

Editorial Note on Palliative Care and Hospice Care at the End of Life Approaches

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Introduction

While death is an inevitable aspect of life, it is frequently viewed as a disease. As a result, many people die alone and in pain in hospitals. Palliative care focuses on helping patients and their families make medically essential decisions by anticipating, avoiding, diagnosing, and treating symptoms experienced by patients with a serious or life-threatening illness. Regardless of the condition, the ultimate goal of palliative care is to improve the patient's and family's quality of life. Although palliative care, unlike hospice care, is not dependent on the patient's prognosis, as death approaches, the function of palliative care becomes more important and focuses on aggressive symptom treatment and emotional support.

A vital part of palliative care near the end of life is assisting patients and their families in understanding the nature of their illness and prognosis. Palliative care professionals also assist patients and their families in determining appropriate medical care and aligning the patient's care goals with the healthcare teams. Finally, palliative care at the end of life includes determining the need for a medical proxy, advance directives, and resuscitation status.

Palliative care and hospice care are phrases that are sometimes used interchangeably. Hospice care, according to the National Quality Forum, is a service delivery system that delivers palliative care/medicine when a patient's life expectancy is less than six months and curative or life-prolonging therapy is no longer indicated. As a result, it's critical to note that, while hospice provides palliative care, palliative care is not hospice. Within the hospice service delivery system, not all therapeutic palliative care techniques are offered.

Management of Common Physical Symptoms: Patients nearing the end of their lives may endure severe physical, spiritual, and psychosocial difficulties. Palliative medicine's purpose is to prevent and manage these symptoms while improving quality of life during the dying process [1]. Affordably controlling pain and other symptoms, avoiding prolongation of the dying process, achieving a sense of self-control, finding meaning in life, and relieving the care burdens of family and loved ones while strengthening and completing those same relationships are nine factors important to seriously ill patients [2]. The symptom burden increases as death approaches, but the patient's and family's tolerance for physical and mental stress decreases. Primary palliative care measures should take primacy during this time, and the emphasis on restorative care should be reduced. The triggers for the shift to palliative care include the following four symptoms. One of the most common symptoms near the end of life is pain. Untreated pain can be extremely distressing for individuals and their families, as well as exacerbating other symptoms. As a result, proper pain treatment near the end of life is critical. Despite the fact that opioid analgesics are the gold standard for treating moderate to severe pain in people with terminal disease, the myth that they cause respiratory depression and hasten death is a major obstacle to their use near the end of life. When opioids are given at the right amounts, however, these effects are rare. Clinicians who work with the chronically ill and people nearing the end of their lives should learn about pain management [3].

Dyspnea, or the subjective impression of being out of breath, is a common and distressing symptom in dying patients. The most commonly used drugs for managing dyspnea are opioids and benzodiazepines. If scheduled or as needed doses are insufficient as death approaches, a practitioner may utilize continuous infusions to manage symptoms and relieve suffering. The clinician should evaluate the patient on a regular basis and make modifications to control symptoms [4].

Providers should be aware of the signs and symptoms of delirium-related restlessness at the end of life [5]. Medication is the most common cause of delirium in hospitals: anticholinergics, sedative-hypnotics (e.g., benzodiazepines), and opioids. Anguish (spiritual, emotional, or bodily), worry, agitation, and cognitive failure are common symptoms of delirium and restlessness at the end of life. The use of a strong tranquilizer such as haloperidol is frequently required to treat terminal delirium [6].

Patient's ability to control oropharyngeal secretions becomes more challenging as responsiveness declines toward the end of life. The sound of air movement across pooled secretions is the death rattle of the actively dying. The death rattle can be distressing for loved ones to hear, even if it is not a source of pain for the dying. The cornerstones of treatment include repositioning the patient's head and employing anticholinergics like atropine or scopolamine [7].

Conclusion

The role of palliative care at the end of life is to relieve the suffering of patients and their families by the comprehensive assessment and treatment of physical, psychosocial, and spiritual symptoms patients experience. As death approaches, the symptom burden of a patient may worsen and require more aggressive palliation. As comfort measures intensify, so does the support provided to a dying patient's family. Once death has occurred, the role of palliative care focuses primarily on the support of the patient's family and bereavement.

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Conflict of Interest

The author declares no conflict of interest

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