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Various Aspects of Palliative Care in Bangladesh

Mahmudur Rahman AHM[1] and Md. Reyad-ul-Ferdous[1,2,3,4]

1 Department of Pharmaceutical Sciences, North South University, Bashundhara, Dhaka-1229, Bangladesh
2 Department of Pharmacy, Progati Medical Institute, Dhaka-1216, Bangladesh
3 Department of Pharmacy, State University of Bangladesh, Dhaka-1207, Bangladesh
4 Department of Microbiology, Northwest A&F University, Yangling 712100, Shaanxi, PR China

Corresponding author:
Md. Reyad-ul-Ferdous

rockyreyad@yahoo.com

Department of Microbiology, Northwest A&F University, Yangling 712100, Shaanxi, PR China

Tel: +880-1719134213

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Abstract

Palliative care ('palliative' approaches from the Latin 'pallium' meaning cloak) is several form of medical care and multidisciplinary approach that focuses on reducing severity of symptoms of diseases rather than delay progression of the disease itself or provide cure. Palliative care is all about accomplishing the possible highest quality of life (QOL) and promoting relieve and dignity for patients whose are suffering with incurable and life limiting diseases. The aspects of the palliative care in Bangladesh concern the matters of concentrating on the rights of the patients in getting release from sufferings of all kinds (physical, psychological, social and spiritual).

Keywords: Palliative care; Effective commutations with patients; Bangladesh

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Introduction

Older citizens with orthopedic conditions need specialized care for the facilitation of early community reintegration and restitution of physical function. We introduced a new community care programmed as an alternative to usual hospital rehabilitation for orthopedic patients. This hospital-at-home service obtained similar clinical results to the usual hospital-based rehabilitation care, and for hip fracture patients attending that service, rehabilitation efficiency was better. Around a million people die in Bangladesh every year where approximately 0.6 million are estimated in need of palliative care [1]. Inside the plan of palliative care, some upsetting ethical issues are nursing ethics and bioethics. The aspects of palliative care in Bangladesh verbalize a lot for the move of the rights of the patients to have a holistic and humane treatment. To convene the huge challenge in Bangladesh, palliative care needs to be mainstreamed into the accessible healthcare scheme for a possible and sustainable public health advance [2]. In 2007, 13% of all deaths global were owed to cancer and among them 72% took place in low and middle-income countries like Bangladesh [3].

Numerous persons and their families are troubled by somber chronic illness in late life. How to unsurpassed sustain quality of life is a significant consideration for palliative care [4]. Following patient death, a bathing and glorification practice with family associate contribution is very optimistic and meaningful, and it supports family associates' initial grieving [5].Hospice provides exhaustive end-of-life care to patients and their families brought by an interdisciplinary squad of nurses, aides, physicians, chaplains and social workers. Significant spaces remain regarding how team members retort to varied needs of patients and families and particularly in the last week of life [6].

The exercise of hospice care in nursing homes (NHs) has grown exponentially, but a rising alarm is the lack of entrance to resident and family-centered palliative care when residents do not choose hospice, and in time periods previous to choice [7]. In the early hours palliative care is more and more recommended but hardly ever practiced and schooling of the public, patients and health care providers is supreme if early incorporation of palliative care is to be flourishing [8]. By proactively executing strategies, researchers can improve the amalgamation of End-of-life (EOL) investigation into the sensitive care surroundings [9]. A diversity of medications is used for symptom management in palliative care, for instance morphine. The pharmacokinetics of these drugs may be distorted in these patients as a consequence of physiological changes that happen at the ending stage of life [10]. PC experts should play a vigorous role in enlightening emergency departments (EDs) physicians about PC, and offer sensible consultations [11].

Objective

The objective of this review is to describe the needs and importance of palliative care in Bangladesh and those of the as long as clinicians, in order to overhaul improvement.

Palliative Care in Bangladesh is a basic right

Article 15A & 18(1) of Bangladesh Constitution instructs on the state the provision of basic medical care mentioned follows [12,13].

15A: The provision of the basic necessities of life, including food, clothing, shelter, education and medical care.

18(1): The State shall regard the raising of the level of nutrition and the improvement of public health as moving its main duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and drugs which are injurious to health.

The concept of palliative care in Bangladesh so far remained limited to the sympathetic caring of the family members toward their loved ones with fatal illness. It is clear that palliative care in Bangladesh is set at basic level, where some could be sought from the extended family care support system. Quality of life (QOL) issues are rarely practiced or even thought in Bangladesh. Furthermore, palliative medicine, in the perspective of total palliative care service does not have its due recognition in Bangladesh.

Challenging issues for palliative care in Bangladesh

First of all misconception comes. The general misconception is that only whose are terminally sick and those whom health center have given up hopes of any progress, need palliative care. Palliative care is an advancement which can improve the quality of patients life and their family facing the problems associated with threatening illness which is life taking through the prevention and relief of suffering by means of early identification and faultless evaluation and treatment of pain and other problems like physical, psychological and spiritual [14].

In advanced stage of diseases pain is the dominant symptom. Pain makes a patient anxious and discomfort and impatient. Because of constant pain patients convoy unhappy death. Pain relief can be successfully achieved by the scientific and holistic advance of analgesic supply in palliative care. Lack of knowledge and skill in assessment and improper medication, fear of opioid and addiction are some of the complex obstacle of palliative care. The fear which comes in mind that drugs (sedatives and opioids) prescribed in the terminal stage may accelerate the death process. Research critics the policies of Dutch end-of-life (EOL) and stated that approximately 20.1% of all deaths were cases in which death happened following an amplification of medication to alleviate symptoms of pain. The Moral explanation to provide analgesia at final stage of disease for the intention of relieving distress provided that other conditions are satisfied. But the officially authorized explanations of use of analgesia for palliative care practices are still less clear [15].

There are some information gaps also. Death is the most natural things and sure event in life. But the custom is not to talk about forthcoming death to a terminal ill patient in many societies in this country. Family members often do not step forward to be the ultimate decision maker when death is inevitable. For that reason health care professionals and Intensive care unit (ICU) may have been challenged for supporting patients and families only for lack of information [16]. Sometimes we find that successful resuscitation is not possible i.e. advanced liver failure and metastatic cancer. In these cases physicians do not plan to offer cardiopulmonary resuscitation (CPR). In Bangladesh like some countries of the world, we find that patients and usually family members do not like to perceive the antagonistic treatment at end stage disease on their love one and seek policy of do-not-resuscitate (DNR) in end-of-life care. Physicians need to avoid giving false hope of cure or false belief. Palliative care team must not hide the truth telling the diagnosis abruptly and gently try for breaking the news on a need to know basis. Bangladesh has more than 1 million patients with cancer at any top of time and about a million suffer from other incurable diseases i.e. progressive neurological, cardiac and respiratory diseases and HIV-AIDs etc. The practice of euthanasia is legalized in some countries (Netherlands, Belgium, some States of USA and Australia). Euthanasia poses an ethical dilemma in palliative care. Euthanasia predominantly the intention of the physician and not the patients wish. Nevertheless, in some religions and the culture of this country, terminating human life is considered as unethical because it violates the ethical belief that life should never be taken intentionally and the basic human right is not to be killed. In circumstances going of health services beyond the biomedical model of health and treat the end stage patients with dignity is a challenging issue. As we know ethno-specific requirements in exacting society, many of which occur from socio-economic factors and religious beliefs and are tinted by fatal illness [17].

Participants identified that pain management was a significant issue. A lack of nurses' ability to advocate effectively for patients because of a lack of relevant skills and knowledge and poor availability of appropriate analgesics was a limiting factor along with doctors' reluctance to prescribe opioids to effectively manage pain.

Lack of resources coupled with lack of training for nurses has a negative impact on palliative care and the delivery of care services to persons living with human immune virus/acquired immune deficiency syndromes in Botswana [18].

Palliative care requires the early identification; thorough assessment; and effective treatment of all problems, physical, psychological, spiritual, and social, in life-limiting illness [19]. There is evidence that palliative care for HIV is effective in the domains of pain and symptom control, anxiety, insight, and spiritual wellbeing [20], although the literature is limited; most studies predate the availability of antiretroviral therapy (ART), almost all are of patients with advanced disease, and very few have been conducted in sub-Saharan Africa where two-thirds of people with HIV live [21]. World Health Organization (WHO) policy states that ‘‘palliative care should be incorporated as appropriate at every stage of HIV disease, and not only when the patient is

dying,'' and that palliative care should be used alongside ART as needed, not as a substitute.

Point of view

Living in a deprived socioeconomic condition like Bangladesh, it is very difficult to encourage the policy makers to divert more resources in palliative care as we cannot ensure curative care for most of the population. As a civilized society we cannot ignore the importance of palliative care for those dying patients each year. In 2006, when palliative care was first initiated in Bangabandhu Sheikh Mujib Medical University (BSMMU) there was a research conducted on 53 patients demonstrated in the **Table 1**.

Nowadays it is also practiced by some other institutes but very short in range. We can propose for [6] Developing of a national policy and allocating yearly budget and establishing palliative care department in every government hospital and motivating and recruiting volunteers and involving charities to donate fund need wide media campaign and arranging training for health workers and developing public education to build up expertise and creating awareness amongst general population [22].

Effective commutations with patients

Best possible palliative care cannot be understood unless we have a complete understanding of what the patient and the family of the patient is experiencing. We can find still a gap in nursing knowledge related to care and cultural minorities. Four factors which are very important: caring, communication, support and home and family. In addition palliative care employees working with Bangladeshi families need to be conscious of the further stresses that these families may experience and be clever to recommend approaches to facilitate them to deal with them [23].

Recommendations

Various research and studies are needed to measure the efficiency of the strategies used so far and to compare the symptoms of similar samples of those terminally ill whose are obtaining palliative treatment in an array of settings.

Conclusion

Bangladesh faces huge unmet needs of patients with life limiting illnesses where it is about achieving the highest quality of life (QOL) and promoting comfort and self-respect for patients with not only incurable but also life limiting diseases. Palliative care promotion has been strengthened by announcing that allocation of palliative care is a human right. To overcome the barriers to successful implementation of palliative care we need continued efforts and it is our not only ethical but also moral obligation to do whatever we can.

Table 1 Demographic data for palliative care patients in Bangladesh.

Total number :	Socio-economic status:	Common symptoms	Primary diagnosis	Observations	Major concern of the patients	Place of death
(n= 53) Male: 25; Female: 28; Age range 22-80 yrs; Average 53 yrs.	Very poor 3; Poor 15; Middle class 23; Affluent class 10.	Pain –47; Sleeplessness-29; Anxiety-27; Loss of appetite-22; Constipation-18.	Breast 5; Oral cavity 4; Gall bladder 3; Rectum 6; Pancreases 4; Lymphoid organs 4; Urinary bladder 3; Colon 3; Prostate 1; Esophagus 3; Bone 2; Lung 4; Kidney 2; Others 8(Primary not detected)	No of contact with single patients: Single to 24 visits.	financial issue Major concern of family : Not to inform the diagnosis/ prognosis to the patient	13 in hospital, 29 at home Earliest time PC team is informed of death : < less than an hour

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