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Problems of Organization and Scientific-Methodological Support of the Medico-Social Help to the Population.

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ABSTRACT

The article analyzes the problems of organization, scientific and methodological support of the medico-social help to the population. Special attention was paid to the prospects of medico-social care for terminally ill patients, was shown its relevance, the principles for the provision and palliative care organization. In this connection was carried out the analysis of possibilities of its provision in international studies. Was discussed the situation in the Republic of Dagestan in the field of palliative care. Was proposed a model of a multidisciplinary palliative care team, as an organizational form of palliative care at home. Based on the problems facing the organization of palliative care was suggested their possible solution.

Keywords: medico-social assistance, psychological intervention work, palliative care, the multidisciplinary team of palliative care.

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INTRODUCTION

According to the international documents and international practice since the second half of XX – the beginning of XXI centuries, a special attention was paid for the ensuring of human rights to an effective medical and social assistance (MSA), providing the improvement of life quality in case of incurable diseases, sickness, disability, old age, etc.

The relevance of MSA in the early twentieth century in Russia, as in other countries of the world, is associated with a number of demographic factors, like a significant increase in the number of persons in older age groups.

The researchers understand MSA as the multidisciplinary professional activities of a medical, psycho-pedagogical and socio-legal nature, aimed at restoring, maintaining and promoting the health of the population [1]. It fundamentally changes comprehensive assistance in the healthcare sector, as calls for systemic medico-social impacts in the early stages of the disease and social exclusion, potentially leading to serious complications or disability. Thus, the MSA has not only rehabilitative, but also preventive orientation [2].

MSA as a professional activity is formed by the junction of two separate sectors - health and social protection of the population. Health workers in practice often act as social workers. In turn, social workers who work with persons with mental and physical pathology serve as physicians.

Therefore, MSA is closely intertwined with the activities of the institutions of the healthcare system. But it does not exceed the limits of its competence, does not claim to perform diagnostic and treatment functions, and involves close collaboration with the medical staff and a clear delineation of areas of responsibility.

MSA has a particular relevance for the terminally ill patients. Social workers are curating the families and meeting their needs, keeping informed about the patient's health, providing assistance in obtaining financial aid and the like.

Social workers help to solve conflicts, represent the client's interests in government. If necessary, they carry out psycho-correctional work with the client and his immediate environment; provide training in restoring family relationships. The family members are involved in the work groups for self – help and social-help training.

MSA for the terminally ill persons with disabilities provides a prevention of complications after treatment. An important place occupies the psychological intervention work for prevent of a suicidal intentions. A special help is received during a conduction of a medico-social examination, reception of pensions and benefits, and if necessary - the arrangement of a delivery in hospice or organization of the MSA at home. Psychological support of families is carried out throughout the period of treatment and rehabilitation. Social workers are involved in the creation of individual rehabilitation programmes, in the provision of prosthetic and orthopedic care, sanatorium treatment. Career guidance is hold if needed, assistance in the rational employment, the formation of social skills [3].

A special place in MSA is the organization of palliative care (PC) for the terminally ill, with a main task - getting rid of the pain, eliminating or reducing disorders of life and other severe manifestations of the disease.

According to the WHO definition, palliative care is a field of medical care and social care of patients with severe incurable diseases and limited duration (prognosis) of life. The main purpose of PC is to improve the quality of human life in its final period, the maximum relief of physical and moral suffering of the patient and his family, the preservation of the human dignity of the patient at the end of life [4]. Thus, the object of palliative care is not only the patients themselves but also their families and others who care for them.

It is unlikely that the final period of a human life is precisely the period when something can be radically improved, but the preservation of human dignity should happen throughout the life, both in its beginning and at its completion. Thus, the problem of PC is the issue of a human dignity. By means of PC are

solving the problems of people with incurable diseases and limited life prognosis, which have no prospects for recovery, and a somatic treatment has already exhausted its possibilities or hampered due to the severity of the general condition of the organism [5]. This question especially sharply affects the elderly and persons with disabilities.

Since the establishment of the diagnosis of an incurable disease one of the main principles was to provide patients the real choice of options for obtaining assistance. Thus, the problem of the specialized medical and social assistance for the persons with serious, incurable diseases and limited life prognosis is becoming increasingly important.

METHODOLOGY

In Dagestan, as in the Russian Federation in a whole, are undergoing profound demographic changes associated with the aging of the population with a significant accumulation in population of persons of elderly and senile age. The progressive aging of the population, a significant change in the structure of diseases in the direction of chronic disease leads to the fact that a number of patients with severe chronic illnesses who lose self-care abilities and need assistance is increasing.

The development of PC should include different organizational forms of its provision, depending on the needs of the population and characteristics of the region, but they can be divided into two main groups - assistance in institutions of stationary type and a help at home.

The latest recommendations of the WHO - reorientation of receiving modern systems of PC for persons who have the terminally illness, community-acquired forms of service that are not inferior to the traditional hospital care and are also cost effective. Besides, in terms of social significance, a comprehensive care at home invariably dominates, as it is more complex MSA, which is necessary for palliative patients. [6,7]

The experience of countries with a high level of the development of PC suggests that this form of organization is a priority. The need of organization of PC at home is also associated with several causes; the traditional family structure has changed, the majority of people, particularly the elderly, live alone and cannot rely on family support; insufficient number of existing specialized inpatient medical and social institutions with the appropriate facilities to meet the needs of in-patient treatment of all palliative patients [8]. In addition, in 75,0% of individuals with progressive forms of chronic diseases and in their relatives prevails the desire to receive this help at home. At the same time, cancer patients mostly need a palliative medicine (pain management), they constitute not more than 10.0% of all who are in need of specialized care. Patients with other diseases to a greater extent need comprehensive care, medico-psycho-social and spiritual support [9].

Palliative patients are on the borderline between the scope of health authorities and social security authorities and, in fact, do not have guaranteed specific help. If the medical component of the PC, including the reduction of pain syndrome, is partially solved, although there remain a lot of problems, the direction of the social component in the country only becomes a subject of study [10].

However, it should be borne in mind that the main goal of home care for palliative patients is not only in a purely medical plane, and even to a greater extent in the social plane. After all, patients at home, especially those with non-cancer nosology, are in need not only in anesthesia but also in a complex care, psychological and spiritual support.

Despite the topicality of the issue, still occurs aborted unified system of views on the problem which reflects a certain understanding of the essence of the process of medico-social services of the in-home palliative patients. The problems of the social, psychological, and spiritual support to palliative patients and their family members remain without attention of developers of normative documents in this field.

The development of aid for the seriously ill (incurable) patients and members of their families cannot be considered without taking into account the general context of the development of the health system as a whole.

THE RESULTS OF THE STUDY

Some times ago there have been some positive changes in solving the problem. Thus, according to the report of S. Saipudinova, the deputy of the head of the department of organization of medical aid to the adult population of Ministry of health of the Republic, in 2015 a palliative care in hospitals of Dagestan have received 931 patients. In addition, in 2015 were issued orders of the Ministry of healthcare of the Dagestan Republic on the approval of the post of chief freelance specialist in palliative medicine, was approved the chief freelance specialist in palliative care of Ministry of health, that held the training on palliative care in Stavropol. In order to ensure qualified medical personnel in providing palliative care to cancer patients in the Republic, in order to complete the most full coverage and uniform distribution of the trained professionals in 2016 it is planned to train specialists in Makhachkala, the Northern zone - in Khasavyurt, southern zone - in Derbent. However, palliative care in the Republic is not sufficiently developed. To solve this problem in the state program "Development of health of the Republic of Dagestan for the period 2014-2020" was submitted the subprogramme "The provision of palliative care, including children", where by 2020 it is planned the opening of an office of palliative care for adult cancer patients with 30 beds in the Annex to the main building of the Republican oncological centre. Unfortunately, still the funding for the program is missing [11].

Also, problems remain in providing care for terminally ill, as there are no hospitals (departments) for the palliative care – hospice, and actually was not developed well the organization of the palliative care at home.

Among the major inhibiting factors, primarily are the following:

- a lack of awareness by the city leaders of the extent of a problem maintenance of a home patients curation, who need but do not have an access to a specialised health and social care;
- the aborted understanding of the importance and social significance of this problem among the medical and social structures;
- the lack of a clear policy for the provision of PC in relation to categories of patients and diseases that are getting sick more often;
- the problem of regulatory support and funding of a network of institutions for the provision of PC at home remains open, which negatively affects the quality of patients service;
- not enough worked out the issue of integration and coordination between health services and social protection, state and non-state organizations;
- the presence of the unresolved organizational issues and the lack of a legal framework for regulation of activities of services of PC patients at home;
- the system of informing the public on the problems of PC is imperfect, which hinders the intake of material and other assistance from business structures, non-governmental and charitable organizations;
- in the media and in the health and social periodicals the provision of PC patients in general, and especially for the elderly who require such assistance at home, are discussed very rarely.

Besides, it is necessary to take into account the negative aspects of professional activities of personnel of critically ill patients - a high stressogenity, significant emotional and physical stress, a constant contact with the process of dying and death, the lack of positive results of the effort, increased risk of development of syndrome of emotional burnout, etc. According to international and domestic experts, these factors can be the cause of the high turnover of medical personnel, inherent in the field of PC throughout the world as a result of its unattractiveness and a low prestige [12].

The negative consequences has the lack of knowledge about the specifics of the PC of the elderly among medical and social workers who oversee the palliative patients at home, without proper training in providing PC. Often are not resolved the issue of training, specialization and advanced training of relevant workers in the field of PC; there is no specialization in the field of "palliative care". There is practically no propaganda-explanatory work among the population about the possibilities of MSA at home for persons with incurable diseases, in addition it is necessary to increase the effectiveness of medications [13, 14].

DISCUSSION OF RESULTS

Thus, all given information is the evidence of a failure of the existing system to ensure patients with available MSA at home, which should be based on the following basic principles:

- accessibility at all stages and levels of the treatment process. Access to the PC service depends on the clinical indicators of the disease, is determined on the basis of an assessment of the likely forecast of its development, it does not depend on the economic status and financial condition of the patient, is provided, in accordance with his needs; supplement of skilled PC for all requiring patients;
- provision the choice of locations and options for receiving PC for the palliative patient;
- the complexity of the PC, consisting of events as a purely medical, social, psychological and spiritual support to patients and family members (guardians).
- the integration of the services of PC at home in the existing regional system of health and social protection.

These principles should be applied already in the early stages of manifestations of the chronic disease.

In the early stages of the illness that medically do not give patient perspectives on recovery, but the lifespan is not limited, should be provided the provision of health and social services by the non-specialized service from among persons engaged in direct patient care (often family members or other persons - guardian), the district medical personnel, general practitioners, social worker, volunteer and the like. They do not have special training in providing PC.

In this regard, we will try to highlight some organizational issues that until now have been paid little attention, and being characteristic for the health system as a whole, make a significant impact on the provision of palliative care for patients and their families affected by serious, incurable disease.

The specialized outreach service can be as the organizational form of the PC at home that is either a separate structure or subdivision residential institutions. The definition of particular organizational forms depends on the needs of the population in PC, the size and characteristics of the region, its actual support with the specialized beds.

In our opinion, the main mechanism for PC at home should become a multidisciplinary team of PC (MTPC).

A model of MTPC gives the opportunity to provide a patient with a comprehensive, and not only a purely medical or social support. The minimum structure of MTPC - professionals from social and health profile, psychologist, social worker, volunteers. In this team could be included the family members of patients, if they have acquired the skills to care for palliative patients.

The structure of a team is not stable; it depends on the specific situation, needs of patients and the available possibilities. PC for sick children, which is primarily provided at home, requires the inclusion in the structure of the team pediatrician.

In the MTPC the medical aspect relies on the anesthesia. Next is a care, which is the prerequisite for the body comfort (as possible). The most difficult are psychological problems, because they affect the inner world of patients and their relationship with the environment, interests, etc.

For palliative patients is vital, in addition to social services, a receiving of a legal aid. Supports for the family members of patients should begin at the very first day of diagnostic of a chronic disease, from the initial assessment of the situation and should continue through the whole period of PC. An important step is a support in the bereavement.

The solution of the above mentioned problems and objectives for the provision of PC should be achieved by implementation of the following steps:

- the analysis of needs, situation and the provision of the services of PC at home. This will identify needs in the relevant services of PC, in the staff of different levels and skills, will allow for identifying obstacles of public access to PC (social, economic, legal, etc.), including at the home;
- a development of normative-legal base on the issues of PC for different categories of patients, including the accepted at home. The main provisions of the internationally accepted documents of the corresponding orientation in the field of health and social services are relied in the basis;
- the ensuring of palliative patients' rights by making appropriate changes in current legislation regulating the turnover of opioid analgesics (with emphasis on patients served by at home) and the drafting of a special law, which will regulate legal relations in the sphere of provision of PC, and to fix responsibility for the violation of the rights of the terminally ill;
- the definition of a clear medico-legal and social criteria for the granting of PC at home;
- a development of quality standards of PC and their distribution among all the institutions specializing on the provision of PC for patients, including at home. Standards are developed at the federal and regional levels. The standards are created at the federal level with the purpose of invention of a strategy of development of PC and a control (monitoring), regional - to adapt the federal standards to the specific characteristics of the region or to the specific institution (institution);
- development and approval of model regulations of the provision of PC and home of the territorial center of social servicing (provision of social services), job (work) instructions for specialists and workers of the office;
- the official definition of the special subject of PC with assigning to him the status of "palliative patient";
- the definition of special social services for persons who received the status of "palliative patients";
- preparing a unified registry of palliative patients with definition of all forms of rendering PC (at home, in the hospice, in specialized departments of medical institutions, etc.) and a development of a specialized software for it;
- psychological, social and legal support for relatives and guardians providing constant care for palliative patients at home. At the legislative level it should be decided the issue of granting them the right to "a vocation for carrying of palliative patients," and of opening institutions "a help at a weekend" and others;
- a development of coordination and delineation of functions of the services that are involved in working with palliative patients in all forms of its rendering;
- the allocation of training in PC in the independent specialty (specialization). This will help obtain statistical data on the number of patients with various forms of chronic diseases who receive PC at home or in medical institutions of a stationary type and the definition of objective needs for appropriate expertise and training;
- a careful selection of qualified personnel from the experienced professionals for the implementation of PC and ongoing process of their education under the programs of improvement of professional qualifications;
- training of specialists for servicing of palliative patients is performed at three levels: basic: training of all health and social workers; intermediate – the advanced training of medical and social workers of various professions on the issues of PC; the highest - on the basis of higher educational institutions of postgraduate education for the obtaining of a specialization on palliative care;
- state support of philanthropy and the development of a culture of philanthropy among the wealthy segments of the population;
- support and a development of civil society organizations that seek for the development of PC, participate in the development of the regulatory framework, promote the training of qualified personnel. Coordination of their activities with the public sector;
- support of private entities, volunteers that are focusing their efforts on the providing of medical-social, legal, moral, and spiritual support for the palliative patients and their families;
- determine the mechanism of entry on the favourable terms to the higher educational institutions of medical and social areas of individuals and volunteers who worked with palliative patients;
- to increase a public awareness on the issues of PC on the possibility of obtaining a wide range of medical, social, legal, psychological, and spiritual services at home in the case of incurable diseases.

CONCLUSION

Currently, the problem of medical support of patients with incurable diseases with severe clinical consequences are moving from the purely medical to the global social and humanitarian problem, and its successful solution depends on the mobilization and on the joint efforts of state and public institutions to raise the necessary resources and the establishment of an appropriate medical infrastructure as possible in order to meet better the needs of PC patients in the terminal phase of life.

In crisis conditions, limited financial and material resources the issue of a closer interaction between public institutions at all levels, business structures and public organizations is one of the key areas of improvement PC. A specific embodiment of such a public project should become the formation of charitable foundations and funds of social support of patients with incurable diseases, the formation in the framework of the national policy of the volunteer movement and training its members for providing social assistance to these patients in their daily lives.

A significant role in this regard, can play the development and implementation of a comprehensive national target program of medical and social protection of patients in the terminal phase of life, as a real manifestation of social-humanitarian policy in today's conditions and future development of society in a qualitatively new principles of social standards. Thus, the question of consolidation of efforts of state and public sector need to be considered as an important vector of development of the PC system, which required the approval of a long-term program at the national level and improving the legal and regulatory framework to create real prerequisites to improve medical and social protection of patients with incurable diseases.

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