Current Status of the Application of Palliative Care in End-stage Cancer Patients

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Abstract: Patients with end-stage cancer often face the dilemma of poor prognosis, limited survival and severe decline in quality of life, accompanied by heavy economic pressure, heavy family care burden, and the dual pain of the patient's body and mind, and the ability to live daily life is significantly limited. This paper summarizes the development of palliative care at home and abroad, the necessity of palliative care for patients with end-stage cancer, and the application status of palliative care in end-stage cancer patients in our country, and analyzes the influencing factors of the implementation of palliative care in combination with the current situation at home and abroad, in order to provide theoretical reference and practical basis for promoting the development of clinical palliative care practice in our country.

Keywords: Terminal Stage; Palliative Care; Review; Hospitalpice; Cancer

1. Introduction

Cancer is a major global public health challenge, and its prevention and treatment situation is particularly severe in my country. According to statistics from the World Health Organization's International Center for Research on Cancer, my country ranks first in the world in new cancer cases and deaths [1]. Cancer not only seriously threatens national health, but also places a heavy economic and care burden on society and families. As my country's population ages and the incidence of cancer continues to rise, clinical demand for cancer care is increasing. With the development of the "people-oriented" medical service concept and the rapid spread of multimedia informatization, the public's awareness of subjectivity continues to increase, and attention to the quality of death has gradually increased, which in turn has promoted the rise in demand for palliative care services [2]. For patients with terminal cancer, the focus of treatment has shifted from prolonging survival to controlling symptoms, alleviating pain, and improving quality of life, and palliative care is an important way to achieve this goal [3]. Multiple studies have confirmed that palliative care can effectively improve the sleep quality of end-stage cancer patients, relieve psychological stress, improve the quality of life, and reduce the pain of bereaved people, showing significant application effects [4]. Although palliative care has significant advantages, its application in clinical practice in my country still has many shortcomings due to limitations such as cognitive level, resource allocation, policy support and other factors, especially in terms of needs assessment. Therefore, in order to clarify the current development trend in the field of palliative care, this article aims to summarize the current research status of palliative care for end-stage cancer patients, with a view to providing reference for the effective implementation of palliative care for end-stage cancer patients.

2. Overview of the Development of Palliative Care

2.1 Foreign Palliative Care Models

The overseas hospice care industry began in 1976 when Dr. Cici Saunders founded St. Christopher's Hospice in the UK, which marked the beginning of systematic hospice care services [5]. The United States and other countries have successively introduced and developed it, and have achieved significant social and medical benefits. In the process of practice, each country has gradually formed a hierarchical and classified palliative care service model that is compatible with its own medical system. For example, in the United

Kingdom, the national medical system provides a wide range of free medical services to the entire population, and hospice care is organically integrated into the system; the United States has developed more diversified service forms, such as the Anderson Cancer Center, which has established a multi-level model including outpatient services, inpatient consultations, acute palliative care wards, community palliative care, and hospice care; and in Singapore, Romania, etc., free medical care is implemented for all. In countries with high standards of care, their systems usually include palliative care services within the scope of coverage, providing patients and their families with necessary treatment and professional consulting services [6].

2.2 My Country's Hospice Care Model

My country's hospice care model began in 1988, marked by the establishment of the Hospice Research Center of Tianjin Medical College (now Tianjin Medical University). In October of the same year, Shanghai Nanhui Elderly Care Hospital also officially launched hospice services. After years of exploration and practice, my country has continued to advance and improve in the field of palliative care. In 2017, the National Health Commission unified "hospice care", "palliative care", "palliative care", etc. as "palliative care" [7]. Li's research pointed out [8] that currently many hospice care services are not included in the charging scope of medical insurance, and their actual service costs are much higher than the patient's medical insurance reimbursement limit. In the long run, this may lead to an imbalance in the income and expenditure of the hospice care team, thereby reducing service quality. Therefore, improving the payment mechanism for hospice care has become a key issue that needs to be solved urgently. In terms of service models, my country has formed various models including comprehensive hospitals, nursing homes, community-based hospice care, family-based hospice care, end-of-life reverse care models, and comprehensive services. However, due to its late start, imperfect medical system, and the influence of traditional concepts, the overall development level of hospice care in my country still needs to be improved [9].

3. Disease Characteristics of Terminal Cancer Patients and the Necessity of Palliative Care

3.1 Disease Characteristics of End-Stage Cancer Patients

Studies [10-11] have shown that patients with end-stage cancer often suffer from a heavy burden of symptoms, which seriously affects their quality of life. These symptoms include cancer pain that is difficult to relieve, even with the use of powerful analgesics; vicious vomiting caused by chemotherapy, which can lead to disorders of the body's water and electrolyte metabolism and acid-base balance, which can lead to loss of appetite, anorexia, and even dehydration, malnutrition, and cachexia; disturbance of consciousness, convulsions, and motor dysfunction caused by brain metastasis; and recurrent infections and fever caused by low immunity. These symptoms often coexist and worsen as the disease progresses. Research [12] shows that the suicide rate in this group is as high as 16.6%. In recent years, although targeted therapy has made certain progress, chemotherapy is still the main treatment method for cancer patients, but its effect is limited, there are not many treatment options, and it is difficult to achieve lasting effects [13]. The impact of cancer on patients is not limited to physical symptoms, but also widely involves psychological, social, interpersonal and family relationships and other levels. These pressures further affect patients' self-perception and can easily lead to a series of negative psychological states such as self-denial, depression, low self-esteem, and social isolation, seriously affecting patients' physical and mental health and quality of life [14]. At present, cancer is still an incurable disease in clinical practice, and treatment is often accompanied by significant adverse reactions, further damaging the patient's quality of life. In this context, palliative care, as a comprehensive medical model, aims to improve the patient's quality of life, relieve physical and mental pain, provide emotional support, and fully respect the patient's personal wishes and medical choices [15].

3.2 The Necessity of Palliative Care for End-Stage Cancer Patients

Cancer patients not only have to endure physical pain such as pain, nausea, and weight loss, but also face a series of problems such as appearance changes caused by drug treatment and heavy financial burdens. These factors work together to easily trigger psychological stress reactions such as anxiety and depression [16]. With multiple pressures, the quality of life is sometimes even lower than that of the patients themselves. In order to protect each other or themselves and avoid increasing psychological distress, patients and caregivers are often reluctant to openly communicate disease-related information and feelings [17]. Caring for patients with end-stage cancer also places significant physical and psychological stress on caregivers. Therefore, negative emotions such as anxiety and depression are common among family members of patients with malignant tumors. Research [18] found that the worse the caregiver's perception of the patient's quality of life, the higher the risk of suicidal behavior after bereavement. Therefore, clinical attention is increasingly paid to alleviating the negative emotions of caregivers of patients with malignant tumors, and more attention is paid to improving their quality of life. As a multidisciplinary collaborative supportive medical model for cancer patients, palliative care has been proven by multiple studies to be effective in preventing and alleviating the physical and mental suffering of cancer patients and their families [19]. Research by Tao et al. [20] shows that palliative care can provide comprehensive, life-cycle and warm care services for patients with advanced cancer, help patients maintain dignity and improve their quality of life at the end of life, and meet the diverse needs of patients with advanced cancer. Research by Shi et al. [21] further pointed out that palliative care can help relieve anxiety, depression and other negative emotions in end-stage cancer patients, improve their attitude towards death, and improve patients’ quality of life and nursing satisfaction. Palliative care not only focuses on alleviating the patient's disease symptoms, but also respects the patient's personal wishes, maintains their quality of life and dignity in death, and also pays attention to the psychological needs and feelings of their family members. Therefore, this model is worthy of further promotion and application in clinical practice.

4. Current Application Status of Palliative Care in End-Stage Cancer Patients in My Country

4.1 The Implementation Rate of Palliative Care for End-Stage Cancer Patients is Low

In foreign countries, palliative care has been developing for a long time, and relatively complete laws and regulations, insurance systems, advance directives and medical agency mechanisms have been established, and a care evaluation scale suitable for the national conditions of each country has been formed. In contrast, hospice care in my country started relatively late, and has not yet formed a sound legal and regulatory system, and the pilot work is still in the preliminary exploratory stage. At present, there is still a lack of localized care assessment tools in China, and the actual clinical care situation needs further in-depth exploration [22]. In addition, the existing research on palliative care needs in my country is mostly conducted from the perspective of medical staff and family members, while relevant research based on the perspective of patients themselves is still lacking [23].

4.2 There are Great Differences in Palliative Care and Population Size among End-Stage Cancer Patients

Different patients have obvious individual differences in their needs for palliative care, which are often affected by factors such as cultural background, family values, personal roles and experiences. Research by Wang et al. [24] shows that the home comfort problems and needs of end-stage cancer patients show a diversified trend, and age, education level, etc. are the main influencing factors. Therefore, medical workers should construct targeted intervention programs based on patients' individual conditions to effectively alleviate their symptoms and meet their actual needs. Research by Zhang [25] found that caregivers with different educational levels have different needs for palliative care. Caregivers with higher education levels usually have a faster ability to receive information and a higher acceptance of the concept of palliative care. Therefore, when carrying out health education, medical workers should choose appropriate publicity and communication methods based on the cultural background of caregivers. In particular, they should strengthen key intervention for family members of patients with low educational levels, and use easy-to-understand methods to patiently explain to ensure effective communication of information. Research by Chen et al. [26] further showed that implementing a palliative care decision support education program can effectively improve the willingness of family members of advanced cancer patients to choose palliative care. This program helps guide family members to correctly understand the development and prognosis of end-stage cancer, and enable them to fully understand the benefits and potential risks of palliative care, so that they can make informed choices about more appropriate medical decisions for themselves or their patients.

5. Factors Affecting the Quality of Palliative Care

5.1 Patients and Their Families

In the process of implementing palliative care for end-stage cancer patients, one of the important influencing factors is the lack of knowledge or misunderstanding of palliative care by patients or their families. Influenced by traditional concepts, Chinese society generally avoids discussing life, death and end-of-life topics, which to a large extent limits the clinical promotion of palliative care. In addition, due to the low popularity and small coverage of palliative care, some people mistakenly believe that palliative care is equivalent to giving up treatment and a manifestation of disrespect for life. This leads to a misunderstanding of the essential content of palliative care and further hinders its promotion process [27]. Some studies have found that families' traditional practices in disclosing disease information, patients' acceptance of death, and poor communication between patients and medical staff on issues related to end-of-life care all suggest the need for further improvements in related service models and communication mechanisms [28]. At present, the number of beneficiaries of hospice care services is still limited, but public demand is growing day by day. At the same time, uneven economic development in various regions has led to the concentration of hospice care institutions in the eastern coastal and Pearl River Delta regions, making it difficult for many end-stage patients to obtain hospice care services nearby. Therefore, it is recommended to strengthen the construction of the palliative care system from the following aspects: increase policy support and establish and improve the relevant institutional system for palliative care; strengthen the training of professional talents, improve the comprehensive quality of practitioners, and provide opportunities for continuous learning and further training; and build a diversified palliative care model to adapt to the needs of different patients and families. In addition, community public welfare organizations should be actively used to communicate face-to-face with the public through health lectures, free clinic consultations, etc., to clarify misunderstandings, answer questions, and gradually increase society's awareness and acceptance of palliative care.

5.2 Medical Staff

At present, when assessing the care needs of end-stage cancer patients and their families in clinical practice in China, most of the assessment tools used are universal scales, while there is a lack of assessment tools for cancer-specific needs. This results in an incomplete assessment that fails to classify patients in detail based on their specific clinical status, resulting in a lack of targeted assessment and follow-up intervention [29]. At the same time, the professional abilities of hospice practitioners in my country are uneven. Research by Liu et al. [30] shows that the professional level of the palliative care team in Guangzhou still needs to be improved, especially in actively recommending hospice care services to terminal patients and their families. The study recommends that managers should take measures to target weak links to enhance the team's professional capabilities, thereby improving the quality of palliative care services. Research by Xu et al. [31] further pointed out that long-term high pressure and high-intensity working environment can easily cause professional burnout and psychological burden among medical staff. Improving the job satisfaction and professional identity of medical staff will not only help improve team stability, but also enhance the implementation effect of palliative care. In addition, establishing an efficient team collaboration mechanism to promote communication and cooperation among medical staff is an important way to improve the efficiency of palliative care work. In order to systematically promote the construction of the talent team, we should strengthen the practical training of medical staff, carry out systematic training and education activities, and optimize the hospital management system to ensure the reasonable allocation and efficient use of resources, thereby providing a strong guarantee for the smooth implementation of palliative care. In clinical practice, medical professionals also need to pay special attention to the psychological readiness of patients and caregivers to face death, and develop effective strategies to enhance their understanding and acceptance of death. For example, promoting communication between patients and caregivers about end-of-life care issues, including concerns about disease prognosis and various challenges that may be encountered during the death process, can help enhance mutual support; reduce the physical, emotional, spiritual and practical distress faced by both parties, and at the same time enhance the consensus and empathy between patients and caregivers regarding their preparedness for death.

5.3 Social Health Security System

It is recommended to strengthen publicity and education and actively explore a palliative care model that is more in line with my country's social culture and actual national conditions. At present, my country's hospice care service system and management standards are not yet perfect, government investment and social support are insufficient, and the social health security system is not yet complete. These constitute the main structural obstacles for end-stage cancer patients to obtain hospice care services [32]. The overall quality of professional personnel needs to be improved, the difficulty in forming multi-disciplinary teams, and the lack of public awareness have seriously restricted the promotion and application of this model. Research [33] shows that caregivers of end-stage cancer patients bear a multifaceted care burden, and their needs are obviously diversified. Therefore, the multidisciplinary team building of palliative care should be further improved, the professional capabilities of the team should be improved, the promotion and practice of home palliative care services should be strengthened, and a more systematic and complete service model should be gradually built. Promoting the standardization and standardization of palliative care services and continuously enriching relevant theoretical knowledge can provide practical basis and experience accumulation for the systematic development of palliative care services. It will not only help patients die with dignity, but also reduce the financial and care burden on families. In the future, efforts should be made to improve the hospice joint care service system, formulate unified standards and specifications, strengthen professional training, set up relevant courses and systematic training, and continue to enhance the public's awareness and acceptance of hospice care.

6. Conclusion

Currently, the research on palliative care for end-stage cancer patients in my country is characterized by multi-dimensional and interdisciplinary development. The overall research and practice are constantly deepening, but it still faces the following challenges:(1) Needs assessment tools are scattered and single: existing needs assessment tools lack systematicness and pertinence, and have not yet formed a unified and standardized assessment system, which restricts the accurate formulation and effective implementation of intervention measures. There is an urgent need to establish a standardized and systematic assessment system to achieve precise intervention; (2) The traditional concept of death has far-reaching influence: Affected by traditional cultural concepts such as "taboo talking about life and death", the public and even some medical staff still have cognitive biases towards palliative care. There is an urgent need to strengthen the scientific popularization and professional education of palliative care knowledge and improve social acceptance; (3) The structure of the talent team is unbalanced: Professional talents are insufficient in quantity and ability. A systematic and hierarchical training system needs to be built and the training system The target extends from medical staff to nursing students, family caregivers and even social workers; (4) Insufficient policy and institutional support: Relevant laws and regulations, financing mechanisms and service standards are not yet complete. The establishment of a multi-disciplinary collaborative care model with three-level linkage of "medicine-social-home" and even "combination of medical and nursing care" should be further promoted to build a systematic support environment. Future research should focus on developing and validating palliative care needs assessment tools that are in line with my country's national conditions, and conduct in-depth exploration of localized practices, so as to provide comprehensive and humanized care services for end-stage cancer patients, and ultimately help achieve the goal of palliative care of "a good death".

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