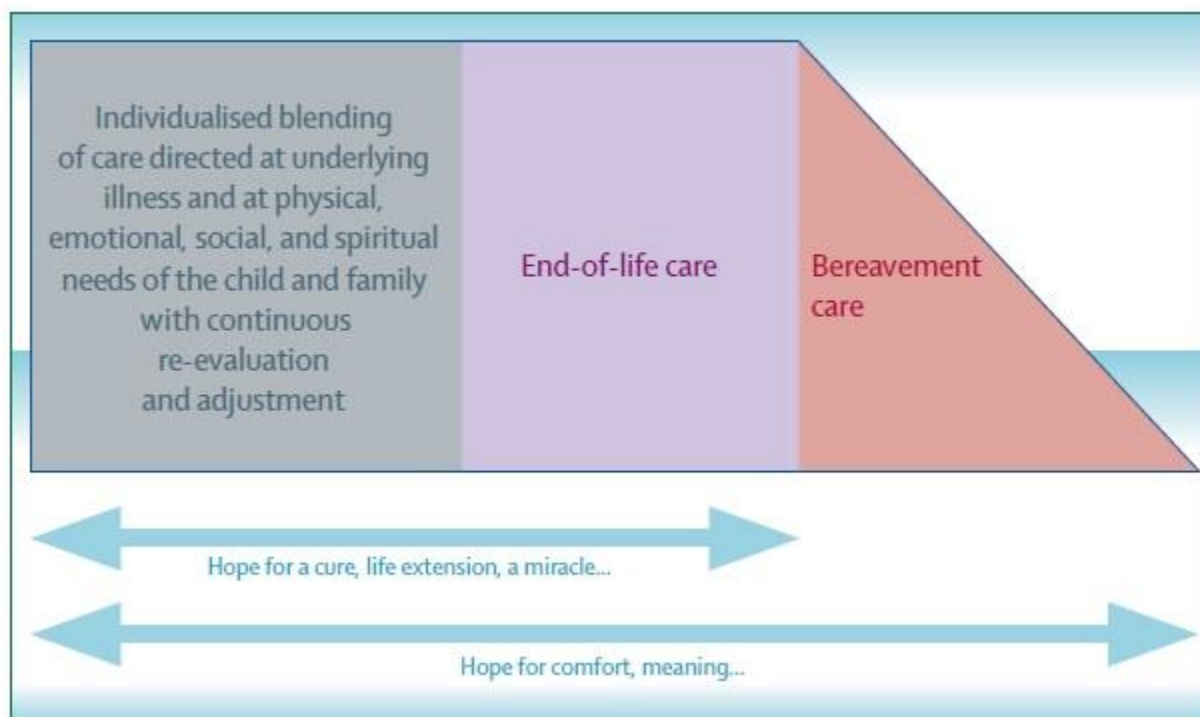


5.1 Palliative Care Overview

What is Palliative Care?

Palliative care is patient- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs to facilitate patient autonomy, access to information and choice.

Figure 1: Model of Palliative Care



Palliative care services are available concurrently with, or independent of, curative or life-prolonging care (see **Figure 1**). Patient and family hopes for peace and dignity are supported throughout the course of illness, during the dying process and after death. This necessitates that the primary team continue to be involved, rather than be replaced.

Palliative care cannot be done in isolation; this form of care is best provided by an interdisciplinary team. Also, patients, families and palliative and non-palliative health care providers must collaborate and communicate about care needs throughout the course of disease and beyond (i.e., into bereavement).

Benefits of Integrating Palliative Care Early

Effective integration can happen at many time points including: at initial diagnosis; when treatment strategies change; or when the primary team, family or patient needs further support.

Some of the benefits to early integration of palliative care include:

- Offering patients and families more autonomy when actualizing their roles in decision-making
- Providing the primary team with new team perspectives
- Enabling families to hold dual goals of care by providing support during curative intent therapy
- Preventing a disruptive transition to a new care team during more difficult times
- Allowing the full scope of support to be available for families. (When palliative care occurs late in the trajectory, it is difficult for palliative care teams to meet families, establish rapport and employ all of the resources at their disposal to enhance quality of life for families.)

Common Myths about Palliative Care

Myth #1: Child must be terminally ill or at the end of life

Palliative care, both as a philosophy and subspecialty, is recommended at any point in the patient's journey as an extra layer of support.

Myth #2: Palliative care = giving up hope

Not only is palliative care not the same as hospice (or end-of-life) care, it also is not associated with the loss of hope. For example, disclosure of a poor prognosis by a physician can actually support hope.

Myth #3: Child must have a DNR to have palliative care

While a Do-Not-Resuscitate (DNR) order is often in line with the goals of care of families when faced with a terminal disease, this is not always the case. In fact, resuscitation should be treated like any other intervention with regards to its benefits and burdens.

Myth #4: Must abandon all disease-directed treatment

Good palliative care often includes disease-directed therapies (e.g., chemotherapy, radiation, or even surgery). These forms of treatment are not only useful for maximizing quantity of life, but they also have a role in maximizing quality as well.

Myth #5: Administering opioids causes respiratory depression and quickens death

When titrated appropriately, the risk of opioid-related toxicity causing significant respiratory depression and hastening death is negligible. If toxicity does occur, there will be a number of sequential warning signs such as drowsiness, confusion and loss of consciousness prior to any significant respiratory compromise.

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Record of Updates

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