Notification of the National Health Commission
On the Operational Definitions of Terms Pertaining to

Palliative Care

for Thailand, B.E. 2563 (A.D. 2020)

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Section 12 of the National Health Act, B.E. 2550 (A.D. 2007), endorses an individual's right to execute a living will in writing to refuse public health services which are provided to merely prolong his/her terminal stage of life, or those that are to cease the severe suffering from illness. This living will is a tool employed for the communication process of palliative care.

At present, palliative care becomes increasingly vital and necessary, as there are patients with chronic diseases that cannot be completely cured, and a increasing number of elderly. Therefore, defining operational definitions of terms pertaining to palliative care shall potentially result in standardisation of quality patient care. Moreover, health professionals and health facilities shall be capable of formulating treatment guidelines, which further lead to budget and health resources allocation.

By virtue of the provision of Section 25(10) of the National Health Act, B.E. 2550 (A.D. 2007), in conjunction with the resolution of the Meeting of the National Health Commission No. 5/2020 on 18 September 2020, the National Health Commission therefore issues and enforces the Notification on the Operational Definitions of Terms Pertaining to Palliative Care for Thailand, B.E. 2563 (A.D. 2020) as annexed hereto in order to facilitate further implementation by agencies and organisations based on their roles and responsibilities.

In this regard, the Notification shall henceforce be effective*.

Announced on 14th October 2020

Anuthin Charnviraukul

(H.E. Mr. Anutin Charnvirakul)

Deputy Prime Minister

Chairman of National Health Commission

Operational Definitions of Terms Pertaining to Palliative Care for Thailand, B.E. 2563 (A.D. 2020)

These published Operational Definitions of Terms Pertaining to Palliative Care for Thailand are required to be accepted and acquire mutual understanding among all stakeholders, whether they are health or non-health professionals, in order to ensure that it shall be further implemented as a guideline when carrying out operations according to missions, responsibilities and authority of their own organisations or those relevant; ranging from policy making, strategy formulation, project planning, budget allocation, human resource management, service provision, to finance and treasury, as well as governance, audit academic development, and R&D.

The Issue-Specific Health Assembly Concerning the Operational Definitions of Terms Pertaining to Palliative Care for Thailand

has considered a (draft) documentation of the Operational Definitions of Terms Pertaining to Palliative Care for Thailand:

Appreciated the academic working team, palliative care experts and relevant organisations for their contributions to the publication of the (draft) Operational Definitions of Terms Pertaining to Palliative Care for Thailand;

Acknowledged Thailand's current situation in which the number of elderly and patients with incurable chronic diseases is consistently increasing, consequently palliative care being more critical and essential;

Realised that, at present, health service providers and health facilities have expanded their palliative care services, with a variety of services, resulting in differences in patient care. This therefore affects the quality of patient care, support system arrangement and public health resource management inevitably;

Realised the necessity of having mutually accepted operational definitions of terms pertaining to palliative care in order to ensure understanding among relevant parties, including relevant health professionals, public and private health facilities, health policy organisations, educational establishments, government agencies, local administrative organisations, public agencies, private organisations, religious organisations and civil society. Hence, these definitions shall be employed as a guideline when carrying out operations according to missions, authority and responsiblities of their own agencies or organisations, in order to provide palliative care in a proper manner under Thailand's contexts.

Consequently, the resolution was passed as follows:

1. Verified the (draft) Operational Definitions of Terms Pertaining to Palliative Care for Thailand according to the attachment annexed to the resolution of the Issue-Specific Health Assembly.

2. Requested that the National Health Commission Office shall:

2.1 Propose the (draft) Operational Definitions of Terms Pertaining to Palliative Care for Thailand before the National Health Commission for further approval and promulgation as a notification of the National Health Commission in the Government Gazette;

2.2 Advocate the Operational Definitions of Terms Pertaining to Palliative Care for Thailand with the Ministry of Public Health, the Comptroller General's Department, the State Audit Office of the Kingdom of Thailand, the National Health Security Office, the Social Security Office of Thailand, the Department of Local Administration, Bangkok Metropolitan Administration and Pattaya City, educational institutes, health agencies, as well as relevant public agencies, private organisations, religious organisations and civil society, to establish mutual understanding.

3. Request the Ministry of Public Health to serve as the main agency in collaboration with the National Health Security Office, the Social Security Office, the Comptroller General's Department, the State Audit Office of the Kingdom of Thailand, the Ministry Of Social Development And Human Security, the Ministry of Interior, the Ministry of Higher Education, Science, Research and Innovation, the Office of the National Economic and Social Development Council, the Local Administrative Organisation, Bangkok Metropolitan Administration and Pattaya City, private organisations, religious organisations and civil society as well as relevant agencies, in adhering to the Operational Definitions of Terms Pertaining to Palliative Care for Thailand as a guideline in applying and developing the palliative care system. This is to make certain that the definitions are suitable and correspond to their missions, authority, responsibilities and contexts;

4. Request the Ministry of Public Health to prepare a Notification of the Ministry of Public Health on the Operational Definitions of Terms Pertaining to Palliative Care;

5. Request health facilities, health research organisations, both of public and private sectors, health policy agencies, public health professional organisations, religious organisations, etc., to consider aligning with the Operational Definitions of Terms Pertaining to Palliative Care for Thailand as a guideline for care provisions to patients and the public, as well as for research and studies, according to their authority and responsibilities.

6. Request that the Ministry of Public Health shall be in collaboration with the National Health Commission Office, the Thai Palliative Care Society, the Health Systems Research Institute, public and private academic institutions and experts to consider revising the Operational Definitions of Terms Pertaining to Palliative Care for Thailand as deemed appropriate.

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Operational Definitions of Terms Pertaining to Palliative Care for Thailand, B.E. 2563 (A.D. 2020)

Introduction

At present, Thailand is encountering an incessant increase in the number of patients who develop incurable chronic diseases and elderly populations, resulting in palliative care being vital and becoming a focus of public health service providers and stakeholders. However, as public health providers and health facilities are broadly providing palliative care services in different models, which are usually based on their own understanding and fields of expertise, it is unable to truly cater systematised support to the needs of health professionals working at hospitals, patients or their relatives who require the care service.

Even though Thailand has already enforced policies, strategies and plans of supporting projects for palliative care, there are still practical problems as the country has not yet determined operational definitions and explanations of the meanings of terms pertaining to palliative care. Hence, palliative care is still vastly controversial in several dimensions. To name a few, types of patients, nature of services, society and culture. These became a cause that led to different definitions of target groups and care guidelines among health professionals and health facilities, based on their knowledge and understanding. These factors had entailed divergent standards of care, which later affected the quality of patient care. In addition, it also had an effect on supporting system arrangement and health resources management.

The National Health Commission Office has thus collaborated with 4 strategic organisations, namely the Ministry of Public Health by the Department of Medical Services, the Health Systems Research Institute, the Thai Palliative Care Society (THAPS) and the Faculty of Medicine, Chiang Mai University, to determine operational definitions of terms pertaining to palliative care for Thailand by working closely with palliative care experts from different organisations throughout the process. For example, those from the National Health Security Office, the Comptroller's General Department, the Social Security Office, Thai Palliative Care Nurses Society (PCNS), Karunrak Palliative Care Center, the Faculty of Medicine, Khon Kaen University, Borirak Palliative Care Center of the Faculty of Medicine Siriraj Hospital, Mahidol University, Cheewabhibaln Palliative Care Center of the Faculty of Medicine, Chulalongkorn University, Ramathibodi Palliative Care Center, Mahidol University, Cheewantabhiban Center, the Faculty of Medicine, Prince of Songkla University, all of which include physicians, nurses, social workers, health professionals from different disciplines, in order to settle definitions that are mutually agreed for further use as a guideline. Such meanings are considered operational definitions under Thailand's contexts. The expressions used should not be too relatively in the academic sense while the language used, specifically sentences and phrases, must be effortlessly understandable by the public. The reason is to facilitate the use of all stakeholders, both health and non-health professionals, according to missions, responsibilities and authority of their organisations. The definitions are applicable to policy making and strategy formulation, project planning, budget allocation, human resources management, service provision, finance and treasury, as well as governance, audit, academic development and R&D.

In preparing the operational definitions, participation of relevant parties was emphasised throughout the process; and academic documents from sources that were nationally and globally recognised had been used as references. Moreover, the National Health Commission Office conducted public hearings through documents circulation and the website for wide audiences. Afterwards, it entered a public hearing stage and followed the required procedures for further consideration of the Issue-Specific National Health Assembly as prescribed under Section 40 of the National Health Act, B.E. 2550 (A.D. 2007), in order to find a mutual consensus between organisations of different sectors, including relevant public or private health facilities, educational institutions, health policy agencies, religious organisations, and the civil-sectors. At the final stage, the National Health Commission Office proposed the Operational Definitions to the National Health Commission for further approval and promulgation in the Government Gazette.

The National Health Commission Office hereby expresses our appreciation to all agencies, organisations and all stakeholders, who took part in drafting these Operational Definitions, expecting that the Operational Definitions shall be beneficial to any of those who require palliative care services and health professionals in the future.

The Sequence of Key Activities

On 5 March 2018, there was an execution of the Order of the National Health Commission No. 9/2561 on Appointment of an Academic Working Group to be Responsible for Providing the Operational Definition of Terms Pertaining to Palliative Care in order to prepare operational definitions for further presentation before the National Health Commission Office, and to organise a discussion forum to obtain opinions of public and private agencies, for determining the Operational Definitions.

On 25 April 2018, there was the signing ceremony of a Memorandum of Understanding on the provision of the Operational Definitions between 5 organisations, namely the National Health Commission Office, the Ministry of Public Health by the Department of Medical Services, Health Systems Research Institute, the Thai Palliative Care Society (THAPS) and the Faculty of Medicine, Chiang Mai University.

There were 4 meetings for the definition drafting as follows:

1. On 8 August 2018, first meeting at Suchon Meeting Room 1, 2nd floor, National Health Building.

2. On 17 August 2018, second meeting at Suchon Meeting Room 1, 2nd floor, National Health Building.

3. On 5-7 September 2018, third meeting at the Faculty of Medicine, Chiang Mai University.

4. On 23 November 2018, fourth meeting at the Faculty of Medicine, Chiang Mai University.

There were also 2 discussion forums to obtain opinions regarding palliative care from experts as follows:

1. On 7 January 2019, 08.00-17.00 hrs., at Amari Don Muang Airport Bangkok.

2. On 3 November 2019, 09.00-16.30 hrs., at Amari Don Muang Airport Bangkok.

There were 2 discussion meetings to obtain opinions from the definition drafting body as follows:

1. On 8 August 2018, 13.30-16.30 hrs, at Suchon Meeting Room 1, 2nd floor, National Health Building.

2. On 5 July 2019, 13.30-16.30 hrs., at Suchon Meeting Room 1, 2nd floor, National Health Building.

On 12 July 2019, the National Health Commission Office sent letters to 2,012 center hospitals, general hospitals, community hospitals, private elderly care or patient palliative care establishments, religious organisations, health policy agencies, provincial public health offices, government agencies, as well as medical and public health experts, educational agencies - including the Faculties of Medicine and the Faculties of Nursing throughout the country, professional councils and royal colleges, in order to acquire opinions about the Operational Definitions of Terms Pertaining Palliative Care via a postal service. The deadline of the hearing was set on 13 September 2019. Among those, 141 responses were sent back, 85 of which indicated a name while 56 of were anonymous.

On 12 July 2019, the National Health Commission Office opened a hearing to the public on its website regarding the Operational Definitions of Terms Pertaining Palliative Care, the deadline of which was set on 13 September 2019. In this regard, there were 15 respondents.

On 17 September 2019, the National Health Commission Office invited representatives from hospitals, professional councils, different agencies and health professionals responsible for palliative care services to attend a meeting for further opinions on the Operational Definitions of Terms Pertaining Palliative Care at Centra by Centara Government Complex Hotel & Convention Centre Chaeng Watthana.

On 17 September 2019, after acquiring opinions from hospitals, public and private agencies, experts convened a meeting that involved the drafting working group for further improvement of the draft Operational Definitions at Centra by Centara Government Complex Hotel & Convention Centre Chaeng Watthana.

On 18 September 2019, a meeting of the Issue-Specific Health Assembly was organised to focus on the Operational Definition of Terms Pertaining Palliative for Thailand at Centra by Centara Government Complex Hotel & Convention Centre Chaeng Watthana.

Section 1

Patient Status

1. Chronic Condition

A physical, psychological, psychiatric illness or deterioration which has been persistent for at least 3 months, perpetuating permanent limitations to physical, mental and cognitive capability, and affecting individual quality of life, daily and social living.[1,2]

2. Life-Limiting Condition

A condition that cannot be reversed by treatment and results in shorter life expectancy. Certain conditions may cause progressive deterioration which requires dependency care from the family and caretakers.[3]

3. Life-Threatening Condition

A life-threatening condition that is caused by a current illness or an acute onset, which makes a patient's condition considerably drop, and is subjected to high possibility of treatment failure.

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[1] Salins N, Gursahani R, Mathur R, Iyer S, Macaden S, Simha N, Mani RK, Rajagopal MR. Definition of Terms Used in Limitation of Treatment and Providing Palliative Care at the End of Life: The Indian Council of Medical Research Commission Report. Indian Journal of Critical Care Medicine. 2018; 22(4): 249-262

[2] National Center for Health Statistics, Centers for Disease Control and Prevention. Summary Health Statistics for the U.S. Population [Internet]: National Health Interview Survey [cited 17-18 Sep 19]. Available from http://www.cdc.gov/nchs/data/series/sr_10/sr10_259.pdf

[3] The International Association for Hospice and Palliative Care. Life-limiting condition [Internet]. [cited 17-18 Sep 19]. Available from https://pallipedia.org/life-limiting-condition/

4. Terminal Illness

A disease or condition that cannot be completely cured or revitalised and is reasonably expected to result in an imminent death of the patient.[4]

5. Active Dying

A condition where the organs vital to life consistently fail to an extent that the respiratory system, the blood circulation system, the central nervous system or the brainstem stops working. Normally, the active stage lasts minutes, hours or days.

6. Death

A condition where the heart and the blood circulation system, the nervous system, or the brainstem permanently stop working.

7. Bereavement

A condition or an experience of an individual caused by the loss of loved ones.

8. Grief

A response to a loss that affects emotions, feelings, such as stress, grief, depression or other emotions, including that affecting physical and mental conditions, behaviours, recognition, which has impacts on social living.

9. Complicated Grief

A response to a bereavement that affects feelings, emotions and living life, which lasts longer than usual based

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[4] Already cited in footnote 1.

on the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5.[5, 6, 7, 8]

10. Disorders of Consciousness

It is a condition where the brain of a person is affected by damage from a traumatic brain injury or affected by a non-traumatic brain injury. For example, hypoxemia, acute inflammatory, resulting in a loss of wakefulness and awareness.

This condition occurs after the brain is affected by a tremendous damage. At the first stage, the patient is unresponsive and cannot be woken even having been urged. This condition is called coma, which may last for 28 days. The disease status and prognosis can be summarised as follows:

(1) Severe Disability: The patient becomes able to perform independent activities at a minimal level. After this, the patient is still recovering.

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[5] The Diagnostic Criteria of the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has classified complicated grief into 5 categories. CG was included in the “Persistent Complex Bereavement Disorder (PCBD)”. There are 5 key criteria categories for the diagnosis of CG or PCBD based on DSM-5, that is, such person must experience a loss of close ones (Criteria A); such person must have at least 1 out of 4 major symptoms specified in Criteria B; such person must have at least 6 out of 12 minor symptoms specified in Criteria C; such person experiencing a loss must have those symptoms for more than 6 months or 1 year (based on his/her age); the above symptoms must affect social competency, work or livelihood (Criteria D); and the grief is more complicated than it should be, or does not conform to age-based cultures, religious practices or social norms (Criteria E).

[6] Kissane DW, Zaider TI. Bereavement. In: Nathan Cherny Marie Fallon, Stein Kaasa, Russell K. Portenoy, and David C. Currow,editor. Oxford Textbook of Palliative Medicine 5ed. Oxford, UK: Oxford University Press; 2014. p. 1110-22.

[7] Twycross R. Bereavement. In: Robert T, editor. Introducing palliative care. 4 ed. Oxford: Radcliffe Medical Press; 2003. p. 45-52

[8] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (DSM-5). 5th ed. Arlington. American Psychiatric Publishing; 2013

(2) Minimal Conscious State (MCS): The patient is in the state of consciousness, but has lost awareness. He/she can follow simple commands for 28 days from an unresponsive state.

(3) Unresponsive Wakefulness or Vegetative State: It is when the patient is in a wakefulness state, but is not aware of and consistently responsive to the surroundings for at least 28 days from the date of being in the state of being unresponsive.

According to current medical evidence, this is referred to as Chronic/Permanent Vegetative State. It is when a person is awake, but is not consistently responsive to the surroundings for more than 3-6 months, in the case where the brain is affected by a non-traumatic injury; or more than 12 months after the brain is affected by a damage, which is highly difficult to recover.[9] These definitions are to ensure that physicians shall not immediately fanalise that a patient in a coma state has already entered the end-of-life stage and life-sustaining treatment must be withdrawn earlier than it should be.[10]

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[9] Giacino JT, Katz DI, Schiff ND, Whyte J, Ashman EJ, Ashwal S. Practice guideline update recommendations summary: Disorders of consciousness: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology; the American Congress of Rehabilitation Medicine; and the National Institute on Disability, Independent Living, and Rehabilitation Research.. Neurology. 2018 Sep 4;91(10): 450–460[6] Kissane DW, Zaider TI. Bereavement. In: Nathan Cherny Marie Fallon, Stein Kaasa, Russell K. Portenoy, and David C. Currow,editor. Oxford Textbook of Palliative Medicine 5ed. Oxford, UK: Oxford University Press; 2014. p. 1110-22.

[10] National Health Service, Disorders of consciousness [Internet]. nhs.uk. 2018 [cited 2019 Sep 18]. Available from: https://www.nhs.uk/conditions/disorders-of-consciousness/

Section 2

Care Persons

11. Surrogate Decision Maker

An individual assigned by the patient to be responsible for making a decision on treatment that is aligned with desires of the patient stated when he/she still has conscious awareness. This includes a proxy or person responsible for explaining the true preferences of the executor of Living Will. In this regard, the surrogate decision maker shall carry out his/her responsibilities only when the patient is not capable of making decisions.

In case there is no authorisation, a close relative, or a caretaker, and an interdisciplinary team shall deliberately make a decision.

12. Lasting/Durable Power of Attorney

A legal document or any other means recognised by law that authorises a person to make decisions on behalf of a patient (Surrogate Decision Maker) when the patient enters his/her terminal stage and is not capable of making decisions. This may be specified in the Advance Directive or Living Will to refuse public health services in accordance with Section 12 of the National Health Act, B.E. 2550 (A.D. 2007).

13. Family

A person who is close, biologically related to the patient, or a spouse or life partner of the patient, or legally, or traditionally related to, or those who is trusted by the patient.

14. Caregiver

A person who provides physical, mental, social, economic care to elderly persons, children, the disabled, patients with chronic diseases, or those at their terminal stage.

15. Primary Caregiver

A person who takes a crucial role in coordinating, providing care, and takes a major part in providing care to the patient.

16. Interdisciplinary Team

A team of caregivers that possess interdisciplinary knowledge and capability, who work within the same agency or conform to the same system, including the community in which the patient resides, in order to provide comprehensive and consistent care to the patient, with a mutual goal to solve complicated problems faced by the patient, the caregiver and the family. The team consists of medical and public health professionals, social workers, psychologists, religious leaders, volunteers, etc., who collaboratively work to achieve shared goals.

17. Multi-Disciplinary Team

A group of individuals that consists of multi-disciplinary experts. Each of them works independently, yet in parallel. There is exchange of information with shared treatment goals.

Section 3

Care and Services

18. Long Term Care

Provision of public health and social services in response to the needs for assistance of those who are in difficult situations due to chronic illnesses, accidents, disabilities, as well as of elderly who are not able to perform their activities of daily living; both formal (provided by public health and social professionals) and informal form of care (provided by the family, volunteers, friends, neighbours). Such substitute services are often social ones that focus on rehabilitation, treatment, as well as health promotion for these groups of people on a consistent and continual basis. This is to ensure that they can have a good quality of life and be able to live independently as much as possible on a basis of respecting human dignity.[11]

19. Palliative Care

Care provided to those with life-limiting or life-threatening conditions, with objectives to enhance quality of life and rehabilitate, relieve and mitigate physical, mental, emotional, social and spiritual sufferings, starting from the beginning stage of disease until death. The care covers the family and persons related to the patient.[12] In this regard, care services can be provided either inside or outside a service establishment.

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[11] The National Health Security Office, Supportive Manual for Long-Term Public Health Care System for Dependent Elderly Populations in the National Health Security System. [Internet]. [cited 2019 sep 18]. Available from: https://www.nhso.go.th/files/userfiles/file/Download/20151202/คู่มือ%20LTC%20.pdf

[12] WHO.WHO Definition of Palliative Care [Internet]. WHO. [cited 2012 Dec 30]. Available from: http://www.who.int/cancer/palliative/definition/en/

There are 3 levels of palliative care as follows:

(1) Primary Palliative Care is a combination between palliative care and general health care, which should be basic skills for health professionals of all levels;

(2) General Palliative Care is a care service provided by primary and specialised health professionals who have considerable knowledge and skills on end-of-life care, even though it is not their major expertise;

(3) Specialist Palliative Care is a care service for a patient who has specific and complicated needs, which are difficult to handle and require special expertise of caretakers who have attended specialised training.

Palliative care includes care services having provided since a patient is first diagnosed with a disease or a condition that is incurable and irresponsive to treatment, whereby the patient may still live for several months or years. It is not only about providing care to patients at the terminal stage of life.

The World Health Organisation (WHO) defines key principles of the palliative care as follows: It is to relieve pains and other sufferings, as well as value a life and consider death as a natural process. It is not intended to accelerate the death process or sustain a life. It combines mental and spiritual patient care, ensure that the patient is living his/her life valuably until death, support the patient's family to cope with the illness of the patient, both physically and mentally, provide care as a team and evaluate desires and preferences of the patient and his/her family, as well as render advice regarding losses of loved ones, promote quality of life, which may positively affect the disease, provide care, starting from the beginning stage of illness, in combination with specific life-sustaining care, including case transfer for further diagnosis in order to better understand and manage symptoms.

The term Palliative Care overlaps with the Thai meaning of Supportive Care. Therefore, if directly translates the term Supportive Care into Thai as “palliation,” it will be perplexing. Experts consider that the term Supportive Care is suitable to be used with patients who still receive key treatments on their disease. Its goal is to enhance quality of life by preventing or managing symptoms, treatment side effects, and mental, social and spiritual impacts related to the illness and treatments.[13] On the other hand, Palliative Care emphasises on patients in the advanced stages through the end-of-life stage. Therefore, the former can be referred to as “supportive care”.

20. Supportive Care

A supportive care for patients who mainly undergo treatment to enhance quality of life by preventing potential side effects from treatments, or managing symptoms and mental, social and spiritual impacts related to the disease and treatments.

21. End-of-Life Care

Provision of care at the end-of-life stage with an aim of a good death.

22. Pediatric Palliative Care

A care provided to children who suffer from age-limited or life-threatening conditions, in terms of physical, mental, social

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[13] Recommendations from the European Association for Palliative Care. White Paper on standards and norms for hospice and palliative care in Europe: part 1[Internet]. European journal of palliative care, 2009; 16(6) [cited 18 Sep 2019] Available from: https://www.eapcnet.eu/Portals/0/adam/Content/LmgAajW9M0Os7VYZs0ZXCQ/Text/White%20Paper%20on%20standards%20and%20norms%20for%20hospice%20and%20palliative%20care%20in%20Europe.pdf

and spiritual, and also a care service that palliates the family, starting from the diagnosis and continuing through later stages without concerning whether the child patient has received a treatment or not.[14]

23. Holistic Care

A care that covers physical, mental, emotional, social and spiritual dimensions.

24. Continuity of Care

Continuity of providing seamless care by integrating, coordinating and leveraging multidimensional data among service providers.

25. Hospice Care

A service to provide care to patients at their end-of-life stage in order to holistically promote their quality of life.

26. Hospice Service

A service system to provide a care to patients at their end-of-life stage, which can be either inpatient hospice service or respite care to ensure that patients have time to rest, daycare, homecare and end-of-life care. Such healthcare facilities are referred to as hospice facilities.

27. Palliative Care Unit/Center

Organisations providing palliative care to patients at their end-of-life stage can be divided into 2 levels as follows:

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[14] Already cited in footnote 12

(1) Palliative Care Unit, which provides services;

(2) Palliative Care Center, which is capable of providing training and conducting research, in addition to service provisions.

28. Advance Care Planning

A care planning made before a patient loses his/her capacity to make decisions or enters into the end-of-life stage. This can be formal or informal as it may employ a discussion method that involves the patient, family and health personnel team; or, the patient may independently provide a plan, or seeks advice from family members or health personnel.

29. Advance Directive or Living Will

A letter in which an individual states his/her wishes to refuse public health services that are merely for life sustaining or to cease a severe suffering from his/her illness in advance.[15]

30. Opioid Accessibility

Accessibility to the opioid class of pain-relieving medicine is possible only when the public health service system facilitates management of this drug class in terms of procurement, acquisition, storage, distribution and prescription within all levels of hospitals and hospice facilities, as well as when there is medication management at home.

31. Accessibility to Palliative Care

Accessibility to the palliative care system of a patient

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[15] The Ministerial Regulation Prescribing Criteria and Procedures to Align with Advance Directive to Refuse Public Health Services Merely for Life-Sustaining at the End-of-life Stage or to Cease Severe Suffering from Illness, B.E. 2553 (A.D. 2010).

at his/her end-of-life stage which is of quality and sufficient, without any geographical, economic, traditional, religious and socioeconomical limitation of the patient, the family or the caretaker.

32. Quality of Life

Giving a meaning and value of life based on preferences, beliefs and faiths of an individual in all aspects, including all facets of well-being, society, economy, culture and surrounding factors. Nonetheless, the meaning and value of life can vary by context.

33. Patient-Centered Care

A patient care that focuses mainly on views of experiences, expectations and desires of the patient by still preserving rights, wills and respecting patient's decisions. The care is conducted through an overall understanding of life based on expectations, desires of the patient, the family and the caretaker, which leads to a holistic care design.

34. Good Death

A death where the patient realises that his/her stated wishes have been fulfilled and that he/she has been protected from physical, mental, social and spiritual sufferings prior to the terminal stage of life, and that family members and the health team have respected and embraced preferences of the patient.[16]

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[16] The Economist. The 2015 Quality of Death Index Ranking palliative care across the world [Internet]. 2015 [18 Sep 2019]. Available from: https://eiuperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf

35. Spirituality

Giving a meaning of human being, while each individual is seeking, determining directions, accepting and understanding the truth of life. It is a dynamic process that is formed within an individual and changes through experiences, beliefs and relations such individual has with his/her own identity, family, surrounding people, community, society, nature, environment and elements, which give a meaning that serves as self-restraints.

Section 4

Ethic and Medico-Legal Issues

36. Life-Sustaining Treatment

A medical treatment for palliation or replacement of organs that are vital to life, including cardiopulmonary resuscitation, endotracheal intubation, ventilator support, administration of inotropes and vasopressors, intravenous infusion, dialysis, blood transfusion, antibiotic administration, etc.[17, 18]

37. Potentially Inappropriate Treatment

A medical treatment which has an intent to completely cure; however, it potentially causes inappropriate treatment results rather than beneficial ones.

38. Futile Treatment

A treatment that is clearly understandable that it shall not provide a preferable medical outcome; for example, using life-sustaining equipment with an aim to regain consciousness of the brain-dead.

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[17] A terminology from the Royal Society of Thailand [Internet]. [cited 2018 Nov 10]. Available from: http://rirs3.royin.go.th/coinages/webcoinage.phpf

[18] Sprung CL, Truog RD, Curtis JR, Joynt GM., Baras M, Michalsen A. et al. Seeking Worldwide Professional Consensus on the Principles of End-of-Life Care for the Critically Ill The Consensus for Worldwide End-of-Life Practice for Patients in Intensive Care Units (WELPICUS) Study. American Journal of Respiratory and Critical Care Medicine. October 15 2014; 190(8): 855-866

39. Allow Natural Death (AND)

A decision made to allow natural death by withholding life-sustaining treatment during the active dying stage in order to fulfill stated wills of the patient, or as desired by a proxy.

40. Withholding Life-Sustaining Treatment and Withdrawing Life-Sustaining Treatment

A decision to withhold life-sustaining treatment, or withdraw life-sustaining treatment for a patient at his/her end-of-life stage once considering that neither treatment nor life-sustaining equipment shall prolong life, and either one indeed causes adverse effects, not benefits. The patient, relatives or a proxy shall be responsible for making decisions about this after being thoroughly informed. In this regard, withholding and withdrawing life-sustaining treatment are not euthanasia.

41. Euthanasia

The practice of intentionally ending life based on willingness of a patient with terminal illness to relieve or avoid pain and suffering of the patient. At present, it is not legal in Thailand.

42. Physician-Assisted Suicide

When a physician aids to end a patient's life based on his/her desire.

43. Palliative Sedation

A treatment by administering sedative medications or anesthetic agents to a patient who cannot be successfully treated by other methods at his/her end-of-life stage to relieve severe and refractory symptoms.[19, 20]

๔๔. The Doctrine of Double Effect[21, 22, 23]

An action that is committed with a good intent, even when it may be followed by an undesirable result. In this regard, it needs to consist of the following four elements:

(1) Such action is good in itself or neutral;

(2) Such action is carried out with an intent to contribute to positive results, with no intent to cause any adverse effect;

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[19] As palliative sedation at the end-of-life stage is a procedure that involves ethical concerns. Therefore, reduction of patient's consciousness to a level that he/she can no longer state desires, eat or drink; this may potentially be perceived as a way to accelerate the death of the patient. Therefore, palliative sedation at the end-of-life stage requires clear clinical indication criteria. For example, such patient must have had already been examined by a specialist to confirm that there are no other ways to alleviate symptoms of the disease. Then, the goal is to reduce the symptoms, not preventing death. Also, ceasing food and water is merely an alternative, and is not 'compulsory' in palliative sedation at the end-of-life stage.

[20] Cherny NI, on behalf of the ESMO Guidelines Working Group. e.g., Jet Powered Engines. Annals of Oncology. 01 September 2014; 25(suppl_3): iii143–iii152

[21] The Doctrine of Double Effect is originally a traditional Roman Catholic moral theology related to abortion. This principle allows unborn child to be removed from its mother to save the life of the mother. Therefore, the medical procedures are performed to save the life of the mother, and is not to threaten the life of the child. The provision of end-of-life care, palliative sedation, or withholding/withdrawal of life-sustaining treatment with an intent to reduce pains and severe sufferings is therefore morally exercisable even the fact that it causes an unintentional result in which the patient becomes unresponsive inevitably.

[22] David Solomon. Double Effect. In: Lawrence C. Becker, editor. The Encyclopedia of Ethics [Internet]. [cited 17-18 Sep 19]. Available from http://sites.saintmarys.edu/~incandel/doubleeffect.html

[23] Stanford Encyclopedia of Philosophy. Doctrine of Double Effect [Internet]. [cited 2018 Nov 10]. Available from: https://plato.stanford.edu/entries/double-effect/

(3) Undesirable results are not a result of bad action;

(4) Good results weigh more than bad results that potentially occur.

45. Best Interests

A decision-making principle of the medical and health team in selecting a treatment approach for a specific patient by weighing between benefits and risks of each, and in choosing one that would contribute to the best interests, with less risks, of the patient. In this regard, this decision-making requires medical and social standard criteria.[24]

46. Shared Decision Making

A decision-making process regarding medical care where the clinical care team and the patient and his/her family, or proxy, mutually contribute to a decision-making process, which may change corresponding to circumstances.[25]

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[24] Donnelly M. Best interests, patient participation and the Mental Capacity Act 2005. Medical Law Review. 15 December 2008; 17(1): 1–29

[25] Coulter A, Edwards A, Elwyn G, Thomson R. Implementing shared decision making in the UK. Z Evid Fortbild Qual Gesundhwes. 2011; 105(4): 300–304

Order of the National Health Commission Office

No. 9/2561 Dated 5th March 2018

On Appointment of an Academic Working Group to be Responsible for Providing the Operational Definitions of Terms Pertaining to Palliative Care

สำนักงานคณะกรรมการ
สุขภาพแห่งชาติ

Order of the National Health Commission Office

No. 9/2561

On Appointment of an Academic Working Group to be Responsible for Providing the Operational Definitions of Terms Pertaining to Palliative Care

At present, Thailand has employed the definitions of palliative care defined by the World Health Organisation (WHO); however, organisations still interpret the definitions differently based on their contexts, authority and responsibilities. The National Health Commission Office (NHCO), as the secretary of the National Health Commission, considered that, in order to ensure there shall be development of knowledge and operation standards concerning palliative care in Thailand, there should be operational definitions of terms pertaining to palliative care so as to acquire operational definitions that suit the contexts of Thailand's health service system and standardise palliative care throughout the country.

By virtue of the provisions of Section 27 (2) and (3) in conjunction with Section 34(4) of the National Health Act, B.E. 2550 (A.D. 2007), an academic working group responsible for providing the operational definitions of terms pertaining palliative care is thereby established, consisting of the following members and responsibilities.

1. Members

1.1 Mr. Suphan Srithamma	Chairman
1.2 Public Health Permanent Secretary, or representative	Committee
1.3 Interior Permanent Secretary, or representative	Committee
1.4 Social Development and Human Security Permanent Secretary, or representative	Committee
1.5 Director-General of Department of Medicine, or representative	Committee
1.6 Director of Health Systems Research Institute, or representative	Committee
1.7 Director of Healthcare Accreditation Institute (Public Organisation), or representative	Committee
1.8 Secretary-General of National Health Security Office, or representative	Committee
1.9 Secretary-General of Social Security Office, or representative	Committee
1.10 Director-General of Comptroller's General Department, or representative	Committee
1.11 Dean of Faculty of Medicine, Chiang Mai University	Committee
1.12 President of Thai Palliative Care Society, or representative	Committee
1.13 Secretary-General of National Health CommissionCommittee	Committee
1.14 Assigned Deputy Secretary General of National Health Commission	Committee and Secretary
1.15 Chairman of Text Revision Committee The Faculty of Medicine, Chiang Mai University, or representative	Committee and Secretary

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2. Responsibilities

2.1 To prepare and propose operational definitions of terms pertaining to palliative care to the National Health Commission Office.

2.2 To organise discussion meetings to obtain opinions from public and private organisations in order to determine operational definitions of terms pertaining to palliative care.

2.3 To take actions related to the provision of the operational definitions of terms pertaining to palliative care as entrusted by the Secretary-General of the National Health Commission.

In this regard, this Order shall come into force from this day onwards.

Ordered on 5th March 2018

Pholdej Pinprateep

(Mr. Pholdej Pinprateep)

Secretary-General of National Health Commission

Palliative care

Care provided to those with life-limiting or life-threatening conditions, with objectives to enhance quality of life and rehabilitate, relieve and mitigate physical, mental, emotional, social and spiritual sufferings, starting from the beginning stage of disease until death. The care covers the family and persons related to the patient. In this regard, care services can be provided either inside or outside a service establishment.

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