

Advancing Palliative Cancer Care in Primary Settings: A Comprehensive Review

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Abstract

To ensure the sustainability of healthcare systems and enhance the quality of life, the (re)organization of care is imperative in the face of chronic illnesses such as cancer and increasing life expectancies. Palliative care, when integrated into primary healthcare, yields positive outcomes, including elevated standards of care for terminally ill patients, reduced hospitalizations and medical costs, and enhanced patient autonomy in symptom management at home. However, this integrated approach is not universally feasible, as many nations isolate or centralize palliative cancer treatment in hospitals, often lacking strategic involvement from primary care. In affluent nations where integrated palliative care is provided at home, there has been an improvement in the prospects of individuals receiving dignified end-of-life care. This analysis aims to evaluate how primary care structures home-based palliative cancer treatment to optimize healthcare resources and elevate patient quality of life. Employing the Cochrane technique in this systematic review, a narrative synthesis will be generated, guided by the Preferred Reporting Items for Systematic Reviews for the final report.

Keywords: Palliative cancer care; Primary care; End-of-life care; Healthcare innovation; Chronic diseases

Introduction

Palliative care, as defined, is the active and comprehensive treatment provided to individuals, irrespective of age, who are grappling with severe illnesses and are in close proximity to the end of life. This approach emphasizes prevention, early detection, thorough assessment, and management of medical concerns, encompassing pain, psychological distress, spiritual discomfort, and social needs. The goal is to enhance comfort and quality of life for both the patient and family caregivers. The World Health Organization advocates for the early integration of palliative care, starting from the identification of life-threatening conditions to achieve these objectives. The evolution of investments in palliative care stems from the merging of clinical and palliative care, responding to people's needs and expectations. Notably, palliative care gains prominence when diseases prove unresponsive to curative or control treatments [1,2]. However, in low- and middle-income countries, palliative care is often insufficient and precarious due to a lack of knowledge among health professionals and the public, inadequate resources, and shortcomings in public-private health systems, hindering the delivery of quality and safe palliative care [3,4]. Dying individuals in these regions frequently experience agony and neglect, as palliative care is not consistently provided. Different paradigms, such as the biological perspective, suggest that treatment failures for cure should not be accepted, palliative care patients should be identified later, and optimistic prognoses should be avoided. Given these constraints, palliative care is more embraced among cancer patients than among those with prolonged illnesses and poor prognoses, justifying the focus on oncology in this review [5,6]. Especially in the oncology field, clinical instability and worsening symptoms in advanced cancer patients can lead to the use of urgencies and emergencies, as well as prolonged hospital admissions, when treatment is not integrated with a professional palliative care team for difficult cases. The absence of in-hospital teams, transitional care, home palliative care, or a structured network for managing individuals with palliative care needs results in substantial financial expenses in hospital-based models [7,8]. Many developed nations invest in well-organized palliative care services, primarily managed by primary care, to address the escalating costs associated with chronic illnesses.

This investment is driven by the recognition of the intrinsic link between palliative care and primary care, both guided by shared values such as equity, solidarity, social justice, universal access to services, multisectoral activity, decentralization, and community participation. Evolving end-of-life care practices, including the shift of hospice care from hospitals to homes, are integral components of the palliative care strategy within primary care [9,10]. Home care serves as the primary delivery method for palliative care, aligning with bioethical values like patient autonomy and expanding access to a broader population. The success of home palliative care hinges on the presence of a family caregiver offering care under professional supervision. The health team, responding to demand, conducts home consultations, with nurses often playing a pivotal role within a multidisciplinary team. Primary care teams have the flexibility to organize home palliative cancer care in diverse ways, catering to the needs of patients and families while offering both generalist and specialist palliative care. The care models may vary across health systems, providing specialist palliative care at home, in hospice programs, and/or in hospitals. The involvement of primary care clinicians is crucial for seamless integration with specialist palliative care in any paradigm. The comprehensive organization of home palliative cancer treatment by primary care has not been extensively studied, presenting a gap in the literature. A thorough investigation could assist numerous nations in urgently strengthening their capacity to deliver palliative care by consolidating diverse and dispersed information. The evidence must be robust in addressing not only the ability to enhance the quality of life for patients receiving palliative care but also the associated costs [11]. In Canada,

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it is anticipated that 90% of the 480,000 annual fatalities by 2056 could be treatable with palliative care. The objective of palliative care is to improve the quality of life for patients and their families by preventing and alleviating pain, often chosen to be received at home. Palliative care at home involves the delivery of specialist palliative care by nurses and/or doctors at the patient's home, with or without a connection to a hospital or hospice. The decision to receive palliative care at home is influenced by a commitment to caring for the patient at home, the desire for a "normal family life," and past negative experiences in institutional care settings. A majority of Canadians express a preference to die at home, and various interventions for palliative care at home are implemented, ranging from offering hope to informal caregiver counseling or after-hours night respite. Assessments of palliative care often rely on retroactive proxy reports and systematic data gathering, including evaluations of cost and resource usage. While the place of death, whether at home or in a hospital, has been a metric for assessing palliative care at home, its validity is debated as it only considers the end of the dying process [12-14].

Research Methodology

The classification of included studies relied on primary outcomes. An independent second reviewer confirmed the data extraction, encompassing objectives, methodology, main results, and topics addressed. For assessing the quality of randomized controlled trials (RCTs), the Cochrane Risk of Bias (ROB) tool was employed [15]. Controlled before-and-after studies were assessed using the same criteria as RCTs, revealing a significant risk of bias concerning allocation sequence concealment and random sequence creation. The Newcastle-Ottawa criteria were applied to evaluate the quality of cohort studies. Qualitative investigations underwent quality assessment using the Critical appraisal skills programme qualitative checklist, following cochrane recommendations. The Cochrane-recommended "Quality assessment tool for quantitative studies" gauged the level of quality in cross-sectional studies. It's worth noting that cost studies, lacking outcome analysis, were deemed unsuitable for application with currently available, validated quality evaluation techniques.

Discussion

Within the palliative home care literature, a total of 53 papers with diverse research designs, reporting various outcomes, and exhibiting varying quality were identified. It is crucial to note that gaps in information exist, particularly regarding the impact on carer distress and the effectiveness of interventions aimed at enhancing the quality of palliative care at home. Generalizing about successful palliative care at home proves challenging due to the size and diversity of this body of information. Almost one-third of the included studies assessed palliative care at home treatments using primary outcomes such as resource utilization, cost, or site of death. Some argue that these outcomes may not sufficiently determine the intervention's benefits, emphasizing the importance of aligning efficacy metrics with the intervention's goals, such as the location of care before death rather than the site of death itself.

Our findings underscore the necessity of quantifying outcomes closely related to the goal of palliative care at home, requiring a departure from conventionally obtained data. The care providers and intervention elements varied among the included studies, with the theme of personalized patient-centered care present in 66% of the reviewed studies, highlighting a focus on meeting patient needs. Due to the diverse nature of these treatments, generalizations about the elements contributing to successful outcomes prove challenging.

The papers included in the review featured nine distinct primary outcomes, complicating the determination of the helpfulness of specific components given the variety of results. Establishing agreement on necessary outcomes to demonstrate intervention success would significantly advance the growing body of knowledge. Despite inconsistent quality, all intervention assessments revealed favorable results, supporting the common-sense notion that patients benefit from receiving palliative care at home. However, publication bias may contribute to this trend, as the heterogeneity in intervention components and primary outcome assessment hinders our ability to ascertain whether trials with negative effects remain unpublished. Intervention assessments underscored the significance of expanded healthcare professional accessibility, symptom reduction, and the inclusion of carers as both beneficiaries and participants in care, aligning with a meta-ethnography evaluating patient and carer objectives for palliative care at home. The results presented here stem from a survey conducted by the American psychological association (APA) on the use of the term "psychological assessment" in the workplace.

Conclusion

Addressing the substantial financial strain imposed by cancer and chronic diseases on society necessitates swift and inventive solutions to cater to the needs of individuals approaching the end of their lives. This study aims to consolidate data that may advocate for the expansion of palliative cancer care within primary care, particularly in-home care, aligning with the objectives of sustainable development and the global advancement of public policies. The authors intend to publish a comprehensive final report in a journal indexed in global databases, ensuring scientific rigor in the review and broad distribution of the findings.

Acknowledgement

Not applicable.

Conflict of Interest

Author declares no conflict of interest.

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