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Palliative Care Services from Past to Present

Murat Can Mollaoğlu, Döne Günay and Mukadder Mollaoğlu

Abstract

Palliative care (PC) refers to all services provided to make the remaining life of a patient meaningful and valuable. It is recommended that palliative care that is applied to improve the life quality of the patients should not be based only on the diagnosis and prognosis of the disease but also on the need of the patients. Even, palliative care was administered only in the late stages of diseases in the past, but these days it is recommended to be administered in addition to therapies starting from the diagnosis of life-threatening diseases. Palliative care requires a multidisciplinary team approach consisting of professionals who serve for a common purpose. No single palliative care model can be fit for all conditions. However, there is a universal fundamental principle of palliative care: it should address the individual wishes and needs of each patient and the relatives of patients. The development and training of palliative care services vary from country to country: palliative care services are in the development stage in developing countries, compared to developed countries. This chapter provides necessary information about palliative care services, a multidisciplinary health service.

Keywords: palliative care, the purpose of palliative care, palliative care models, palliative care levels, palliative care in the world

1. Introduction

Scientific and medical advances in the last century have prolonged and facilitated life and delayed death. Advances in biomedical and clinical medicine have enabled the prevention and/or treatment of many diseases [1]. Recently, improvements in treatment models have significantly reduced or palliated the crucial effect of many diseases which were killing people in a short time in the past [2].

The World Health Organization (WHO) defined palliative care for the first time in 1989 as follows: “palliative care is an approach that improves the life quality 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” [3]. In 2014, the WHO added another view to the definition: “Palliative care is the responsibility of all physicians”; thus, the definition of palliative care became comprehensive [4, 5]. Palliative care is a multidisciplinary care that aims to prevent or palliate the symptoms, *relief of suffering of patients*, and improve life quality of them [6]. Palliative care should not only be applied to patients in the final stages of life: it should be integrated into medical care and curative and life-long treatment, regardless of disease stage

[7, 8]. In palliative care, patient-specific care, family support, multidisciplinary teamwork, and effective communication are essential [6]. In short, palliative care is a philosophy of care and is based on holistic care and support for families including the mourning period [9, 10].

2. Purpose, philosophy, and components of palliative care

2.1 The purpose of palliative care

The goal of palliative care is to restore the functional capacity of a patient by being sensitive to the cultural and local values, beliefs, and practices of the individual, to alleviate pain, and to improve the life quality by controlling the symptoms [6, 11, 12]. In other words, the purpose is to reduce or eliminate the symptoms of the disease without any further examinations when the cure is no longer possible in the disease. Indeed, what the WHO expected from palliative care team is to respect patients and their relatives and to consider their wishes. This expectation should be interpreted as providing health care to the patient and his/her relatives that will ensure their well-being regardless of their age, economic or social status, and disease characteristics [1, 4, 7, 9, 13].

2.2 Basic principles of palliative care

The basic principles of palliative care can be summarized as follows:

- To integrate the psychosocial and spiritual aspects of patient care
- To reduce other symptoms, pain in the first place
- To ensure that the patient and the relatives of the patient accept death as a normal process
- To neither expedite nor delay death
- To make the patient as active as possible until death
- To provide support to patients' relatives to cope with problems during the illness
- To identify and meet the needs of the patient and his/her family including the mourning period
- To manage the clinical complications resulting from treatments such as radiotherapy and chemotherapy [7, 9, 14, 15]

2.3 Philosophy of palliative care

According to the philosophy of palliative care, the patients are provided with care and support in various institutions; death is part of ordinary life; physical, social, and spiritual aspects of care all are integrated; and the main targets are to enhanced life quality of the patients and to ensure that the patient quickly returns to his/her social life [10, 16].

Cancer patients in need of palliative care are a group of patients with high psychosocial, spiritual, and physical needs who experience many different symptoms, especially pain [6, 8]. In addition, the level of distress experienced by the family and its members increases in this period, and this situation affects the family order intensively. The most common problems experienced by cancer patients include physical symptoms such as pain, nausea, vomiting, fatigue, constipation, and loss of appetite. However, psychological problems such as anxiety, fear, helplessness, hopelessness, exhaustion, and depression are also common in patients. Economic and social problems are other important problems for cancer patients [6, 8, 10, 13]. Patients' need for palliative care to cope with all these problems is increasing. Palliative care includes a holistic approach to cancer treatment that can improve or optimize the quality of life of cancer patients and their relatives in the best possible way, meeting the needs [4, 6, 9].

Palliative care is one of the most critical building blocks of the war against cancer. Palliative care is a significant health service, responsibility, medical requirement, and need from the diagnosis of cancer to the end of life and is an indispensable element of national health policies. Therefore, it is imperative that the palliative care service for cancer patients has basic dimensions such as symptom control; psychological, spiritual, and emotional support; support for the families and relatives of cancer patients; and support during the mourning period [4, 7, 13]. The World Health Organization envisages the development of palliative care services in all countries. The WHO also envisions the establishment of a palliative care service network, which can serve the whole country, in underdeveloped countries with low-income levels even if they can do nothing about cancer [7]. The WHO recommends the completion of shortcomings in palliative care, rather than the investments that could bring considerable burdens on the country's economy, such as expensive treatments, radiotherapy devices, or screening programs [1, 5].

2.4 Palliative care team

Palliative care is provided by a team of experienced and trained medical staff who serve for a common purpose and volunteer. This service needs multidisciplinary healthcare services, including an algologist, oncologist, neurologist, surgeon, palliative care nurse, cleric, social volunteers, and psychologist [10, 17].

Besides what is mentioned, it also needs an interdisciplinary approach; the palliative care team provides care to the patient and his/her family and plans the care plan to include the various components according to the current and future needs of the patient [17, 18].

These components are listed as follows:

Patient population: palliative care is for patients in all age groups who are affected by chronic illness or trauma and whose life quality is adversely affected [12, 17].

Patient- and family-oriented care: in palliative care, the patient and his family should be given tailored care, and the care plan should be applied and evaluated individually taking into account the patient's and family's preferences and objectives [8, 17].

The continuity of palliative care: palliative care should start with the diagnosis of a life-threatening disease and should continue throughout the treatment period, after treatment, and until the death of the individual and during the mourning period [6, 17].

Comprehensive care: in palliative care, multidimensional diagnosis is required to eliminate the psychological, spiritual, social, and physical problems of the individual and his/her family and to alleviate pain [4, 17].

Interdisciplinary team: a palliative care team should primarily include medical, nursing, and social work professionals. Palliative care may also require a broad

team of collaborators, such as psychologists, pharmacologists, religious officials, mourning consultants, dietitian, physics/vocational/art/game and music therapists, case managers, trained volunteers, home care assistants, and voluntary organizations [7, 17].

Alleviation of the pain: the primary objective of palliative care is to take measures to prevent the pain and other symptoms, as well as the many problems caused by the disease and treatment, and to eliminate these problems [6, 17].

Communication skills: effective communication in palliative care is crucial for helping to make medical decisions, determining goals and preferences, active listening, and sharing of useful information.

The skill of care during death and mourning period: in the process of mourning and loss, the palliative care team must be aware of the age-related physical and psychosocial symptoms, the care and support needs of the patient and his family, the early signs and symptoms of death, and the prognosis of death [8, 17].

Ensuring continuity of care between institutions: palliative care should work in conjunction with all systems involved in health care (such as hospitals, emergency services, hospices, home care, community, and school). The palliative care team should cooperate with professional and nongovernmental organizations in these specified healthcare settings to ensure the continuity and coordination of palliative care [17, 18].

Equality in accessing palliative care: the palliative care team is responsible for providing a service that is accessible to all, regardless of race, ethnicity, gender, socioeconomic status, place of residence, and cultural attitudes [12, 17].

Quality service delivery: palliative care services should be of high quality and outstanding. It is vital to regularly determine the requirements for a quality service, to measure the care process using appropriate measurement tools, and to ensure continuity [4, 8, 10, 17].

2.5 Palliative care needs

Palliative care provides a cost-effective service by reducing unnecessary diagnostic and therapeutic interventions, ineffective intensive care, and emergency department admissions [14, 19]. It has been reported that the integration of palliative care from the early stages of the disease increases the quality of care and prolongs the life span [18, 20].

Patients, who are bedbound, do not have curative treatment and have difficulty in controlling physical and emotional symptoms evaluated by the palliative care team. If the palliative care team thinks that it will improve the life quality of the patient and his/her family, the patient is admitted to the palliative care unit [19, 21].

Criteria for admission to palliative care unit:

1. Patients with a visual analogue scale (VAS) pain score of ≥ 5 despite medical treatment, impaired sleep patterns due to pain, and persistent pain even at rest and patients that cannot be administered with medical treatment due to side effects
2. Malnutrition patients whose oral intake is impaired, who have a nutritional risk screening 2002 score of ≥ 3 , have a weight loss over 10% in the last 6 months, and who need enteral or parenteral nutrition because they cannot feed orally
3. Patients who is infected and treatment-resistant and who has stage III–IV (according to Norton/Braden) decubitus ulcer

4. Patients who are diagnosed with delirium and whose etiology is multiple or uncertain
5. Geriatric syndromes: falls, incontinence, neglect, and abuse
6. Fragile patients with treatment-resistant stage IV heart failure
7. Patients with worsening clinical symptoms and laboratory symptoms (dyspnea, hemoptysis, uncontrolled pain, etc.) despite treatment; patients with a Karnofsky Performance Scale score of <70%; patients with oncological emergencies such as vertebra metastasis and hypercalcemia; patients who had pneumonia more than two times in the last 3 months; oncology patients with high comorbidity, shorter life expectancy than 6 months, and progressive disease despite treatments such as surgery, radiotherapy, and chemotherapy
8. Patients with treatment-resistant end-stage chronic lung disease
9. Dementia patients with acute changes in the clinical picture: Functional Assessment Staging of Alzheimer's disease (FAST) [19, 20]

2.6 Target groups in palliative care

The World Health Organization (WHO) Worldwide *Palliative Care* Alliance (WPCA) states the medical conditions that require palliative care as follows:

Diseases requiring palliative care in adults: cancers, Alzheimer's, dementia, cardiovascular diseases, cirrhosis, chronic obstructive pulmonary disease, diabetes, acquired immune deficiency syndrome (AIDS), renal failure, multiple sclerosis, Parkinson's disease, and rheumatoid [19, 22].

Diseases requiring palliative care in children: cancers, neonatal diseases, congenital anomalies, cardiovascular diseases, blood and immune disorders, meningitis, cirrhosis, AIDS, kidney diseases, and neurological disorders.

Persons who will provide palliative care to children should receive specialized training, and palliative care should be family oriented. Parents' comments on palliative care, taking part in the care of the child and being in a decisive position on legal issues, may cause disagreement with the team. Therefore, cooperation with the family is required. Families generally prefer home care after the acute period. In developed countries, this system is more suitable in terms of cost and compliance of the child. The palliative care team should cooperate with the family through home visits, educate the family on care, and provide psychosocial support to the family [8, 22].

3. Palliative care levels

3.1 Basic palliative care approach

It is a system where palliative care principles are applied by all health professionals and clinicians [4, 22]. Most patients with severe and progressive diseases are cared for by these clinicians in the hospital. Thus, this system focuses on the principle that all clinicians should have good knowledge and skills about the palliative care approach [23]. Therefore, these clinicians should be able to meet the healthcare needs of these patients who need palliative care [4, 22, 23].

3.2 General palliative care

At this level palliative care will be provided to the patients and their families by non-palliative care physicians and nurses who have palliative care experience. This understanding is defined as an intermediate level of palliative care, and a full-time palliative care is provided at this level [4]. These services can be provided in private centers or nursing homes. On certain days of the week and at certain times, a physician reviews the palliative care requirements at the care center where these patients are staying. He/she plans symptomatic therapy. Nurses work for limited hours in these centers. Other auxiliary health personnel also help with palliative care [23]. When complex cases occur at the level of general palliative care, these cases are referred to centers providing palliative care at a more advanced care level. This team also works as a local resource and training group [1, 17].

3.3 Specialist palliative care

This level of palliative care approach requires patient and family care and support depending on patient needs and available resources. There is a multidisciplinary approach to health care [1, 23]. This is the branch of specialization whose primary training and service area is palliative care. This branch deals with complex patients who require more time and need more care and require higher education and more staff and resources [4]. Palliative care specialists and other healthcare professionals trained in palliative care serve complex patients who need more care in hospitals or palliative care centers and hospices. In developed western countries, physicians who complete their education as an assistant in palliative care or palliative medicine departments in medical faculties are entitled to receive a palliative care certificate. Palliative care professionals are assigned to palliative care services of university hospitals or other hospitals or may work as a consultant in these services. Palliative care specialists may be consulted for patients in the ICU or other departments [23]. This team also works as a national resource and training group [1, 17].

4. Palliative care delivery models

Palliative care is delivered to the patients via four main models [1, 17].

4.1 Ambulatory palliative care clinics

This care for outpatient patients can be delivered in inpatient units, nursing homes, or other units, and patients can visit these places for 1 or several days a week for palliative care. These services include services such as medical support such as blood transfusion, pain treatment, symptomatic treatment, social services such as shower and bath, physiotherapy/vocational training, rehabilitation, massage, or psychosocial and spiritual support [4]. These centers offer low-cost care; hence, these centers have come to the forefront in recent years. In these clinics, services such as symptom control and nutritional support are provided, and patients and their families are supported psychosocially and morally. Families of patients are also trained in care [4, 15, 17].

4.2 Home-based palliative care

Healthcare professionals or nonprofessional caregivers provide care to the patient in their homes. In this way, hospital-level palliative care is provided at the

patient's home. Home-based palliative care is based on traditional medical care and a supportive institutional model (hospital) [1, 13]. The patient can reach the palliative care support 24 hours a day, 7 days a week. In the home-based palliative care model, symptom control and terminal care services and basic needs of cancer patients are available through palliative care units at hospitals [17].

4.3 Inpatient palliative care units

These are the units in a hospital where the primarily responsible official is an internal medicine specialist or general surgeon and recommendations and support are frequently received from specialized palliative care staff [4]. In recent years, an increased number of hospital-based palliative care programs have been available to palliative care patients. General patient services in these clinics may not be appropriate for cancer patients with specific physical and psychosocial problems and who require a specialized approach. When a patient's care at home becomes harder in the advanced stage of the disease, palliative care centers accept the patient and support both the patient and his/her family in terms of pain relief, nutrition, psychological and social support, care, and training of the family [1, 4]. These units have improved care quality and reduced care costs for complex, high-risk patients who suffer from pain and other symptoms and whose basic needs are not met adequately [1, 17].

4.4 Inpatient consultation services

Providing services through consultancy is the most frequently used information method from past to present. Consulting services are an on-demand evaluation and management service [8, 10]. Clinical care may be requested by clinical physicians or other health professionals according to the care needs of inpatients. In palliative care, inpatient counseling services are provided by an interdisciplinary team. The team includes social workers, priests, psychologists, volunteers and therapists, and primarily doctors and nurses trained in palliative care services [4, 24]. This system provides uninterrupted service every day and every hour of the week. It is advantageous for it to be cost-effective because it contains fast, low-resource applications [4, 8, 24].

5. Palliative care practices in the world

Throughout the history of humanity, all societies have endeavored to provide adequate care, support, and respect to patients and the dead. In this historical process, as a result of the ever-increasing innovations in drug therapy since the 1950s and the better understanding of the dying patient's psychosocial and spiritual needs, the foundation of palliative care principles was laid [4]. Hospices were first established at the beginning of Christianity during the Roman Empire. In the fourth century AD, these places were transferred to religious institutions. Although this tradition was tried to be kept alive in the middle ages, many of the hospices were closed or converted into monasteries during the Reform period. This continued until the nineteenth century until Jeanne Garnier opened the first hospice center (Calvaire) in France in 1842, dedicated to terminal patients [11].

The first modern hospice named "Saint Christopher," founded by Dr. Cicely Saunders in London in 1967, laid the foundations for palliative care in the world and inspired other countries and people. With this hospice, protocols for palliative care of terminal patients were identified, and the number of palliative care providers increased rapidly in the United Kingdom and other European countries [25]. America and other

western countries began to establish hospices for palliative care. Until the mid-1980s, the concept of palliative care was used instead of hospice care. In the early 1990s, the concept of palliative care was used for the care of individuals dying of cancer in America. Besides, individuals with other chronic diseases such as heart failure and lung disease also began to benefit from palliative care. Palliative care began to develop as a special branch in the mid-1990s and currently covers the care of patients with chronic diseases [4, 10, 26]. Over time, the understanding of palliative care has changed. Following this, the WHO defined palliative care and in 2004 published the “National Palliative Care Guidelines.” Due to the need for palliative care and the need to provide effective care for patients, an independent area of expertise called “palliative medicine” was introduced in the United Kingdom, and specialists were trained in this field [25].

The European Association for Palliative Care demands formal certification programs and expertise in palliative care from policymakers and national councils. The European Association for Palliative Care conducts studies on training in palliative care and publishes guidelines on this issue. Through palliative care training manual for nurses [17, 25] and a guide to developing palliative care training in medical education, issues to be considered in palliative care training (palliative care and its importance; management of pain and other symptoms; psychosocial and spiritual care; ethical and legal issues in palliative care; communication and teamwork) by universities were identified [17, 27, 28].

The first palliative care in Germany began in 1983 with the establishment of a palliative service in the surgical department of the University of Cologne. The number of palliative care centers increased rapidly with the launch of a sample study by the German Ministry of Health between 1991 and 1996. According to Germany’s 2005 data on palliative care, 111 hospice services, 131 hospices with beds, palliative care units in 116 hospitals, and 40 home-based palliative care services are actively performed [17, 29].

Italy is the leading country in palliative care, professional training, and research. The Academy of Palliative Medical Sciences in Bologna has been carrying out the necessary educational activities for the development of PC culture since 2007. The academy strengthened many international cooperation programs to be active in PC training activities [8, 10, 19]. To develop specialist nurses who have palliative care qualities and can provide the best palliative care services with evidence-based practices, Australia established a palliative care curriculum for nursing education and integrated palliative care into the undergraduate curriculum [10, 17].

Palliative care covers many disciplines. The palliative care process, which is developed parallel to the prevalence of cancer in the world, is carried out in different levels in developed and developing countries. Some countries where palliative care is considered a separate area of expertise include the United States, the United Kingdom, Canada, and Australia. There are guidelines for the treatment of different symptoms (bone pain, neuropathic pain, vomiting, depression, dyspnea, muscle spasm, terminal delirium, etc.). The American Medical Association applies a training program for end-of-life care for doctors and nurses. These programs include standards for the control of symptoms (pain, delirium, dyspnea anxiety, etc.) seen in the terminal stage [17, 27, 29].

The American Medical Association applies a training program for end-of-life care for doctors and nurses. These programs include standards for the control of symptoms seen in the terminal stage. Harvard University’s Palliative Care Center organizes regular programs for nurses and doctors on palliative care. These programs aim to create awareness of interdisciplinary palliative care and to train educators specializing in palliative care [4, 10, 17]. Harvard University’s Palliative Care Center organizes regular programs for nurses and physicians on palliative care to create an interdisciplinary palliative care awareness and train trainers who are specialized in palliative care [4, 17, 27]. Harvard University created the “Palliative

and End-of-Life Care Training Project” in 1997 to train health professionals and increase their clinical competence in palliative care. This project was supported by the American Medical Association, the Robert Wood Johnson Foundation, the National Cancer Institute of America, and some national organizations, and more than 2000 trainers in 16 countries have received training under this project to this day. With a distance education program of 16 modules, the training program for health professionals has been continuing for about 17 years [10, 17, 30].

The Middle East Cancer Consortium organizes postgraduate courses for health professionals from member countries such as Cyprus, Israel, and Jordan. In undergraduate nursing education in Israel and Jordan, palliative care is part of clinical education. In the Arodaphnousa Hospice in Nicosia in Cyprus, the second and third year nursing students practice for 2 weeks. There are plans to make palliative care a minor in Israel [4, 17, 28].

5.1 Palliative care criteria of the worldwide palliative care alliance

According to the Worldwide Palliative Care Alliance (WPCA) 2014 report, 234 countries in the world have been classified in 4 groups that have sub-groups according to palliative care development. The WPCA has classified palliative care according to the following criteria [8, 22]:

- Palliative care throughout the country
- Comprehensive palliative care service integrated into the health system
- The inclusion of palliative care in general public health policies and transferring funds from other funds
- Participation of health personnel and local associations
- Effective and continuous palliative care policies
- Advanced and defined palliative care training systems
- Availability of morphine
- Palliative care awareness in the local community and health personnel
- Academic cooperation with universities
- National palliative care associations

5.2 Palliative care service classification

Today, palliative care services vary according to the level of development of countries as seen below [4, 8, 17, 28].

Group 1 countries whose hospice-palliative care activities are unknown: this group includes 75 countries (32%) such as Afghanistan, Chad, Guinea, Comoros, Korea, Libya, and Uzbekistan. There is no hospice-palliative care in these countries. Also, these countries do not have any palliative care policies that cover the whole country [4, 8, 17, 28].

Group 2 countries whose hospice-palliative care services are being developed: this group includes 23 countries (10%) such as Azerbaijan, Bolivia, Algeria, Haiti,

Montenegro, and the Vatican. There are no active palliative care units in these countries. However, efforts are being made to establish palliative care services [4, 8, 17, 28].

Group 3 countries which have only local palliative care services and hospices:

Group 3A countries: these countries have an insufficient number of localized clinics and low-capacity palliative care. These units are not integrated into the health system and are mostly funded by personal donations. Morphine availability is limited. Governments do not adequately support palliative care activities. This group includes 74 countries (31.6%), including Angola, Bahrain, Bangladesh, Brazil, Bulgaria, Iran, Kuwait, Lebanon, Mozambique, Paraguay, and Sudan [4, 8, 17, 28].

Group 3B countries: localized palliative care services are not integrated with the general health system. Financial resources are personal donations, public and private health insurance, and local government resources. There are limited educational activities carried out by associations. Morphine is easily accessible. This group includes 17 countries (7.3%). Some of them are Portugal, Cyprus, Argentina, Malta, Turkey, India, Nepal, Lithuania, Croatia, Bosnia, and Herzegovina [4, 8, 17, 28].

Group 4 countries with hospice-palliative care services integrated into a health system:

Group 4A countries: several palliative care services are shared in these countries. Healthcare staff and people are aware of the importance of palliative care in these countries. Morphine and strong analgesics are easily accessible. These countries have limited palliative care policies and national palliative care associations. This group includes 25 countries (10.7%). Some of these are Costa Rica, Kenya, China, Denmark, Israel, Finland, Hungary, New Zealand, Malaysia, Mongolia, the Netherlands, and Spain [4, 8, 17, 28].

Group 4B countries: this group includes 20 countries (8.6%). Comprehensive palliative care services are available throughout these countries. These countries have active palliative care policies. There are advanced palliative care education systems and national palliative care associations that cooperate with universities. Some of these countries are Romania, Singapore, Sweden, Switzerland, Uganda, the United Kingdom, the United States, Australia, Iceland, Austria, Belgium, Canada, France, Germany, Hong Kong, Poland, Ireland, Italy, Japan, and Norway [4, 8, 17, 28].

In developed countries, a comprehensive palliative care service is available, while in developing countries, palliative care is under development. According to the WHO-WPCA 2014 report, in 2006, 21 countries (9%) had hospice-palliative care units, while in 2011, 136 (58%) of 234 countries had 1 or more palliative care units [8, 30]. The report indicates that there were positive developments in palliative care services in 2013. Seventy-five countries do not have palliative care; in 23 countries, palliative care services are being developed; 91 countries provide palliative care through local services; and 45 countries provide palliative care services integrated to health services. In short, developments are continuing in palliative care services in many countries of the world [17].

6. Palliative care practices in Turkey

The first step of palliative care in Turkey was performed by the Ministry of Health Department of Cancer Control in 2008: to eliminate the problems related to palliative care, the relevant units of the Ministry prepared a project called “Palli-Turk” with the contribution of many institutions, especially the WHO, and launched this project as of 2011 [11, 31, 32].

Nowadays, the increase in the number of palliative care centers is of great importance for the patients and their relatives. The Ministry of Health supports

these centers both in terms of institutionalization and training of employees. For this reason, both the Ministry of Health and the palliative care association organize workshops and training programs [16, 31]. Moreover, guidelines prepared by the Ministry of Health according to the conditions and priorities of Turkey aim at identification and institutionalization of palliative care; development of awareness of palliative care, gradually increasing the number of palliative care services until 2023; creation of trained and experienced professional teams in the field of palliative care; and service to patients in need of palliative care. The reasons for the neglect of palliative care services in Turkey until today include family structure, problems in human power, lack of curriculum, lack of expertise in palliative care, and lack of awareness in health workers and patients [9, 33].

The number of palliative care centers in Turkey is not yet sufficient. However, serious efforts in the last 15 years have led to a significant increase in the number of palliative care centers. According to current data, as of May 2018, palliative care services are provided with 3971 beds in 307 health facilities in 80 cities [25, 33, 34]. The infrastructure and trained staff needs of these centers need to be prioritized.

Parallel to the developments in the world in the area of palliative care, the progress (although the level of education in developed countries has not been achieved yet) is continuing in the field of palliative care in Turkey. However, palliative care services in Turkey cannot be provided by expert teams. The teams that provide palliative care in hospital-based units do not consist of professionals who receive a training program at the level of palliative care expertise. Medical faculties do not include palliative care as a minor after graduation or as a graduate education program at nursing schools [4, 8, 10, 17, 19]. Curricula for primary medicine and nursing include only limited hours of palliative care training. However, palliative care services are in the process of development in our country, and health professionals (medical oncologists, nurses, and other health professionals) want to participate in postgraduate training programs related to palliative care [8, 10, 17, 35]. Also, palliative care training programs for nurses are organized with the cooperation of universities and hospitals. In this context, it is aimed to reach all nurses who provide palliative care services in 81 cities in Turkey through certificate programs.

7. Conclusion

In conclusion, a rapid increase in the number of people with chronic, life-threatening or incurable diseases, and health professionals' interest in the quality care of these patients has allowed rapid integration of palliative care, a new discipline, into other areas of medicine.

The main objective of palliative care, which is a philosophy of care, is to maintain the life quality of a patient in his/her last days when medical treatment is incapable and the healing process has stopped. Therefore, it is not the life span but the life quality of an individual that is important in palliative care. Therefore, the content of palliative care may vary depending on the individual's needs and the course of the disease. Today, there is a significant increase in the number of patients in need of palliative care, and this number is expected to increase further soon. For this reason, palliative care should be made in high quality and accessible all over the world. This can only be achieved through the development of national health policies, increasing the quality of training for health personnel, and further cooperation between countries. These steps will undoubtedly improve the life quality of patients and families who need palliative care.

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