

A Brief Review on Palliative Care: End-of-Life Care in India

Umaima Khan*

Department of Pathology, Jawaharlal Nehru Medical College, DMIMS (DU), Sawangi, Wardha, Maharashtra, India

Abstract

Palliative care is a type of medical care focused on providing relief from the symptoms, pain, and stress of serious illnesses. The goal of palliative care is to improve the quality of life for patients and their families by addressing their physical, emotional, social, and spiritual needs. Palliative care can be provided at any stage of an illness and can be integrated into other medical treatments. It is not limited to end-of-life care and can be used to manage symptoms and improve quality of life throughout the course of an illness.

Keywords: Palliative care; Illness; Medical treatments; Quality of life; End-of-life care

Introduction

Justice is the underlying concern for the welfare of the entire and improves the patients quality of life in palliative end-of-life care. In order to maximise the patient's welfare through an integrated strategy and prevent counterproductive assessments in clinical practises, it is appropriate to assess the patient. The physicians duty in end-of-life care is to uphold medical ethics, policy, and professional treatment standards in every circumstance rather than to grant every request of the patients. On the other hand, the legislation also affirms that doctors are explicitly encouraged not to go against the patient's will or choices about the rejection of the ongoing medical treatment, even if doing so results in the patient's death, in end-of-life care settings [1-3]. The doctor's role is to fully explain the medical treatment options and defer to the patient's decision-making process. The legislation requires doctors to always act in the patient's best interest, free of any obligation, and to provide a decent death by allowing the patient and family to make an informed decision about how to prepare for the inevitable end. A set of guidelines known as medical ethics directs the actions of medical practitioners and shapes their duties in accordance with moral standards. The patient has the absolute right to know the specifics of their diagnosis and can choose to accept or reject therapy. Medical ethical standards, which are not laws but rather a set of guidelines, are of the utmost significance when it comes to providing care for people who have severe illnesses like cancer and HIV. The ethical tenets of patient autonomy, beneficence, non-maleficence, social justice, and adequate treatment served as the foundation for Indian Palliative End-of-Life Care. The patient's autonomy is a crucial aspect of palliative end-of-life care [4,5]. Being independent involves respect for oneself and one's rights, especially when it comes to choosing a treatment plan. In order for patients to exercise their autonomy in healthcare settings, they must participate actively in management decisions and team meetings. The patient regains a sense of full control over their disease, the risks vs. advantages, and the main determining factor that outweighs the troublesome concerns thanks to autonomy. Additionally, it is crucial for doctors providing end-of-life care to make decisions that are in the best interests of their patients by fully understanding the medical treatment plan or the patient's condition. Physicians should be well-versed in pain and symptom management since palliative end-of-life care seeks neither to shorten nor lengthen patient life but to deliver the quality of life and well-being of the entire through all available methods. Mercy killing or any other method of easing the patient's suffering and anguish is not an option, but the ethical principle permits the use of opioids to treat the pain and other distressing symptoms. When providing for the requirements of a patient receiving

palliative end-of-life care, this is known as non-maleficence. It stays away from poor medical care that offers no potential advantages and might perhaps raise the risk factors for a fatal diagnosis. The main goal of end-of-life care is to make death a more positive experience rather than a frightening or horrifying hospital stay. Individuals should find purpose in their suffering during the process of dying, and at that point, all of the dying person's needs should be attended to in any way that is practical. In order to have effective communication where the patient may freely express their views and wants, it is crucial for health care practitioners to gain their patients' confidence [6]. Clinicians should respect and cherish patients even in the latter stages of terminal illness diagnosis, when patients typically lose their sense of self and ability to make decisions for themselves. The doctors were required under the principle not to continue aggressive life-prolonging measures or to stop administering current treatments without the patients consent [7-12]. Overall, the main emphasis of the ethical principle in end-of-life care is that fair treatment offers the patient the right to demand what they are legally entitled to.

What makes a meaningful death: a decent death?

In the majority of clinical settings in India, end-of-life care for the quality of life and death is still a taboo subject. The industrialized nations, including the United Kingdom, the United States, Canada, Australia, etc., are well along in their efforts to provide good death in the face of excruciating final experiences. According to cultural and ethical norms, a meaningful death is free from worry, pain, and suffering related to dying [13-15]. Death anxiety, often known as the dread of death or the fear of dying process, is the level of worry about the impending death that is persistent and interferes with daily functioning.

The components of a decent death in clinical settings are as follows:

- Effective symptom and pain control.
- Avoiding a drawn-out death process and feeling in charge.

*Corresponding author: Umaima Khan, Department of Pathology, Jawaharlal Nehru Medical College, DMIMS (DU), Sawangi, Wardha, Maharashtra, India, E-mail: umaimak_h@gmail.com

Received: 01-Apr-2023, Manuscript No. jpcm-23-96603; Editor assigned: 03-Apr-2023, PreQC No. jpcm-23-96603(PQ); Reviewed: 17-Apr-2023, QC No. jpcm-23-96603; Revised: 21-Apr-2023, Manuscript No. jpcm-23-96603(R); Published: 28-Apr-2023, DOI: 10.4172/2165-7386.1000517

Citation: Khan U (2023) A Brief Review on Palliative Care: End-of-Life Care in India. J Palliat Care Med 13: 517.

Copyright: © 2023 Khan U. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

- Open communication between patients, families, and doctors regarding decisions.
- Adequate death planning for the patient and their loved ones.
- Obtaining a spiritual or emotional sense of closure and reaffirming the patient's identity as a special and deserving individual.
- Strengthening bonds with loved ones and avoiding isolation.
- To ensure a good death for every individual who is dying, regardless of circumstance, location, diagnosis, or length of sickness.
- Quality of life and quality of dying are emphasized.
- Recognize that everyone has a right to a decent, peaceful, and dignified dying and that excellent EOLC is a human right.

Discussion

Many terminally ill individuals are denied end-of-life care for a variety of reasons, including the palliative care facilities' limited availability and the greater costs of medical care. Integrating palliative end-of-life care into the nation's medical schools as primary health education is urgently needed. To provide the whole person treatment and quality of life, the medical-related curricula that have neglected the holistic requirements of the dying patients in end-of-life care urgently need to be revitalised. Significant obstacles in the undergraduate medical curriculum include clinical management in terminal diagnosis, peaceful death, dying with dignity, handling various mental disharmonies, and psychiatric disorders. While upholding the nation's ethical values and legal regulations and highlighting the critical need for palliative end-of-life care in India today, the many elements of the patient's requirements should receive particular attention.

Conclusion

Despite the fact that many legal and religious systems discourage. Another aspect of a decent death is anticipating it and being prepared. Another useful component of bringing a nice conclusion is respecting the dying patients' desires and letting them decide when to die. However, because there is no such option in India, many people view the country as a place where they should not pass away. There is now an appeal before the Supreme Court about the acceptance of advance directive care in Indian healthcare settings. According to the existing circumstances, the majority of terminally ill people in India die in a difficult way. The lack of 'good death' ideas and associated infrastructure required in Indian palliative end-of-life care is the cause. The term disadvantage dying refers to a group of persons whose bodily, social, and spiritual needs run the danger of being subverted or ignored as a result of societal attitudes, ignorance, or discrimination against those who are approaching the end of their lives. Most frequently, those with HIV/AIDS, learning difficulties, elderly individuals, cancer patients who are most often poor, and those with dementia. Even the community

of third gender people is more vulnerable. As a result, modern India falls short in providing the urgently needed comprehensive treatment.

Acknowledgement

Not applicable.

Conflict of Interest

Author declares no conflict of interest.

References

1. Higginson IJ, Finlay IG, Goodwin DM, Hood K, Edwards AG, et al. (2003) Is there evidence that palliative care teams alter end-of-life experiences of patients and their caregivers? *J Pain Symptom Manage* 25:150-168.
2. Zimmermann C, Riechelmann R, Krzyzanowska M, Rodin G, Tannock I (2008) Effectiveness of specialized palliative care: A systematic review. *Jama* 299:1698-1709.
3. Gomes B, Harding R, Foley KM, Higginson IJ (2009) Optimal approaches to the health economics of palliative care: Report of an international think tank. *J Pain Symptom Manage* 38:4-10.
4. Normand C (2012) Setting priorities in and for end-of-life care: Challenges in the application of economic evaluation. *Health Econ Policy Law* 7:431-439.
5. Smith S, Brick A, O'Hara S, Normand C (2014) Evidence on the cost and cost-effectiveness of palliative care: A literature review. *Palliat Med* 28:130-150.
6. Prinja S, Kaur M, Kumar R (2012) Universal health insurance in India: Ensuring equity, efficiency, and quality. *Indian J Community Med* 37:142-149.
7. Balarajan Y, Selvaraj S, Subramanian S (2011) Health care and equity in India. *Lancet* 377:505-515.
8. Lagomarsino G, Garabrant A, Adyas A, Muga R, Otoo N (2012) Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *Lancet* 380:933-943.
9. Gupta S, Sagar R (2018) National mental health programme-optimism and caution: a narrative review. *Indian J Psychol Med* 40:509-516.
10. Mandal SC (2003) Pharmacoeconomics- Regulatory perspective and its relevance in Indian Context. *Pharma Times* 45:18-20.
11. De Roo ML, Miccinesi G, Onwuteaka-Philipsen BD, Van Den Noortgate N, Van den Block L, et al. (2014) Actual and preferred place of death of home-dwelling patients in four European countries: making sense of quality indicators. *PLoS one* 9: 93762.
12. Richards CT, Gisondi MA, Chang CH, Courtney DM, Engel KG, et al. (2011) Palliative care symptom assessment for patients with cancer in the emergency department: validation of the Screen for Palliative and End-of-life care needs in the Emergency Department instrument. *J Palliat Med* 14: 757-764.
13. Mohanti BK (2011) Research focus in palliative care. *Indian J Palliat Care* 17: S8.
14. Choudhary S, Mahala P (2021) Role of Palliative Care at the End of Life: To Enhance the Quality of Life and Positively Influence the Course of Illness. *P J Nurs* 14: 42-45.
15. Rome RB, Luminais HH, Bourgeois DA, Blais CM (2011) The role of palliative care at the end of life. *Ochsner J* 11: 348-352.