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ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ И ОБЩЕСТВЕННОЕ ЗДОРОВЬЕ
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ОРИГИНАЛЬНОЕ ИССЛЕДОВАНИЕ
ORIGINAL RESEARCH

Management structure and organization of oncological care

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Abstract. *Relevance*. Healthcare today faces the inevitability of change as it faces a wide range of challenges in the face of complete uncertainty. Through effective change management, success can be achieved in states, globalization and complementarity. The scientific community recommends developing approaches to changes in management that focus on coordinated work in the field of healthcare of personnel, continuous training, exchange of experience, and professional development of medical personnel not only as specialists in the field of oncology, but also as successful managers. It is also necessary not to ignore social factors, namely the so-called “power of compassion”, which is expressed in the introduction and improvement of palliative care. The purpose of this article is to analyze the structure of management and organization of cancer care and proposals for improving the quality of treatment and care for cancer patients. This publication is devoted to a comprehensive analysis of the problems and prospects for the development of cancer care. Oncology is considered by us as one of the largest health problems. In this regard, ideas have been proposed on the need to modernize and optimize the processes of providing oncological care. According to the literature, important aspects in this process are the coordination of the actions of medical personnel, both doctors and nurses, and patients; their qualifications as oncology specialists and managers; provision and implementation of palliative care everywhere; quality control of provided medical services carried out directly by medical personnel. However, all of these components of the cancer care structure face the reality of a lack of actual time for medical personnel to train management skills, a lack of resources for regional health structures to implement palliative care and train staff in management skills. A positive aspect in this situation is the desire of the scientific community to improve itself and improve the skills of both oncologists and managers. *Conclusion.*The creation of specialized courses on management in the field of oncology and continuous international training through distance education and telemedicine is an important milestone in resolving these issues.

Key words: oncology, hospice, palliative care, quality control, multilevel healthcare system, telemedicine, healthcare structure

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Introduction

Considering all the epidemiological, social and economic importance, oncology is one of the most difficult problems for healthcare. The World Health Organization estimates that cancer could become the leading cause of death by 2030. At the moment, he ranks second in the ranking of "causes" of death worldwid [1]. Information about this group of diseases, their treatment and prevention have increased significantly in recent years; but there is nothing more far-reaching than health promotion, prevention, early diagnosis and timely treatment [2].

Cancer patients require specialized care, the use of which needs to be discussed at the health care level. The authors indicate in the literature data that the main points to be paid attention to when organizing care for cancer patients include: only scientifically based clinical recommendations confirmed by clinical trials; accessibility of medical care for all those in need; continuity of care; provision of comprehensive primary, secondary and tertiary care; comprehensive care; the possibility of using management tools for the clinic; ongoing education for medical professionals and health education for users of medical services [3, 4].

Taking all these variables into account, management and continuing education become important tools in fighting cancer and improving patient care. Despite major investments in diagnostic and therapeutic technologies, the number of cases and the death rate from cancer remain unchanged. The healthcare sector is currently in the process of implementing quality management as a vital patient care strategy. Thus, the main purpose of this article is to analyze the management structure and organization of cancer care and proposals for improving the quality of treatment and care for cancer patients.

Organizational and managerial structure of the oncology service

To begin with, it is important to understand what is the basis of any effective organizational and management structure. As E. Mikhalkina notes: "The basis of organizational and managerial support for the organization's activities is primarily formed by organizational culture, interpreted as a set of common values, beliefs and norms that affect how employees

think, feel and behave in the workplace, how they associate themselves with the goals and objectives of the organization, consider whether they consider themselves a part of it. Organizational culture is traditionally considered as a set of values in the broadest sense of the word, behavioral norms that are shared by all employees and contribute to overcoming various obstacles both internal (administrative regulations) and external. Organizational culture promotes the development of a sense of identity and belonging among employees of the organization, increases their commitment and involvement in the affairs of the organization, ensures the growth of its effectiveness and image among customers, strengthens organizational values, increases responsibility in decision-making and ensures satisfaction from activities" [5].

Further, if we talk specifically about the structure of cancer care, according to the analysis Krivonos O.V. it is necessary to identify and understand what the levels of care are (this program was designed until 2015, then it was reduced to a 3-level system). The main objectives of this program were prevention, early diagnosis, and optimization of the actions of cancer patients at different stages of the disease.

The first level: the implementation of occupational examinations by district therapists, gynecologists, etc., the delivery of primary tests to detect the presence of oncological diseases (cytological studies for cervical tumors, etc.), diagnostics using improvised devices available in all medical institutions: fluorography, mammography, ultrasound.

The second level: informing the patient in case of cancer detection and subsequent transfer of data to primary oncology offices.

The third level: referral of the patient to the consultative and diagnostic department of the regional (territorial) oncological dispensary, where the full range of diagnostic studies should be used, as well as antitumor treatment both in outpatient (one-day hospital) and inpatient settings.

The fourth level: referral of the patient, if necessary, for a more accurate follow-up examination, as well as treatment using the latest high-tech techniques to the district oncological dispensary.

Fifth level: referral of the patient to federal oncological institutes (Research Institutes of the Ministry of Health of the Russian Federation, RAMS, FMBA of Russia) as well as the provision of high-tech medical care.

Sixth level: The Ministry of Health and Social Development oversees the work of all levels, closely cooperates with federal cancer institutes.

For us, such an approach to providing medical care to cancer patients seems to be the most logical and clear. Each stage is a kind of part of the route that the patient needs to go through and there is a responsible person for passing each stage, it is also possible to track and constantly monitor the patient's condition and the treatment process. Also, a big plus is the fact that such a routing of the process leads to early detection of oncological diseases and, accordingly, to a decrease in mortality, since oncology, diagnosed at an early stage, is easier to treat.

However, a three-tier system has been introduced to date. In general, this is a more optimized 6-level system described in the works of O.V. Krivonosov.

The first level is the provision of oncological care in oncological care (hereinafter — CAOP) in central district and city polyclinics.

The second level is the provision of oncological care in oncological dispensaries.

The third level is the provision of specialized medical care, including high-tech medical care.

According to the literature, namely in the Gopal D. article, data were collected on what patients think about the structure of cancer care and how they would like to modify it. Thus, according to patients, the fact would have a positive effect on the treatment process if the doctors who examine them at the first level, namely general practitioners, therapists, would not only provide diagnostic services for the detection of oncology and direct them to subsequent examinations, but would also be able to provide the services of a psychiatrist, oncologist, rehabilitologist, a specialist in palliative care, an informant on all issues. If we look at research on patients' expectations from the primary health care team, scientists come to the same conclusion, everyone needs universal specialists. Patients are raising concerns

that they want specialists to become more qualified and versatile, so that their level of education in their specialty is constantly increasing, so that they have access to refer patients to other specialists through less bureaucratic thorns than they are now. After analyzing the opinions of the doctors themselves in this work, the scientists came to the conclusion that the doctors agree with the opinion of the patients, as they believe that more careful care will contribute to improving the psychoemotional state of the patient and reduce the economic component of this issue. However, all this has so far been voiced only in theory, since in everyday life doctors face harsh realities and realize that they do not have enough time and knowledge to provide adequate care to all those who live with and after cancer.

The main obstacles to providing cancer care were limited time and resources; lack of coordination of care with secondary care; lack of training and time for training; and financial constraints [7].

All this makes us think about another important point in providing cancer care, namely palliative care. Palliative care, what is it? This is a type of service provided by healthcare to alleviate the condition of an oncologically ill patient as much as possible [8]. The term "palliative care" was first used by a Canadian physician named Balfour Mound in 1974, when he introduced the principles of the British hospice movement to emergency hospitals first in Canada and then around the world [8, 9]. Subsequently, three main features were developed in palliative care programs: multidimensional assessment and treatment of severe physical or emotional disorders, professional medical care in several disciplines, and an emphasis on caring not only for patients, but also for their families [8, 10]. Currently, the academic community generally agrees with the definition revised by the World Health Organization (WHO) in 2016: "Palliative care is an important part of comprehensive, human-centered health services and the relief of serious health-related suffering" [8, 11]. Thus, palliative medicine, also known as palliative care, is not only an effective medical intervention, but also a comprehensive method of improving the quality of life at the terminal stage, which has become the consensus of most definitions [8,12]. At the same time, palliative care also has a holistic approach and takes into account various aspects, including the physical, mental, social, spiritual and economic condition of patients, which is especially useful for terminally ill patients with advanced cancer experiencing pain and suffering [8, 13, 14].

The promotion of palliative care is a global ethical responsibility. Patients suffering from various diseases such as cancer, cardiovascular diseases, acute organ failure, severe burns, end-stage chronic disease, severe trauma or extreme fragility, as well as many other acute or chronic diseases, can benefit from palliative care for treatment. symptoms and improve the quality of life. Thus, palliative care should be given special attention and eventually integrated into all levels of medical practice. According to WHO statistics, it is estimated that in the world only 14 % of patients in need of palliative care can receive it [9]. To achieve the Sustainable Development Goals, all countries need to strengthen palliative care services and make it a key part of health systems.

The scientific community broadly interprets hospice care as support, including psychological and spiritual assistance provided by medical specialists and volunteers. This assistance is aimed at providing a dying person with peace, comfort and dignity, focusing primarily on alleviating end-of-life experiences for both patients and their families. Thus, hospice care refers to the care and care services provided by medical staff, social groups and volunteers to critically ill patients and their families so that they can all properly accept and accept the end stage of the disease and death [8,15].

At the moment, it is recognized worldwide that the provision of specialized care in hospices is an effective measure taken by healthcare to alleviate suffering and improve the quality of life as much as possible in cancer patients, as well as a partial reduction in the psycho–emotional burden on the families of patients. There are few positive aspects in outpatient hospitals, but comfortable conditions of stay always give hope for an easier course and outcome of diseases [8, 16]. It is also worth noting that being in such healthcare organizations as hospice at the terminal stage is encouraged and is gradually being implemented all over the world, since

combining treatment processes with palliative care can bring positive results [8, 17].

Who provides palliative care? The main medical staff [8, 18]. What conclusion can be drawn from this? The healthcare system should include a cost line for training medical personnel working with cancer patients to provide palliative care. And this line of medical personnel should include not only doctors, but also junior medical personnel, pharmacists and social workers. In this regard, it is necessary to increasingly introduce training programs to train personnel who will provide palliative care [18]. The medical staff accompanying a patient in the last stages of cancer should be universal, that is, they should have high qualifications in providing oncological care, extensive experience in managing such patients and a positive attitude. Such a set of qualities provides qualified and supportive care for cancer patients. In this regard, medical professionals need to accumulate practical and theoretical experience, professional knowledge in the field of palliative care in oncology, participate in the continuous popularization of public education and contribute to a common understanding of palliative care worldwide.

Of course, the decision to accept palliative care from the state should be made by the whole family, and in this case there should be an open dialogue between the patient, the patient's family and the medical staff. In this discussion, it is necessary to consider issues related to the current condition of the patient, the patient's readiness for treatment, what will be required along the way, and what treatment is planned to be used. Doctors in this case play a key role, but not the only one. Junior medical staff should also be actively and sincerely involved in the process of communicating and working with the patient. The success of this approach lies in the symbiotic relationship between the medical staff and the patient, since only a doctor, by virtue of his experience and knowledge, can provide qualified assistance to the patient, but who is more aware of his condition than the patient himself? As a result, consensus occurs and joint efforts are possible to come to joint work, which allows us to achieve the most favorable results [8,19].

Another important point in the decision to receive palliative care is full respect for the patient's choice. This is a complex process, but the measures taken at the end of life are based on the voluntary acceptance and approval of patients and their families [20]. This is the only way medical interventions can bring maximum clinical benefit. Given the significant development of collaborative decision-making in clinical practice, especially in the field of cancer treatment, this useful healthcare model should also be applied and promoted in palliative medicine [8].

Palliative care and hospice accommodation in advanced stages of cancer are still of concern to an increasing number of doctors, humanitarian scientists and community activists. For example, in 2014, the World Health Assembly (WHA) adopted a landmark resolution calling on all member States to provide palliative care as part of comprehensive cancer treatment, as well as to give it sufficient attention and practical application in multidisciplinary cancer treatment. Nowadays, the participation of a multidisciplinary team is commonplace in many medical institutions around the world. Teamwork is also perceived by many experts as an indispensable function of palliative care teams [21]. Among the palliative care models implemented in Asian countries, most of them were as follows:

1) professional institutions and palliative care programs: community chambers based on a multidisciplinary program, with medical services and entertainment facilities (for example, the Indian National Palliative Care Program);

2) palliative departments in general hospitals: the use of hospital resources to provide medical care, care and supportive care for terminally ill patients through interdisciplinary collaboration (for example, the Palliative and Care Department of the Fourth Hospital in Western China);

3) specialized palliative care units established at cancer hospitals [8].

Thus, the presentation model of palliative care may differ in all countries, but the success of this process lies in the collaboration of an interdisciplinary team. Therefore, it is extremely important to attach importance to multidisciplinary professional medical training.

Despite the fact that palliative care in a broad sense benefits cancer patients by improving the quality of the

last days of patients' lives, it also faces obstacles to implementation in the healthcare system. In most cases, this is due to limited resources, technology and the level of the economy in some developing countries [8]. Today, thanks to artificial intelligence, automated learning, robotic surgery and a huge amount of information on the Internet, a large amount of work performed even by doctors can be replaced by modern technologies. This kind of technology is used in various medical practices. In the field of palliative medicine, the combination of modern scientific technologies with careful care and professional experience of medical personnel can contribute to the further development of palliative care. It is also worth paying attention to the changing public attitudes towards the use of modern technologies in palliative care, as doctors are more likely to be able to provide high-quality palliative care to cancer patients and their families in the terminal stages of cancer.

Considering the different physical and psychosocial conditions of each cancer patient, a personalized approach should be applied in providing palliative care. In this regard, accurate diagnosis and appropriate therapeutic treatment regimens are of great importance for the development of the level of palliative care [22].

Currently, personalized medicine based on tumor characteristics is rapidly modernizing and optimizing cancer treatment approaches. Personalized oncology is evidence — based field of medicine that provides the right care to a specific cancer patient at a specific time, thus leading to measurable improvement in outcomes.

The basis of effective palliative care lies in optimal and personalized patient care, considering the values, beliefs, social and economic situation of each of the patients and their families. Caregivers should attach great importance to meeting their subjective needs and helping them to properly resist cancer. In order to provide patients with comprehensive positive palliative care, medical staff must change the key point from "disease orientation" to "patient orientation". Only on this basis can the quality of palliative care for cancer patients be improved, which will contribute to the progress and development of palliative care practices in Asian regions.

Quality control as a key strategy in oncology. Another important factor in the structure of medical care is quality control. And as strange as it may seem, this is a key strategy to ensure better patient care [3].

A little historical background, according to the literature, it is known that quality management first appeared and began to develop not in the field of healthcare, but in industry. If we talk about medicine, the phrase "quality control" is more related to managerial functions, but what role do patients play here? A straight line. Because improving the quality of medical procedures, increasing staff motivation through their participation in job evaluation and decision-making, as well as the introduction of structural and organizational changes are ultimately aimed precisely at improving the patient's position in the healthcare system [3]. However, until today, healthcare has paid full attention only to improving the medical qualifications of staff, which has influenced the creation of an effective management system in healthcare. A study in Italy showed that most health workers are aware of their lack of managerial skills and highlighted the need for more educational programs in this area. The same researchers noted that education aimed at developing leadership and managerial qualities in the field of healthcare can help reduce social inequality, thereby contributing to the development of a more equitable healthcare system. Through quality management training programs, the level of patient care increases since the actions implemented are more in line with the specific requirements of medical institutions and are developed by people familiar with the organization. One of the disadvantages of providing adequate and international training is the individual non-compliance with learning tools due to geographical barriers and/or limited time, which is currently being solved using distance education, telemedicine. The widespread use of distance education as a strategy for continuing professional education has successfully expanded access to information and democratized education. Indeed, thanks to technological innovations, distance education helps people already in the labor market to cope with the disadvantages of distance and time constraints. Therefore, if we want to make learning more accessible and accessible, it is necessary to identify and implement

new approaches to learning in educational activities. In this regard, the use of active methodologies proves to be a powerful learning tool both at the undergraduate and postgraduate levels.

A few authors offer a specialized course in management in the field of oncology — this is an important initiative aimed at helping specialists cope with the main management problems associated with the provision of oncological services and providing better and more effective care.

In the publication of Andreev D.V., the issues of the organization of quality control and safety of medical care are widely considered activities in the field of "oncology" on the example of countries Western Europe (Belgium, Germany, and the Netherlands). Table 1 shows the established and already working quality control systems of oncological care using the example of these countries [23].

Table 1

Quality control systems for cancer care

Aspects of quality control	Description
Development of regulations and strategies	Formation of legislative and strategic frameworks for improving cancer services.
Training of specialists	Ensuring the high qualification of medical personnel through training and certification.
Improvement of recommendations and procedures	Updating and optimizing clinical guidelines and medical practices based on the latest research.
Quality assessment and needs analysis	Regular assessment of the quality of medical care and identification of patients' needs through cyclic studies.
Application of innovations	The introduction of advanced technologies and innovative methods of treatment into practice.
Ensuring information openness	Providing patients with accessible and understandable information about treatment methods and criteria for evaluating the quality of services.

The authors also argue that a positive correlation would be brought by the creation of specific internal documents and methods that correspond to both the specifics of the work of individual medical institutions and national standards and recommendations [8]. However, it is worth remembering that manuals on various disciplines, including oncology, are regularly updated as events develop rapidly in our countries. Moreover, the recommendations developed on different continents and in different countries adapt their standards not only to widely recognized evidence-based developments, but also consider regional/national capabilities and characteristics, appropriate quality assurance measures and the structure of the health system. However, of course, wherever professional guidelines are established, their ultimate and unified goal is to ensure and certify the highest possible standards and quality of patient care [24].

In the context of information support, there is a tendency to create so-called "quality registers" that will allow comparing the performance of medical institutions and average indicators for the region and the country. With the introduction of such technologies, a sense of open dialogue is created between medical institutions, doctors and patients, including providing detailed information about the quality of cancer care through specialized web portals and involving patients in the decision-making process about treatment. Procedures have also been established to collect and analyze feedback from cancer patients.

Within the framework of scientific and clinical institutions, work is actively underway to develop, improve and update criteria for assessing the quality of oncological activities and indicators for evaluating medical technologies, using a wide range of mathematical modeling methods based on a variety of theoretical and practical approaches.

Scientific research aimed at establishing criteria for certification and accreditation of medical institutions considers both general and specific aspects of antitumor treatment for various types of cancer. This creates prerequisites for situations where a medical institution can obtain accreditation for the treatment of certain types of cancer, having restrictions on providing services to patients with other types of cancer [23].

Conclusion

In conclusion, it is worth noting once again that oncological diseases are an urgent problem, the impact of which on the medical community is not only not decreasing, but rather increasing. In this regard, it is necessary to modernize and optimize the processes of providing oncological care. According to the literature, important aspects in this process are the coordination of actions of medical personnel, both doctors and nurses, and patients; their qualifications as specialists in oncology and managers; provision and implementation of palliative care everywhere; quality control of the medical services provided, carried out directly by the medical staff. However, all these components of the cancer care structure face reality in the form of a lack of actual time for medical staff to train management skills, a lack of resources for regional health structures to implement palliative care and staff training in management skills. However, a positive aspect in this situation is the desire of the scientific community for self-improvement and professional development of their skills as oncologists and managers. Since the world community has repeatedly received proposals from medical professionals themselves to create specialized courses in management in the field of oncology and continuous international training through distance education and telemedicine.

Thus, this scientific article is a valuable contribution to the discussion of organizational and structural aspects of providing cancer care.

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Структура управления и организации онкологической помощи

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Аннотация. *Актуальность*. Здравоохранение на сегодняшний день сталкивается с неизбежностью перемен, поскольку на его пути встречаются широкий спектр проблем в условиях полной неизвестности. Эффективное управление изменениями можно добиться при сотрудничестве, координации и взаимодополняемости. Научное сообщество призывает к разработке подходов к управлению изменениями, которые акцентируют свое внимание на скоординированной работе всего персонала здравоохранения, постоянном обучении, обмене опытом, повышении квалификации медицинского персонала не только как специалистов в области онкологии, но и в качестве успешных управленцев. Также необходимо не оставить без внимания социальные факторы, а именно, так называемую «силу сочувствия», которая выражается во внедрении и улучшении паллиативной помощи. *Целью* данной статьи является анализ структуры управления и организации онкологической помощи и предложения для улучшения качества лечения и ухода за онкологическими пациентами. Данная публикация посвящена комплексному анализу проблем и перспектив развития онкологической помощи. Онкология рассмотрена нами, как одна из наиболее крупных проблем здравоохранения. В связи с этим предложены идеи о необходимости осуществления модернизации и оптимизации процессов предоставления онкологической помощи. Согласно данным литературы важными аспектами в этом процессе являются согласованность действий медицинского персонала, как врачей, так и медсестер, и пациентов; их квалификация как специалистов в онкологии и управленцев; предоставление и внедрение повсеместно паллиативной помощи; контроль качества предоставляемых медицинских услуг, осуществляемый непосредственно медицинским персоналом. Однако все эти компоненты структуры онкологической

помощи сталкиваются с реальностью в виде отсутствия фактического времени у медицинского персонала для обучения управленческим навыкам, отсутствия ресурсов у региональных структур здравоохранения для внедрения паллиативной помощи и обучению персонала управленческим навыкам. Положительным аспектом в данной ситуации является стремление научного сообщества к самосовершенствованию и повышению квалификации своих навыков, как врачей онкологов, так и управленцев. *Выводы*. Таким образом, важной вехой в решения этих вопросов, по нашему мнению, станет создание специализированных курсов по менеджменту в области онкологии и непрерывном международном обучении через дистанционное образование и телемедицину.

Ключевые слова: онкология, хоспис, паллиативная помощь, контроль качества, многоуровневая система здравоохранения, телемедицина, структура здравоохранения

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