

Palliative Care is a specialty in Ecuador.

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Conflict of interest: The authors declare not to have any interest conflicts.

Received: June 18; 2022

Accepted: July 23; 2022

Published: August 24; 2022

Editor: Dra. Evelyn Valencia Espinoza

Cite:

Vallejo M. Palliative Care is a specialty in Ecuador. Rev. Oncol. Ecu 2022;32(2):266-275.

DOI: <https://doi.org/10.33821/637>

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DOI: 10.33821/637

Palliative care perspective

Palliative care (PC), or palliative medicine, is a new and growing specialty with a very defined and essential role. It has had some successes, but it has to successfully respond to new challenges to survive, prosper and become an ally of curative medicine and to be able to interact at the same time to improve care for patients and families facing complex diseases such as cancer.

Currently, much is known about CP, but this knowledge does not benefit the people who need it due to little academic training. For PCs to be incorporated into a health system, it is necessary to establish four fundamental components (Figure 1).

1. Policies. - Establish policies that integrate PC into the national health plan.
2. Availability of drugs. - Improve the availability and access to opioids to increase the opioid quota of the country's International Narcotics Control Board (INCB).
3. Education. Convince the public, community, health professionals, and politicians to include PC programs in undergraduate and postgraduate courses.
4. Implementation. Create new full-time PC positions and provide the infrastructure for reference centers of excellence, including home care that will be replicated.

All this will allow us to estimate the need for the proper development of PCs [1, 2].

The emergence of palliative care through the WHO

PC has made significant progress in the health system; the World Health Organization (WHO), in resolution WHA 67.19, urged all member states to improve access to PC through health systems, focusing on it as a central axis [3, 4].

An official paper on the global promotion of PC presented in 2018 reaffirms the responsibility of health systems for PC. Moreover, it positions them as a fundamental right of the person and family that requires PC in any disabling disease that generates suffering. It also urges the development of education for professionals and the general public. The WHO 2019 surveyed noncommunicable diseases in 194 countries, reporting that funding for PC is available in 68% of the countries, of which 40% report that PC services reached only half of the countries. Patients in need in Europe and high-income countries. Furthermore, it reports that only 14% of patients receive PC at the end of life [5-8].

Arias et al., in the analysis of the trends of specialized PC services, reveal that in the last 14 years, there has been an absence of national or regional official records in Europe to describe the status of specialized PCs as the provision of services such as home care or hospital support teams [9].

The American Society for Clinical Oncology (ASCO), in a step in favor of access to specialized PC, updated the 2016 guide on the integration of "Early palliative care," providing updated recommendations to medical oncologists, patients, caregivers, relatives, friends, and even palliative care specialists [10, 11].

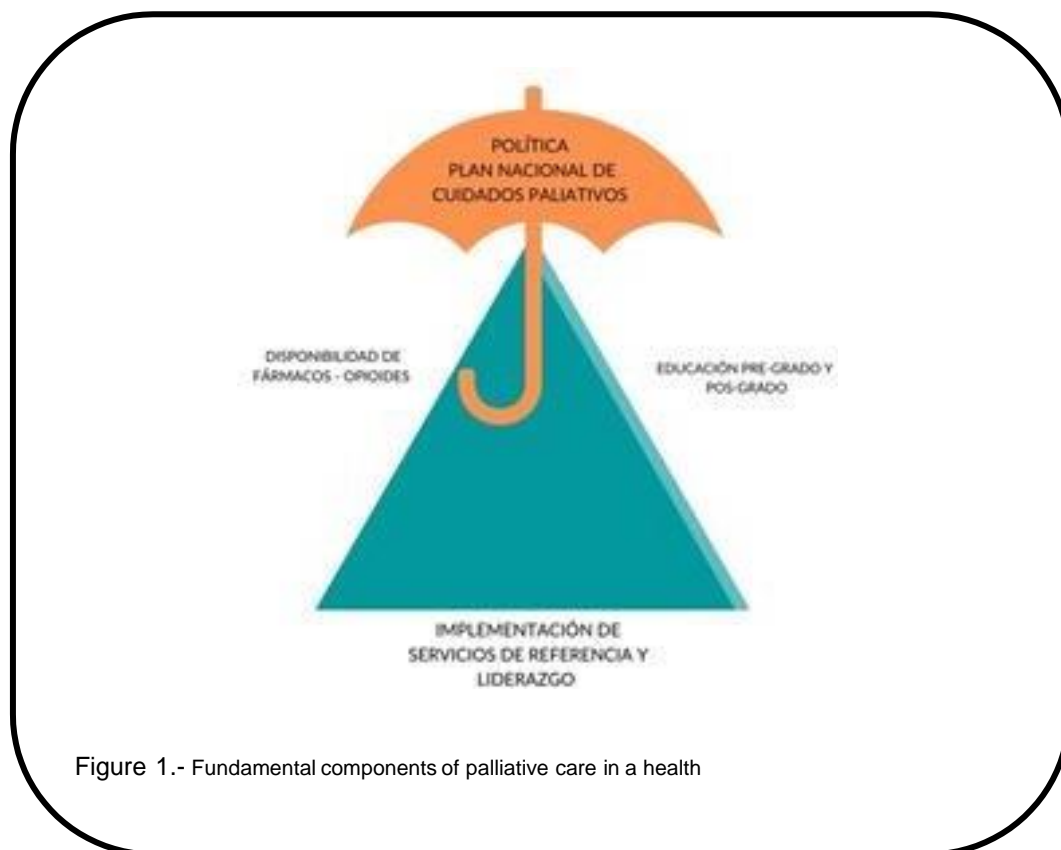


Figure 1.- Fundamental components of palliative care in a health

In contrast, in Latin America, only 4% of people had access to a PC, according to the Atlas of Palliative Care published online in 2012. These data increase interest in PC in the region and the creation of services, considering that a global increase of 87% in health-related severe suffering amenable to the timely intervention of PC is expected by 2060 [12, 13].

Palliative care as a medical specialty

The PC promulgated new patterns and algorithms pretending to give rise to new scenarios. Thus, in 2018, the 30th anniversary of palliative medicine, recognized as a medical specialty, was celebrated. Much has been achieved, but more remains to be done to reduce the inequality gap (professional/patient), as emphasized by García in his review of a long-term vision of PC [14].

The interest in positioning this specialty as a resource and a right is reflected in the review by Centeno et al., 2007. The study covered 52 countries that offered PC as a specialty, finding that these had official certification in only seven countries. In five countries in the UK and Ireland, PC had become a subspecialty consisting of a second specialization after certification in an entire specialty (Poland (1999), Romania (2000), Slovakia (2005), Germany (2006) and France (2007)). Later, in ten other countries (Czech Republic, Denmark, Norway, Sweden, Finland, Iceland, Spain, Malta, Israel, and Latvia), PC was also positioned as a subspecialty [15-17].

The Atlas of Latin America collected information on the situation of PCs in 19 Latin American countries, reporting that only five countries have official accreditation as a medical specialty and subspecialty. The first accreditation was obtained in Colombia in 1998 [18].

Palliative care in Ecuador

The purpose of this editorial is to publicize the development of PC in Ecuador from informality to postgraduate medical specialty. The CP initiative in Ecuador began in the 1990s in the largest cities of Quito and Guayaquil and initially focused on hospice-type residences dedicated to medium and long stays and care until death. In Guayaquil, cancer patients began to be assisted, this being an exclusive service at the tertiary care SOLCA Hospital, which began its work as an outpatient complemented with home support and currently with an availability of 8 beds, to efficiently transition from hospital to home with plans in place.

The legal framework of palliative care

The Constitution of the Republic of Ecuador of 2008 requires and society demands PC care in the public health system; for this reason, the Ministry of Public Health (MPH) issued Ministerial agreement number 101 on February 9, 2011, the same agreement that reaffirms that it is its responsibility, to organize within the framework of the Comprehensive Health Care Model (MAIS), the conformation and operation of comprehensive PC services with an intercultural approach that guarantees the right of patients in an advanced, terminal stage, alleviating pain, suffering; addressing the emotional, social, physical and spiritual aspects; including family members in decision making [19, 20].

The MPH has developed the 2015-2017 National PC plan, the 2014 PC clinical practice guide, the 2015 PC care standard, the 2017 clinical practice guide for cancer pain, and the 2021-2026

National PC Policy, whose objective is to allow the leadership and financing of palliative care services in an integrated manner in the National Health System (SNS) [21].

The Specialty in Ecuador

The training of specialists at the postgraduate level in the palliative context will allow teaching to be combined with research and position the latter as a clarifying element for the training of academic staff capable of responding to the needs of patients and the country, reforming the thinking that it is required to consolidate a society of good living [22, 23].

A study of the relevance of the PC in Guayaquil is carried out, analyzing the demand as a University career using the tool designed by R. Wenk, socialized by the Latin American Association of PC on its website [24-27] (Figure 2).

The specialty is a reality.

Many factors and processes have participated in the implementation of the specialty of PC as previously reported; this arises as a product of the combination of impetus, desire, need, and obligation, not only of the person of the leader but also of the government, the university and the hospital. With the main objective of covering the palliative needs of people who face diseases that threaten life and generate suffering and training specialists with a high spirit of collaboration, humanism, and dedication in this new medical discipline with a long way to go.

Currently, there is highly relevant academic material on PC managed by national specialists, to which they have contributed directly or indirectly (Figure 3).

Aware of all the preceding, SOLCA Hospital signs an academic commitment to offering the specialty of palliative care, presenting the first postgraduate degree to the community in general; this program has a duration of 3 years, 12,000 academic hours, distributed in three units of essential, disciplinary and degree organization (Figure 4). They are focused on practical activities, on-call and care activities in which the resident acquires specialty knowledge, reinforcing their learning by participating in or preparing conferences, talks, attending conferences with active interaction, presentation of posters related to the specialty, supervised and supported by teaching staff.

This postgraduate course began in 2018 and ended successfully in 2022, providing the community with 8 PC specialists with expertise in treating patients with advanced and terminal nononcological and oncological diseases. Finally, the training culminates with the support of the thesis project that empowers him as a specialist in palliative care.

Necesidad estimada de Cuidado Paliativo ®

Tasa de mortalidad (por 1000 habitantes) 4.40

Causas de muerte

Cardiovascular 30.8 % Cáncer 14.1 % Diabetes 10.4 % Digestiva 7.3 % Lesiones 8 % Respiratoria 1.32 % Otras no-comunicables 4.79 %

Guayas, Ecuador

26 de abril de 2018

Población 4207610

Muertes por año, de todas las causas: 18513

60 % se beneficiarían con Cuidado Paliativo » 11108 pacientes, 22216 cuidadores

Pacientes		
741	GRUPO C (5% - 10%) SITUACIÓN COMPLICADA Sufrimiento intenso Internación en camas específicas o asignadas	Nivel 3 CP especializado
3703	GRUPO B (25% - 30%) SITUACIÓN COMPLEJA Sufrimiento moderado Consultorio, domicilio internación general	Nivel 2 CP general
10367	GRUPO A (60% - 70%) SITUACIÓN SIMPLE Sufrimiento leve Consulta telefónica, consultorio, domicilio internación	Nivel 1 Orientación en CP



Muertes por cáncer por año: 2610

80 % se beneficiarían con Cuidado Paliativo » 2088 pacientes, 4176 cuidadores

<http://palliativecare.org.au/wp-content/uploads/2015/05/A-guide-to-palliative-care-service-development-a-population-based-approach.pdf>

Información provista por INEC

Fuente <http://www.ecuadorencifras.gob.ec>

Fundación FEMEBA
Diseño funcional: R Wenk - Desarrollo: DaniloEE

Figure 2. Estimating the demand for palliative care concerning the number of professionals and patients.



Figure 3.- Academic contributions that have strengthened the CP

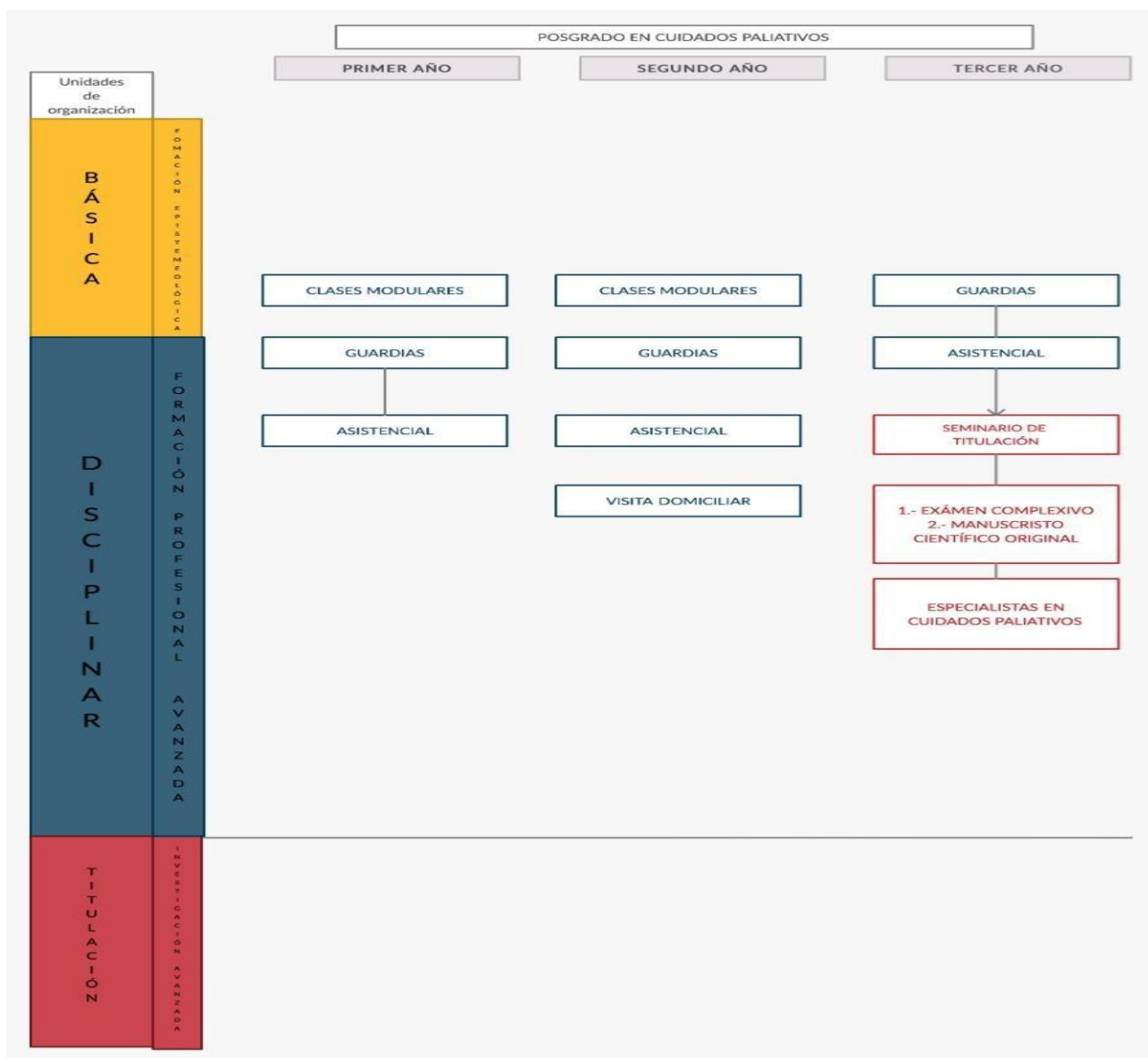


Figure 4.- Layout of the academic program's three organizational units.

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Conclusions

Training specialists based on the need of a country is a historic achievement because it allows knowledge of the comprehensive basic model of care and identifies the multidimensional needs of the person, family, and immediate caregiver, identifying preferences, values, and early decision-making, as well as bereavement care in addition to strengthening the health network at the different levels of care.

Abbreviations

PC: Palliative care.

Administrative information

[Additional Files](#)

The author declared none.

[Acknowledgments](#)

The author thanks the teaching department of the National Oncology Institute, Dr. Juan Tanca Marengo, of the Society for the Fight Against Cancer, Solca-Guayaquil.

[Financing](#)

The author did not receive any financial recognition for this work.

[Availability of data and materials](#)

Data availability is available upon request to the corresponding author. No other materials were reported.

Statements

[Ethics committee approval](#)

It does not apply to observational studies with a review of databases or medical records.

Consent to publication

This does not apply to studies that do not publish explicit images such as CT scans, MRIs, and physical exam images.

Conflicts of interest

The authors declare that they have no conflict of interest or competence.

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