessment tools, such as the Edmonton Symptom Assessment Scale or the Condensed Memorial Symptom Assessment Scale) and follow-up at least once per month by palliative care multidisciplinary team members which "made up of seven palliative care clinicians: six physicians and one advanced practice nurse" [26]. "The average preliminary session with a member of the team took 55 minutes, of which 20 minutes were spent on symptom management, 15 on patient and family coping, and 10 on education about the illness" [26]. Patients were also presented with an informational visit to the hospice three to six months before the individual was anticipated to die. These researchers measured the effect of the intervention on patients' quality of life, disposition and hostility of end-of-life care (e.g., chemotherapy within 14 days of death, lack of hospice care, hospice admission less than 3 days before death). Patients who had the intervention had meaningfully greater quality of life scores than those who had only standard oncology care [26]. They experienced less depressing symptoms and a reduced amount of

forceful care, and notwithstanding getting less aggressive care, they lived, on average, 2.7 months longer. [26]. The researchers concluded that, accepting the prospects and aims of treatment had the strongest influence on the patients' successive adoptions of therapy and their survival.

IV. Conclusion and Recommendations

Problems encounter in palliative care policy in Africa is lack of palliative care research among the health care professionals and non-financial support for such project [27]. Most budgets allocated for the health sector focus around communicable diseases such as HIV/AIDS [27]. African Palliative Care Association (APCA) ascribe to the World Health Organization (WHO) public health approach to palliative care development. Their task is to make sure that care is extensively understood, incorporated into health care systems and strengthened by proof in order to decrease pain and anguish through Africa [28]. To get this done, APCA has provided guidance and coordination in the development of palliative care tools and resources design to the needs of African patients and healthcare providers. They are mainly concerned with awareness, policy, advocacy, education and quality improvement in palliative care [28]. If this is done, it will go a long way to improve care given to cancer patients especially, when considering comfort and quality of life at the end of life stage of the disease. Therefore, it is vital to integrate palliative care early into the care of patients diagnosed with cancer early in the illness trajectory.

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