

Palliative Medicine: Past - Present - Future

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Modern medicine is divided into three categories, namely preventive, curative and palliative. Palliative medicine and palliative care focus on people suffering from progressive incurable diseases with an expected fatal outcome, as well as their family members. It is conducted by an interdisciplinary palli-

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ative team at all levels of health care. Palliative care is a broader term than palliative medicine, as it encompasses other activities carried out by social welfare institutions as well as civil society organizations, religious institutions and other stakeholders in the community. Although elements of the palliative approach have been encountered throughout history since the beginning of medical treatment, in the last fifty years we have witnessed the rapid development of palliative medicine as a distinct specialization and subspecialisation in many countries around the world. Palliative care is a civilizational step forward and a true example of person-centered medicine. Given the aging population and the growing technological capabilities of modern medicine, we expect a large increase in the need for palliative care which requires the active contribution of all participants involved in creating and implementing social and health policies, both locally, nationally and internationally. This paper presents the historical development and current state of palliative medicine in the world with special emphasis on the situation in Croatia.

Keywords: palliative medicine; palliative care; palliative team; quality of life; strategic plans; person-centered medicine; total pain; education.

INTRODUCTION

Modern medicine is divided into three categories, namely preventive, curative and palliative. One of the important human rights and the issue of modern civilization is the dignified confrontation of a person with a progressive and incurable disease in which we expect a fatal outcome. Such an approach is enabled by the procedures and attitudes of modern palliative medicine. Palliative medicine is part of comprehensive care for the patient and it represents the continuity of preventive and curative medicine. People with progressive and incurable diseases with an expected fatal outcome make up approximately 1-5% of the population of certain countries. These diseases include primarily incurable oncological diseases, the fourth stage of heart failure, severe dementia, amyotrophic lateral sclerosis and many other progressive neurological and internal diseases as well as some infectious diseases (Đorđević & Braš, 2012). According to the World Health Organization (WHO), palliative medicine is defined as care that improves the quality of life of life-threatening pa-

tients and their families, by preventing, identifying and alleviating suffering, pain and other physical, psychosocial and mental difficulties (Mimica, 2011). This newer WHO definition has replaced the previous definition, which was limited to patients whose disease did not respond to treatment procedures and it extends the scope of palliative care to patients and families facing deadly disease-related problems (Radbruch & Payne, 2009). It is important to emphasize that palliative medicine is an active and comprehensive approach that always looks at the physical, psychological, social and spiritual factors involved in health and disease and its interdisciplinary action always involves the patient, family and community. Palliative medicine is a narrower term than palliative care since it refers to the activities of health professionals in various models of organization whilst palliative care additionally includes activities of civil society, religious institutions, volunteers and the community as a whole (Radbruch & Payne, 2009). Palliative care encompasses caring for a patient's needs whether at home or in a health care facility. The main goal is to

achieve the best possible quality of life for patients and family members through symptom control, psychosocial support as well as good and continuous communication and coordination. Despite the differences between national approaches to palliative care, a number of common values and principles can be identified in the literature, among which respect for patient autonomy and dignity, the need for individual planning and decision-making and a holistic approach are particularly important. Numerous aspects of palliative medicine are applicable from the early phase of the disease and as such should be made available from as early as the diagnosis of the incurable disease with an expected fatal outcome. This process should continue until the period of mourning after the death of the patient. Incurable diseases including death as a part of life have received little attention. Until recently, no one has taught us how to accept these situations and how to deal with them, how to help a sick person and family members and how, as professionals, not to perceive this as our own failure. With that aim in mind, it is necessary to deal with an individual as a person, regardless of whether it is a child, an adult or an elderly person (Braš et al., 2013a). The palliative team of professionals is interdisciplinary and consists of a variety of disciplines, including physicians, nurses, nutritionists, pharmacists, occupational therapists, speech therapists, psychiatrists, psychologists, social workers, art therapists, and clergy. Other members can be volunteers and informal caregivers such as family members and friends who provide physical, emotional and spiritual support. Members of the interdisciplinary team share responsibility and each team member contributes according to their own professional abilities and thus quality coordination and communication among team members is

of utmost importance. Research indicates that palliative care teams fulfil patient and family needs and are thereby reducing the total cost of care since patients spend less time in acute health care facilities. The composition of the multiprofessional team differs depending on the groups of patients involved, the scope of care it provides, the local area it covers as well as the laws and regulations governing the organization of palliative medicine.

HISTORICAL DEVELOPMENT OF PALLIATIVE MEDICINE AND PALLIATIVE CARE

Caring for people who suffer and die is part of human history, so in different civilizations we can trace how those who are incurably ill and dying have been cared for over thousands of years. Hospices have existed in many countries around the world since the beginning of the era, caring for critically ill and incurable patients. However, since the 1960s, we have witnessed a real revolution in the care of those suffering from incurable diseases, which is the result of numerous changes in medicine in general. After the Second World War, there was a large increase in the number of elderly people in almost all countries of Europe and the United States (US), which led to an increased interest in the problems of aging. Today, due to improvements in medicine we are witnessing a reduction in infectious diseases mortality with an increasing number of patients requiring continuous medical care, such as cancer or cardiac patients (Braš et al., 2016). The intense changes related to medical ethics that took place after the Second World War led to the development of a model of collaborative partnership between health professionals and patients with an emphasis on communication skills in medicine and health. At the same time, a number of

specialist and subspecialist medical disciplines were gradually developed and the problem of dehumanized treatment in hospitals was increasingly emphasized. The development of palliative medicine in the 1960s in the United Kingdom (UK) and in the 1970s in the US and Canada arose precisely as a reaction to these changes in medical culture and were prompted by the work of several outstanding visionaries and historical figures in medicine. One of them is Cicely Saunders, the founder of the hospice movement which had a major international influence in promoting palliative medicine and palliative care. Cicely Saunders had three professions, she was a doctor, a nurse and a social worker and in a way, she was “an interdisciplinary team in one person”. In 1967, due to the efforts employed by Saunders, St. Christopher’s Hospice in London was transformed into the first medical and academic modern health institution in which interdisciplinary care was offered to people suffering from incurable diseases. Cicely Saunders has changed several paradigms in medicine globally, particularly regarding people suffering from incurable diseases. These include emphasizing the quality of life and focusing on human suffering as well as existential and spiritual issues that are important in approaching the patient as a person. She was very committed to caring for people suffering from severe and incurable diseases and introduced the concept of “total pain” which includes mental, physical, social and spiritual components (Saunders & Sykes, 1996). A historical figure in the development of palliative medicine was the American psychiatrist Elizabeth Kübler-Ross, who since the 1960s advocated open and honest communication with patients facing death. Her clinical, public health, scientific and publishing activities changed the social view towards the dying patients and humanized the ap-

proach and care for them (Kubler-Ross & Kessler, 2001). In addition to hospice palliative medicine, inpatient palliative medicine began to develop very quickly. Thus, in 1974, urological surgeon Balfour Mount established the first palliative care service and department at Royal Victoria Hospital at McGill University in Montreal, Canada. Balfour Mount, looking for an adequate name for this inpatient unit in the hospital, proposed the term palliative care according to the Latin word *pallium* meaning a cloak or overcoat. The pioneers of modern palliative medicine and the spread of the hospice and palliative movement around the world have led to the significant development of this medical discipline which in many countries has become an independent specialization and subspecialisation with significant ties to universities. As a result, today we have thousands of palliative medicine specialists employed in thousands of different palliative care units (Sepulveda et al., 2002).

PALLIATIVE MEDICINE TODAY

The right to adequate palliative care is now considered one of the important human rights. It is imperative that national governments fund and develop a plan of health activities that include preventive, curative and palliative care. In some countries different national strategies and different levels of development exist, however the basic principles and methods of work are standardized. It is important that the patient can be provided with palliative medicine wherever he/she is at the time of his/her illness (home, nursing home for the elderly and infirm, hospital, etc.) and that family members are always involved in the care. Therefore, the organization of palliative medicine is needed at all levels of health care, with more than a hundred countries around the world have differ-

ent approaches (Centeno et al., 2007). Non-specialized palliative care services include home health services, family medicine specialists, home care facilities, units in general hospitals as well as nursing homes for the elderly and infirm. Specialized palliative care services are inpatient palliative care units, hospices, hospital palliative care support teams, mobile palliative care teams, community hospice teams, hospice day care centres, so-called "Hospital at home" and outpatient services (Radbruch & Payne, 2010). Today, approximately half of patients using palliative care services have some form of cancer and there is an increasing number of patients with dementia and other neurological diseases, as well as end-stage liver or heart disease. The traditional/old model of palliative care emphasized that palliative care was equivalent to care for a dying patient and it was implemented only when all other possibilities for active treatment of the disease were exhausted. Newer models of palliative care are completely different, since palliative care should be made available from the moment of diagnosis and is provided at the same time as active treatment. Care at the end of life, whilst important in palliative care, plays only a small part. Most patients need palliative care only in the advanced stage of the disease; however, some require palliative interventions earlier during their illness. There are several tools for determining when a patient needs palliative care and the period of that care can last for several years, months, weeks or days (Radbruch & Payne, 2010).

People with incurable diseases generally wish to continue disease control therapies for as long as possible, require relief from physical, mental, social and spiritual symptoms, need help with decision-making, advanced care planning and preparation for death as well as support for their

family members (Miljanović et al., 2017).

Palliative care should be provided on different levels of health care, from primary health care to specialist services whose main activity is palliative care. Thus, according to the levels of palliative medicine, we distinguish between the palliative approach, general palliative care, specialist palliative care and centres of excellence. The palliative approach is a way of integrating palliative methods and procedures in environments that do not specialize in palliative care. This includes measures to combat symptoms, communication with the patient, family members and other healthcare professionals, as well as decision-making and goal setting all in accordance with the principles of palliative care. General palliative care is provided by professionals who are involved in palliative care due to the nature of their work or the larger number of patients who require palliative care, even though palliative care is not the main focus of their work. Specialist palliative care describes services whose main activity is the provision of palliative care. These services typically care for patients with complex and difficult needs and therefore require a higher level of education, staff and other resources (Radbruch & Payne, 2009). Therefore, specialist palliative care is provided by an interdisciplinary and well-educated palliative care team. This team works together with the patient's family physician to provide not only clinical expertise, but also an additional level of support to the patient and his family. The specialist service must be easily recognizable to patients, families and other professionals and must have an independent budget. Team members need to be highly qualified with recognized training in specialist palliative care and having experience in clinical problem-solving in multiple domains so as to meet complex patient needs. The

fourth level consists of centres of excellence, which should provide specialist palliative care in a variety of settings or for specific groups of patients, including outpatient and inpatient care, home care and counselling services. Centres of excellence are also extremely important as teaching bases and places for research and development of standards and new methods (Đorđević et al., 2016). In any case, a modern palliative care program includes a combination of treatment with education, research and a public health approach. Every modern academic medical centre aims to integrate a palliative program into clinical, educational and research activities. Palliative care programs greatly reduce pain levels and numerous studies have shown that palliative care helps control fatigue, anxiety, shortness of breath, nausea, constipation and other physical symptoms that cause suffering. Psychosocial interventions on social and spiritual dimensions are an extremely important part of palliative medicine and palliative care. Patients wish to remain as independent and healthy as possible and they need help in decision making and overall communication with health care providers, as well as practical support with respect personal needs be it at home, nursing home or in the hospital. This kind of support is also of great importance for family members. Palliative care should be based on the following moral values: integrity and trust, which are essential for the professional-patient relationship, compassion of professionals and experts for the patient and his family, right treatment, honesty and justice. These values allow caregivers to address moral and ethical issues at the end of patients' lives.

Equally important is communication with the patient and family members. It has been shown that they require help with decision-making, advanced care planning and preparation for death, clear and con-

stant communication with their doctors and other health care providers regarding their expectations and planning process of their treatment as well as their future (Đorđević et al., 2011). Among the biggest challenges in communication in palliative medicine is communicating bad news, talking about prognosis and risks, responding to different emotional reactions of patients, leading family meetings, end of life conversations and quality communication among team members (Kissane et al., 2010). It is important to emphasize that communication in itself brings therapeutic benefits and it is sometimes the only component of therapy. Problems in communication lead to stress, professional burnout and changes in experts. Communication is the key to effective teamwork as it primarily serves to assess needs, provide information and aid in decision making. Successful communication assumes that experts have acquired non-verbal communication skills, counselling skills and case presentation skills as well as cooperation with other associates (Ferreira-Padilla et al., 2015)

Palliative medicine aimed at the person

Although the approach to the patient as a person, rather than diagnosis, is at the very foundation of palliative medicine, this has been particularly emphasized in the last fifteen years with the development of the international movement of person-centered medicine.

From its first steps, human medicine has often emphasized the importance of a holistic approach to the sick person, respecting the biological, psychological, social and spiritual in the origin, course and outcome of the disease. The doctor often cannot cure the disease, but his important role is to take good care of the

ill person and always provide hope and alleviate suffering. Today, human life expectancy has significantly increased and we are witnessing an epidemic of chronic non-communicable diseases that are largely related to the lifestyle and behaviour of individuals. In recent years, personalized medicine has been strongly developing in the world. This form of medicine aims to individually adjust treatment with the use of the so-called “smart drugs”, increasingly modern methods of brain imaging and the latest knowledge of medical genetics and nanotechnology. Due to this technological development, more people survive and live longer including those with previously incurable diseases, there are fewer side effects caused by medications and diagnostic procedures. Further, modern technologies have enabled easier communication, the development of bioethics and the advancement of science opening up new possibilities for treatment. At the same time, a growing fragmentation of medicine, the inability to cover costs, in some cases even over-informatization in health care and rising problems in communication skills may lead to a growing number of complaints about relationships and communication. Often, the focus is mainly on the diagnosis, the diseased organ or the pathophysiological mechanism rather than the sick person with his life story, positive aspects of health and his interpretation of the disease. Due to these processes, over the last three decades in many countries, increasing emphasis during medical education has been placed on communication and communication skills in medicine and almost all leading medical associations and intergovernmental institutions in health are gathered in the international movement of person-centered medicine and people-centered health. In this movement, special attention is paid to palliative medicine aimed at the person respecting

the biological, psychological, social and spiritual factors of the origin, course and outcome of the disease. The aim is to respect the patient’s life perspective, his views on the world and disease in general, his desires and needs. Great emphasis is placed on the personality of the healthcare professional, communication and relationships, use of informed consent, joint decision-making, work with the patient’s family, as well as partnership with other professionals in the medical team (Braš & Đorđević, 2013b). A necessary prerequisite for this approach is good medical education, particularly in the field of communication and communication skills in medicine. Learning communication skills in medicine is not an event, but a process that takes place in several stages and is upgraded over the years. It begins during secondary education, develops throughout the study of medicine as well as in the higher education of other health professionals and improves through lifelong learning (Đorđević et al., 2012).

Palliative medicine today cannot cure a person, but it can take care of him, alleviate his pain and suffering while preserving the dignity of the person as a unique human being. In palliative medicine, the sentence “nothing more can be done” should not be used since we should always ask ourselves “what else can we do for the patient and his family?”. In this case, the ability to be a good clinician, our communication skills, ability to work in a multidisciplinary team as well as our empathy and humanity are tested.

PALLIATIVE MEDICINE TOMORROW

Reflecting on the future of palliative medicine, we believe that a number of factors suggest that palliative medicine and palliative care will develop even more

rapidly in the years and decades to come. There are major demographic changes in aging populations, statistical mortality rates are also changing and will continue to change. People will live longer, the proportion of the elderly will increase and as life expectancy increases, more people will die from severe chronic diseases such as heart disease, cerebrovascular and respiratory diseases, as well as from various types of cancers. Owing to the technological development of medicine, patients will survive longer with chronic disabling disease and consequently they will need palliative care for an even longer period of time. The COVID-19 pandemic, which began two years ago and is still ongoing, unfortunately showed us that palliative medicine is needed by an increasing number of people suffering from infectious diseases. It also pointed out the need to overcome numerous communication barriers enabling better communication between family members and patients, particularly those that due to the stringent epidemiological measures were unable to say goodbye to their loved ones thus leading to possible complications in the process of mourning. Equally, special attention will have to be paid to the overall care of the elderly, particularly to people with dementia, and that will require a better integration of the health and social systems (Braš et al., 2022).

We believe that palliative medicine, with its principles and way of working in this century of conflicts, wars, pandemics and all kinds of crises that threaten humanity represents a real civilizational step forward. Medicine and all related professions dealing with people need to encompass a combination of profession and skill which arises from the relationship of experts with every individual who needs help as well as other professionals involved. This is important since no two people are the same,

nor do they have identical problems, each being unique (Braš & Đorđević, 2013b).

Given that palliative medicine has advocated a holistic approach from the beginning, we believe that it has shown the direction in which all medicine should go in terms of care levels and organizational models, since interdisciplinary teams and comprehensive care are needed in overall medicine.

COMMUNICATION IN PALLIATIVE MEDICINE

Communication is one of the most important issues in palliative medicine in general. It is evident that communication skills have become one of the four fundamental skills which determine healthcare professionals alongside medical knowledge, clinical skills and problem-solving abilities. Furthermore, these skills affect patient treatment outcomes, including patient satisfaction, cooperation, and a lower incidence of complaints due to medical errors. Communication in palliative medicine requires a specific approach. Formulating messages for patients, particularly those with an incurable disease and an expected fatal outcome requires special skills regarding the form and means of communication showing an example of person-centered medicine (Đorđević & Braš, 2012). This encompasses a wide range of communication including direct doctor-patient communication, communication with family members, the interdisciplinary palliative team, the media, patient organisations, health insurance providers and relevant government institutions. In palliative medicine, dyadic doctor-patient communication has been almost completely replaced by an interdisciplinary team which has necessitated numerous adjustments ((Đorđević & Braš, 2011). It is very important to un-

derstand the dynamics within the team and the processes involved, as well as the relationships between the team members and communication with the patient and family members. In patients with incurable diseases, we try to implement active coping skills which will enable them to successfully adapt to the situation and thus all these patients require the support of a well-educated team in terms of communication. It is important to note that the lack of self-confidence and knowledge of communication skills among health professionals significantly contributes to the development of burnout syndrome and a number of other health problems that lead to increased absence from work or the need for frequent replacement of staff. Key situations in palliative medicine requiring specific communication skills include communicating bad news, discussing the prognosis and risks of certain forms of treatment and joint decision-making regarding treatment. Further, these specific skills are essential for proper responses to emotional reactions of patients, communication with family members, leading family meetings, communication regarding the transfer of patients to palliative care and other issues related to decisions at the end of life. Good education in communication skills in palliative medicine can greatly improve patient and family decision-making, emotional, spiritual and practical support, symptom management and overall quality of life and care.

PALLIATIVE MEDICINE IN CROATIA

The development of palliative medicine and palliative care in the Republic of Croatia is connected with the rich heritage left to us by Andrija Štampar and his associates as well as with objective obstacles that slowed down the development

of this important part of medicine. For this reason, we are still in the process of establishing an organized system of palliative medicine and are lagging behind most European Union (EU) countries. The ideas of palliative medicine and palliative care easily found fertile ground in Croatian health care even before the Homeland War, because we had a rich history of public health and social medicine with significant care for the needy and highly developed primary health care with interdisciplinary approach and nurturing family medicine. In addition to contacts and cooperation with the founders of the international hospice movement and the launch of the first trainings, before the beginning of the Homeland War, the first palliative care units were established in some hospitals. Unfortunately, from 1991 to 1995, Croatia was exposed to the consequences of the war, with a significant deterioration in living standards and the directing of state health care funds to other high priority areas. On the other hand, the hospice movement began to develop further during the war years, and in 1994 the Croatian Society for Hospice/Palliative Care was founded within the Croatian Medical Association. The first president of the society was Anica Jušić, neurology specialist, who with great enthusiasm gathered several hundred experts and volunteers and worked tirelessly on the development of palliative care in our country. Her work was aimed at education of experts, volunteers and the general public, inviting international experts to Croatia and founding associations of educated volunteers with the first hospice home visits. The first legal framework for the organization of palliative care was created in 2003 as part of the new Health Care Act, which lists palliative care as one of the health care measures included in the activities of health centres. The same law defines the Institution for

Palliative Care which includes a day care centre, an outpatient clinic for pain and palliative care and legally defines the composition of the palliative interdisciplinary team of home visits, namely a doctor, a nurse, a pharmacist, a physical therapist, a social worker and a clergyman. However, the 2004 Patient Rights Protection Act does not mention the patient's right to palliative care and existing amendments to the Health Care Act could not be implemented in practice due to inconsistencies with other laws and bylaws. A significant step forward was the establishment of the Centre for Palliative Medicine, Medical Ethics and Communication Skills (CEPAMET) at the Medical Faculty of the University of Zagreb on September 21, 2010. CEPAMET soon became a national centre of education and a breeding ground of ideas for the development of palliative medicine in Croatia. To date, about 2 500 experts have been educated through interdisciplinary continuing medical education courses, Palliative Medicine has become a compulsory subject for medical students in the sixth year and a Palliative Medicine Council has been established. Numerous books and scientific and professional papers have been published, and much has been done in educating the general public through various media. At the Centre for Palliative Medicine, Medical Ethics and Communication Skills (CEPAMET) of the School of Medicine of the University of Zagreb, continuous post-graduate medical training courses dedicated to communication skills in palliative medicine have been conducted over the last ten years. These programs have been attended and completed by more than a thousand health professionals. Experiential learning methods such as role playing, simulated patients, real patients and various video materials are used in teaching communications skills and are constantly being improved.

Continuous efforts are also made in communication and education of the public in general regarding palliative medicine and palliative care, so as to ensure the effective functioning of the system (Đorđević & Braš, 2011). The strong momentum of the palliative movement in the last ten years has led to numerous changes that have enabled the gradual implementation of palliative medicine in the Croatian health care system. Accession to the European Union required changes in the health sector and the implementation of palliative care in the health system of the Republic of Croatia. Continual pressure on responsible ministries by the experts from our country led to gradual changes in laws and bylaws which enable the opening of various palliative care units at the primary and secondary levels of health care, and from 2019 at the tertiary level. Today, in Croatia we have approximately 40 mobile palliative teams at Health Centres and nearly 350 contracted palliative beds available in hospitals. Some Croatian counties have already developed a system of palliative medicine, and some are still in their infancy, posing a problem since every citizen should have the right to adequate palliative care, regardless of the ability to pay.

In Croatia, an increasing number of patients with serious chronic conditions and incurable chronic patients are placed in homes for the elderly and infirm, instead of hospitals which do not have enough accommodation for that purpose. Some remain in their own homes, where the problem of incompetence and unwillingness of family members to care for the patient is present. For this reason, homes for the elderly and infirm have been transformed into care and treatment facilities, with more than a third of inpatients being immobile, severely ill or dying, and with a third of severely mobile patients who are dependent on help of others. Less than

a third of home users who are located in the residential part of the home are mobile and independent. Due to this situation, the main reason for placing the elderly in homes is precisely the health indication, so they are not only social, but also health institutions that take over part of the hospital problems and unburden the hospital capacities. From the above, it can be concluded that it is necessary to conduct continuous education in palliative care for employees of social institutions and to standardize health care in homes for the elderly and infirm.

In the last ten years, several national strategic programs related to the development of palliative care have been adopted. Whilst we are still lagging behind in the development of palliative medicine compared to many EU member states, the palliative movement in Croatia is getting stronger every day. The excellent work of an increasing number of palliative care centres in Croatia and better education of professionals and volunteers are the best guarantee for the future development of this important part of medicine in our country. It is important that palliative medicine and palliative care are even more involved and strengthened by health and social policies with special emphasis on vulnerable groups such as children, people with dementia and Croatian veterans who, according to numerous studies and clinical practice, are a more vulnerable group in relation to the general population.

It is important to continue the battle against many prejudices associated with palliative medicine in our country and the most difficult part is to deal with our own prejudices or perceptions that we have been building for years. We have often heard not only from the general population, but also from professionals the identification of the terms palliative medicine, palliative care and hospice, thinking that

palliative care is needed only for the last few days of life, for the elderly, cancer patients, or in remote hospitals or centres where patients “for whom nothing more can be done” are accommodated.

Only good education at all levels can make a qualitative step forward in caring for the terminally ill and their family members. Without good education there is no implementation of anything new and universities and their components should be the cornerstones in creating new knowledge and new professions that base their skills in the biomedicine, humanities and arts.

CONCLUSION

In palliative medicine, more than anywhere else, we meet people suffering from incurable diseases as well as their families and we are expected to take a highly professional and empathetic approach in solving their physical, psychological, social and spiritual problems. Palliative medicine is the best example of the art of medicine (*ars medica*), which connects science, clinical knowledge and art towards the path of a culture of health and humanity. It is civilizational, humanistic and professionally inadmissible to allow anyone today and especially the seriously ill to experience any pain and suffering. Some of these patients are lonely, socially vulnerable and alienated from the community, while others have significant family and social support, but each of them reacts emotionally to an incurable disease in their own way. It is important to raise awareness of the need for interdisciplinary work based on new postulates of teaching and cooperation of all disciplines involved in this field, while leaving each discipline the opportunity for independent growth and development. Working in a team of different professionals is a top profession-

al step forward that can only be made by people who are willing to do good in order to feel good. Today, more than ever, it takes courage and strength to take further steps in caring for the terminally ill and their families in a century that is proudly called the Century of the Mind. The battle for palliative medicine is a battle for humanity and quality of life to the end and every person on Earth deserves it.

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Sažetak

PALIJATIVNA MEDICINA: JUČER – DANAS – SUTRA

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Suvremena se medicina dijeli na preventivnu, kurativnu i palijativnu. Palijativna medicina i palijativna skrb bave se osobama koje boluju od progresivnih neizlječivih bolesti s očekivanim smrtonosnim ishodom i članovima njihovih obitelji. Provođi ju interdisciplinarni palijativni tim na svim razinama zdravstvene zaštite. Palijativna skrb je širi pojam od palijativne medicine, jer obuhvaća i brojne druge aktivnosti koje provode institucije vezane uz socijalnu skrb kao i organizacije civilnog društva, vjerske institucije i drugi

dionici u zajednici. Iako elemente palijativnog pristupa nalazimo u ljudskoj povijesti otkad postoji liječenje, zadnjih pedesetak godina svjedoci smo naglog razvoja palijativne medicine kao posebne specijalizacije i subspecijalizacije u brojnim zemljama u svijetu. Palijativna skrb je civilizacijski iskorak i pravi primjer medicine usmjerene prema osobi. Obzirom na starenje populacije i sve veće tehnološke mogućnosti suvremene medicine, očekujemo veliko povećanje potreba za palijativnom skrbi, što zahtijeva aktivno sudjelovanje svih koji sudjeluju u kreiranju i provođenju socijalnih i zdravstvenih politika zajednice, kako na lokalnoj tako i na nacionalnoj i međunarodnoj razini. U ovom je radu prikazan povijesni razvoj i sadašnje stanje palijativne medicine u svijetu, s posebnim naglaskom na situaciju u Hrvatskoj.

Ključne riječi: palijativna medicina, palijativna skrb, palijativni tim, kvaliteta života, strateški planovi, medicina usmjerena prema osobi, totalna bol, edukacija.