Palliative Care

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Continuing Education Activity

The World Health Organization characterizes the field of palliative care as a form of specialized medical care which aims to optimize the quality of life and alleviate the suffering of patients. One of the primary ways to achieve this is through early identification and treatment of new symptoms along with the management of those that prove refractory. This activity reviews palliative care and highlights the role of the interprofessional team in evaluating and treating patients near the end of life using an appropriately trained team of professionals.

Objectives:

- Describe how the World Health Organization defines palliative care.
- Explain the signs and symptoms addressed by palliative care.
- Describe the members of the healthcare team that should be in place to offer palliative care.
- Review palliative care and the role of the interprofessional team in evaluating and treating patients near the end of life using an appropriately trained team of professionals.

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Introduction

The World Health Organization characterizes the field of palliative care as a form of specialized medical care which aims to optimize the quality of life and alleviate the suffering of patients. One of the primary ways to achieve this is through early identification and treatment of new symptoms along with the management of those that prove refractory. Palliative care addresses the physical, psychosocial, and spiritual aspects of patients with a life-threatening disease by employing an interprofessional team approach. A palliative team is comprised of a wide array of professionals, including the palliative physician, nurse, social worker, chaplain, and pharmacist. Of note, palliation consists of comprehensive care provided to patients with life-limiting illnesses and should not be considered an alternative to failed life-prolonging care.

The physicians who specialize in palliative care have often completed a fellowship in hospice and palliative medicine (HPM). As an official subspecialty recognized by the American Board of Medical Specialties (ABMS), completion of a fellowship is needed to sit for the ABMS or American Osteopathic Association (AOA) board certification examinations.

Currently, the following specialties are pathways to completing an HPM fellowship: internal medicine, family medicine, emergency medicine, psychiatry, neurology, surgery, pediatrics, radiology, OBGYN, anesthesiology, and physical medicine and rehabilitation. Therefore, palliative care physicians most often have underlying formal training in at least one of these specialties. Of note, almost always pediatric palliative care physicians have completed a residency in pediatrics before subspecializing.[1][2]

Function

The primary goal of the palliative care interprofessional team, consisting of nursing, spiritual care, social work, and pharmacy, is to improve the quality of life of patients and their families. As alluded to above, it is a common misconception that palliative care only concentrates on physical needs. In reality, there is a wide net of consideration cast out to assess psychological, cultural, ethical, legal, psychiatric, religious, and social needs as well.

Nevertheless, the management of symptoms, whether commonly encountered or rare, is a central focus of the field. Some of these symptoms include pain, dyspnea, nausea, anxiety, depression, and fatigue. For the treatment of acute pain, identifying the etiology and intervening therapeutically when possible is the objective. Depending on the situation, pain medication such as opiates is usually a valuable mainstay. Additionally, opioids may be necessary for the management of dyspnea and air hunger; again, providers should determine the etiology. Preventative measures should be considered, such as prescribing stimulant laxatives to patients at high risk of developing constipation (whether from utilizing opiates, being dehydrated, or decreased oral intake). Additional examples of symptomatic management include the use of steroids to relieve bone pain and the performance of a therapeutic thoracentesis for symptomatic pleural effusions. Anticholinergic agents, such as atropine, can be administered to assist in secretion reduction. Furthermore, dopaminergic medications that target the chemoreceptor trigger zone, such as haloperidol or metoclopramide, are considered first-line agents for nausea and vomiting at the end of life.[2][3]

Issues of Concern

Hospice first appeared in the United States in 1971, and variably evolved geographically throughout North America. The hospice movement was controversial, creating myths and misconceptions about palliative care. Erroneous believes that palliative care was only intended for patients that

are dying, that entering hospice was akin to "giving up," and that palliative care hastened death developed from the medicalization of the dying process, having moved out of the family home to hospitals and nursing homes. These misconceptions can be dispelled appropriately. Palliative care does indeed look to provide comfort to patients that are dying; however, palliative care encompasses all individuals and their families suffering from chronic or life-limiting ailments regardless of age, gender, nationality, race, creed, sexual orientation, disability, diagnosis, or ability to pay. Palliative services are not for when a patient's primary physician has “given up”; instead, the clinician requests services when the primary physician feels that integrating the palliative team into the patient’s care would improve the quality of that patient’s life. Palliative care focuses on easing a person’s suffering before, during, and for the family after the patient dies. Further, these services are not limited to a hospital; there are many community clinics and in-home opportunities from which to benefit when services are necessary.[3][4]

Clinical Significance

Palliative care correlates with improvement in symptom control, patient satisfaction, and understanding of diagnosis and prognosis. A goal of palliation is to align the patients’ values and preferences for treatment while attending to family members’ concerns and desires. Family support through respite care can be an immense help to caregivers providing round-the-clock care for their loved one. Furthermore, palliative care consultation can be of assistance for clinicians managing the complexities of patients’ comorbidities.[4]

Other Issues

As a practitioner of palliative care, the physician must know about serious and complex illnesses and be adept at managing palliative emergencies. The physician becomes skillful in prognostication and advanced care planning. She or he collaborates deftly with the interprofessional team to care for the whole patient, focusing on body, mind, spiritual, and social needs. Using mastered techniques in communication, palliative physicians facilitate complex decision-making, consultation, and transitions of care. Often palliative care physicians are seasoned in the logistical aspects of care delivery, including services, payment models, and coordination for care off-site, in the hospital, home health, and hospice.

Hospice and palliative care are not synonymous services, but instead, hospice is an offering that falls under the umbrella of palliative care. Hospice provides palliative service to patients in the last months of life. To qualify, a patient must have a terminal diagnosis with a six month or less prognosis of survival, progressive signs, and have declined pursuit of further curative treatments.[5]

Enhancing Healthcare Team Outcomes

Patients approaching imminent death can benefit from palliative care services by receiving aggressive management of symptoms such as pain, air hunger, and secretions. However, it is worth reiterating that palliative care services are not solely for patients at the end of life. Palliative treatments might indeed take place alongside curative care.

Overall, palliative care provides an interprofessional team-based approach to patient care with both seasoned and new efficacious means of improving quality of life, whether treating potentially curable or incurable disease.[6][7][8] The team consists of clinicians, specialists, hospice/palliative specialty nursing staff, social workers, medical assistants, and pharmacists. Each has their particular function, but must work collaboratively; pharmacists need to assist with medication selection for palliation, and nursing will administer these drugs. Psychological professionals will attend to the needs of the patient as well as the family. Nurses need to be alert for changes in conditions that may warrant modification of care and alert the clinicians. If all these disciplines coordinate and communicate, then patient care will benefit. [Level 5]

Review Questions

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