Journal of Palliative Care & Medicine
ISSN: 2165-7386
Smith, J Palliat Care Med 2023, 13:12
Short Communication Open Access

Patient-Centered Decision-Making in Life-Sustaining Treatment: Insights from a Retrospective Analysis during the COVID-19 Pandemic

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Background

The prolongation of human lifespans has led to a growing interest in improving both the quality of life and quality of death [1]. The Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life, effective since February 2018, aims to respect patients' autonomy during the dying process and uphold their human dignity and values [2]. This study focuses on patients with lung diseases who completed Physician Orders for Life-Sustaining Treatment (POLSTs) to determine the methods of life-sustaining care. The goal is to limit meaningless medical interventions, reduce unnecessary pain, and provide a comfortable end of life. Patients falling into categories such as cancer, AIDS, chronic respiratory disease, liver cirrhosis, or those terminally ill with no chance of fundamental recovery are anticipated to pass away within a few months due to worsening symptoms [3]. However, distinguishing the terminal stage from the dying process becomes challenging for patients with non-malignant chronic lung diseases, such as interstitial lung disease (ILD), pulmonary hypertension, and chronic obstructive pulmonary disease (COPD), who may experience alternating periods of improvement and deterioration [4,5]. While both terminal cancer and non-malignant lung disease patients share similar physical and psychological burdens, symptom profiles, and functional deterioration, the provision of hospice and palliative care can be misunderstood. Patients and their families may misinterpret hospice care as discontinuation of treatment, and healthcare professionals may lack sufficient education on the subject. The study emphasizes the need for early palliative care, proactive management, and a balance between potential survival benefits and short-term quality of life impairments. The study also delves into the challenges of decision-making regarding life-sustaining treatment. Despite the preference for terminally ill patients to determine their treatment preferences, the majority of decisions are made by families or attending physicians. Physician Orders for Life-Sustaining Treatment (POLSTs) are often filled out by others, raising questions about patient autonomy and the cultural taboo surrounding direct discussions of death. Moreover, the study explores the complexities of decisions made by terminal cancer patients regarding life-sustaining treatment [6-8]. Patients experience a range of emotions and concerns, accepting their fate and feeling at peace with their choices. However, the study reveals shortcomings in the system, such as accessibility and explanation, highlighting the importance of patient education and support. The inadequacy of time given for decision-making and insufficient information on life-sustaining therapy are underscored in the study. Timely and accurate explanations of the dying process are deemed crucial for patients and their families to make informed decisions about life-sustaining care [9,10]. The definition of life-sustaining therapy has evolved to include various medical procedures, emphasizing the need for clear communication and understanding. In conclusion, this study aims to analyze the practices of life-sustaining treatment for patients with lung diseases, encompassing both lung cancer and non-malignant lung diseases like COPD. The goal is to identify POLST-related characteristics and support the implementation of a system for choosing life-sustaining therapy based on the specific features of patients with lung diseases.

Conclusion

The COVID-19 pandemic may have contributed to the observed higher percentage of self-determination in the current study compared to previous research. The limitations of the study include its retrospective nature, relying on medical data, and the inability to delve deeply into the selection process of the Physician Orders for Life-Sustaining Treatment (POLST) decision-maker. The constraints in identifying specific procedures and considerations for life-sustaining treatment decisions, as well as the study's generalizability due to being conducted at a single hospital, should be acknowledged. Interpretation of the data should be approached with caution, considering the inclusion of non-malignant lung disorders like COPD and acute illnesses such as sepsis and pulmonary embolism. Healthcare professionals are encouraged to invest more in providing comprehensive life-sustaining care for patients with non-malignant diseases and contribute to the development of a holistic system.

Acknowledgement

Not applicable.

Conflict of Interest

Author declares no conflict of interest.

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Received: 04-Dec-2023, Manuscript No. jpcm-23-123235; **Editor assigned:** 06-Dec-2023, PreQC No. jpcm-23-123235(PQ); **Reviewed:** 11-Dec-2023, QC No. jpcm-23-123235; **Revised:** 15-Dec-2023, Manuscript No. jpcm-23-123235(R); **Published:** 20-Dec-2023, DOI: 10.4172/2165-7386.1000597

Citation: Smith M (2023) Patient-Centered Decision-Making in Life-Sustaining Treatment: Insights from a Retrospective Analysis during the COVID-19 Pandemic. J Palliat Care Med 13: 597.

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