Early access to palliative care: urgent!

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Until recently the vision shared about palliative care by most people among the general population and the health professionals was a reductionist one, as it purported to deal merely with hospital and institutional care given to cancer patients in the last weeks of their terminal illness. Resorting to palliative care was regarded as impending death announcement. It did not imply, as should have been, the announcement of a serious degenerative illness that "might" result in death after months or even years.

Welcome to reality: we are overwhelmed by our aging population. If our vision of palliative care is not to change radically to translate into immediate overhaul, our hospitals will get paralyzed by the ever-growing flow of elderly patients suffering from terminal conditions but not aware of this.

Cancer is not the only terminal illness: severe organ failure (heart, lung, liver, kidney, neurological degeneracy, dementia) are common. They take more than a few weeks to kill, but they do kill with great certainty. Refraining from giving those patients an over-optimistic prognosis will grant better and most of all earlier access to palliative care, whatever the diagnostic.[1]

Waiting until the "final hour" before providing palliative care deprives many patients of the relief they need. It denies them a care that has been proven to reduce the need on hospital's technical facilities with far greater quality of life.

How can this be achieved?

1) First line physicians, specialists and external clinic teams must learn to identify early among their patients the ones suffering from medical conditions so serious as to entail a risk of death within the current year: those patients should be a top priority for the health network as to access to early palliative care.

2) The attending physician should learn to work with the local palliative care team to develop an open approach with their patient: discussing early the eventuality of death and the importance of alleviating suffering

3) Patients suffering from severe and terminal conditions are, through their suffering, entitled to ongoing hope, under the form of a combination of active palliative and curative care. Family physicians should be trained in the specifics of those complex cares given outside hospitals.

4) Appropriate training for first line but also second line medical practitioners specifically concentrating on the prognosis of patients suffering from organic failures and ways of communicating this basic information to patients, should be a national priority.

This global vision of palliative care is to be made known throughout the Canadian healthcare network but also among the general population:

- Early home based palliative medical care should be an absolute priority, including all the long-term care facilities.

- Patients and caregivers should be provided with an accurate knowledge of their prognosis and the treatments alternatives to acute intense hospital treatments.

- The medical practitioner gravitates around a core team composed of the patient himself, his caregivers and the home head-nurse in charge. For the unstable patients, the nurse should be able to call the treating physician (or one of his team) without delay, 24 hours a day.

- Our medical duty is to ensure fluid medical continuity between home care and palliative care units: care in emergency rooms should not be the normal pattern for palliative care, nor for patient transfer from home to a palliative care unit.

Palliative care for all, urgent!

Reference

1. Portail canadien en soins palliatifs. www.virtualhospice.ca

Pallium Canada : www.pallium.ca