

End-of-Life Decision Making in the Context of Chronic Life-Limiting Disease

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Abstract

Variability in practice, insufficient predictive models for death, elusive knowledge of patient preferences, poor communication between staff and surrogates, insufficient or absent training of health-care providers, the use of imprecise and insensitive terminology, and incomplete documentation in medical records were among the issues identified by the jurors. The research towards improving end-of-life care is performed. The verdict recommends a "shared" approach to end-of-life decision-making that includes caregivers and patient surrogates. Respect for the autonomy of the patient, as well as the desire to honor the patient's decision to refuse undesirable therapies, should be communicated to the family. The negotiating process will decide the conclusion, which will be influenced by the personalities and beliefs of the players. In the end, it is the Variability in practice, insufficient predictive models for death, elusive knowledge of patient preferences, poor communication between staff and surrogates, insufficient or absent training of health-care providers, the use of imprecise and insensitive terminology, and incomplete documentation in medical records were among the issues identified by the jurors. The research towards improving end-of-life care is performed. The verdict recommends a "shared" approach to end-of-life decision-making that includes caregivers and patient surrogates. The sufferer must be guaranteed a painless death. The Consensus Conference jury agrees with the moral and legal grounds prohibiting the administration of therapies intended to hasten death. The patient must be provided enough analgesia to relieve pain and anguish; if this analgesia hastens death, the "double impact" should not detract from the primary goal of providing comfort.

Keywords: Advance care planning; Resuscitation orders; Advance directives; Living wills

Introduction

Palliative care is a sort of medical treatment for those who have a terminal illness. This type of treatment focuses on reducing the symptoms and stress associated with the condition. The objective is to enhance the patient's and his or her family's quality of life. Palliative care is offered by a team of doctors, nurses, and other healthcare workers who collaborate with a patient are other clinicians to provide an extra layer of support. In palliative care, the patient's needs take precedence above their prognosis. It can be given to people of any age, at any stage of a serious illness, and in conjunction with curative treatment [1].

Improves the quality of life

Palliative care teams place a high value on quality of life. They assist people who are suffering from cancer, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), renal disease, Alzheimer's disease, Parkinson's disease, Amyotrophic Lateral Sclerosis (ALS), and other serious illnesses.

Relieves Suffering from Symptoms and Stress [2].

Palliative care strives to relieve pain and provide the best possible quality of life for patients and their families. Symptoms include pain, melancholy, shortness of breath, tiredness, constipation, nausea, loss of appetite, difficulty sleeping, and concern [3].

Who is end of life and palliative care for?

Anyone in Victoria who has a life-limiting or life-threatening disease is eligible for end-of-life and palliative care. Chronic life-threatening conditions for which end-of-life and palliative care is available include, but are not limited to [4]:

- Cancer, heart and lung disease, multiple sclerosis, and motor neuron disease.

- Alzheimer's disease and dementia are both caused by kidney illness.
- Other life-threatening disorders include stroke and other neurological problems.
- End-of-life and palliative care, on the other hand, aren't simply for those who are reaching the end of their lives. Regardless of your age, culture, origin, or beliefs, you can get end-of-life and palliative care if you have a life-limiting or chronic continuing disease.
- Palliative and end-of-life cares aren't exclusively for cancer patients [5].

Conclusion

In the United States, students and residents believe they are unprepared to offer, and teachers and residents believe they are unprepared to educate, many critical components of appropriate end-of-life care. Current educational procedures and institutional culture in medical schools in the United States do not support effective end-of-life care, and curricular and cultural changes are required to improve end-of-life care education

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