ICU
MANAGEMENT & PRACTICE

Enriching the Term “Palliative”

Palliative care is an important component of the medical course of many patients. This is particularly applicable for patients with cancer, neurodegenerative diseases, and heart, respiratory or liver failure. However, the term palliative is used uniformly, whatever the stages of disease evolution or the specific therapeutic avenues that might still be possible. It might be more practical to use more nuanced and discriminating terminologies that more accurately clarify different clinical situations.

In medical terminology, palliative refers to a clinical situation with no prospect of complete recovery from a particular disease. Therefore, the patient is basically undergoing treatment that is primarily targeted towards alleviating their symptoms. Palliative care generally involves the management of physical and psychological pain and other symptoms that might cause discomfort to the patient. In many instances, palliative care begins early on in the patient’s life when the prognosis is still good. During this initial stage, there is an implication of prolonged life expectancy and normal or sub-normal quality of life.

At a latter stage, the end of life is approaching, and the patient’s physical condition is significantly altered. Their activities are reduced, and they may need assistance with some of their daily activities. At this point, the patient's mental capacity may be close to normal, and quality of life is limited but still acceptable. During this stage, curative care becomes less effective, and palliative care increases.

When the end of life is near, the patient’s physical capacities tend to be extremely poor, and their quality of life is deeply altered. In most cases, patients need assistance with all their daily living activities.

The distinction between these three different stages is associated with prognosis, comorbidities and quality of life evaluation. But the problem is that the boundary between these three stages is unclear, and there is a need for healthcare teams to decipher the grey areas between them.

It might be possible to schematically define an appropriate management strategy. During the initial stage, there should be no restriction, and the patient should be provided unlimited treatment. They may even be admitted to the ICU with full code management if required. During the latter stage, treatment may be withheld depending on the complications and the probability of death. However, even at this stage, there is hope, and the goal may be to restore a satisfactory quality of life in the short, medium and, hopefully, long term. During the final stage, specific treatments are usually withdrawn, and the expected outcome is death. At this stage, the priority is to ensure the patient receives the best possible quality of death in accordance with their wishes and that of their family.

The term palliative is thus too broad to be used for all three stages. Other terms may more closely correspond to the specific clinical condition of palliative care patients. While many words have already been in use, such as supportive care, hospice care, end-of-life care, terminal illness, terminal care, transition of care, quality of life care etc., ambiguities still exist.

To overcome these ambiguities, a new word ‘pallitative’ is suggested to characterise palliative care focused on end-of-life support. This would apply to patients whose death is expected within a few days or few weeks, and there is no curative treatment or vital support treatment. Comfort is the main priority for these patients.

The term “meliorative” may be used when the goal is to achieve the best possible quality of life. There is no prospect of recovery or improvement, but patients can benefit from symptomatic treatment and care primarily aimed at improving their wellbeing.

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Overall, the term palliative with semantic additions such as the word meliorative or the word palliative may be better at characterising the nature of palliative care.

Source: Critical Care

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Published on : Tue, 15 Jun 2021

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