

Offering Life-Sustaining Treatments for Patients at the End of Life through Hospice and Palliative Care

James Baker*

St. Benedicts Hospice, Specialist Centre for Palliative Care, Sunderland, United Kingdom

Introduction

There is growing interest in enhancing both quality of life and quality of death as medical advancements extend human lifespans [1]. The Act on Hospice and Palliative Care and Decisions on Life-Sustaining Treatment for Patients at the End of Life (hereinafter referred to as the Act on Decisions on Life-Sustaining Treatment) has been in effect since February 2018 [2] in order to respect patients' autonomy throughout the dying process and to safeguard their human dignity and values. Patients in one of two categories those with cancer, AIDS, chronic respiratory disease, liver cirrhosis, or who are terminally ill with no chance of fundamental recovery despite active treatment are anticipated to pass away within a few months due to a gradual worsening of symptoms [3]. The goal of this study was to determine the methods of life-sustaining care used by lung disease patients who completed POLSTs. In order to provide them with a comfortable end of life, meaningless medical interventions are restricted and unneeded pain is reduced. Although patients with terminal non-malignant diseases are now included in the scope of hospice and palliative care, some of these patients may live for a long time after diagnosis, making it challenging to distinguish between the terminal stage and the dying process as their condition alternately gets better and worse [4,5]. While a quick transition to the dying process is prevalent, other patients may not receive the required hospice and palliative care [6]. Moreover, patients and their families may mistake hospice care for a discontinuation of treatment due to misconceptions and misunderstandings of hospice and palliative care for terminal non-malignant diseases, and healthcare professionals may not be well educated. Yet, patients with non-malignant chronic lung disease have similar physical and psychological requirements, symptom burden, and function deterioration as lung cancer patients [7,8]. The objectives of hospice and palliative care in both kinds of situations include easing physical symptoms for patients and their families [9], enhancing QoL through emotional, social, and spiritual support, and decreasing pain [4]. Interstitial lung disease (ILD), pulmonary hypertension, chronic obstructive pulmonary disease (COPD), and lung cancer all carry a significant mortality risk and adversely affect patients' quality of life (QoL) due to symptoms like dyspnea and depression. Patients with COPD in particular frequently require palliative care because of physical symptoms including uncontrollable dyspnea and exhaustion as well as emotional, social, and functional issues like sadness and anxiety. They receive more diagnostic testing than lung cancer patients, but less symptomatic therapy and fewer palliative care services [10,11]. Early palliative care is required when planning treatment, and proactive interest and management are required since patients with severe lung illness and those who care for them experience the same physical, emotional, spiritual, and financial burden as cancer patients. It is preferable for terminally ill patients to determine and record their own treatment preferences. However, a retrospective analysis of 334 patients who provided informed consent for life-sustaining care found that only 26.0% of the participants had completed the form themselves, while the form had been filled out by parents or guardians, other family members, or doctors in 53.3% of cases [12,13]. Physician orders for life-sustaining treatment (POLSTs) are made by attending physicians to record the intentions of terminally

ill patients, whereas advance directives (ADs) for life-sustaining treatment and hospice care are directly completed by people aged 19 or older. The majority of decisions regarding life-sustaining treatment were made by families or attending physicians, not the patients themselves, according to a survey of 71,327 individuals receiving such care, which discovered that 32.3% had patient-written POLSTs. This outcome is believed to be a reflection of situations in clinical settings where patients are unable to make decisions on their own due to the rapid exacerbation of their condition, including deterioration of consciousness, as well as the cultural taboo that restricts direct discussion of death at a patient's bedside. According to categories such as "having complicated feelings," "making choices to protect everyone," "accepting and preparing for death," "feeling distress," "pursuing spiritual wellbeing," and "evaluating a new system," decisions made by terminal cancer patients regarding life-sustaining treatment fell into these categories. It was proven that patients with terminal cancer experienced complex emotions and concerns about their families prior to death, but they accepted their fate and felt at peace as a result of their choices on life-sustaining treatment. They also discussed the system's shortcomings, such as lack of accessibility or explanation, even if they were grateful for the implementation of a system for life-sustaining treatment. Initial judgements on life-sustaining care were overturned on average five days after each decision, according to a research on older patients with terminal chronic cardiopulmonary illness [14]. These findings support the notion that the length of time given for decision-making and the information provided on life-sustaining therapy are both inadequate. In order for terminally ill patients and their families to make their own decisions about life-sustaining care, it is crucial to provide timely and accurate explanations of the dying process. Life-sustaining therapy is a medical procedure that has no impact on the patient's continuing care and simply serves to lengthen the dying process. With the 2019 amendment, this definition has been expanded to include extracorporeal life support, blood transfusion, inotropic agent administration, and other treatments that the attending physician may choose to withhold or withdraw [15]. Previously, this treatment was defined as cardiopulmonary resuscitation (CPR), use of a ventilator, hemodialysis, and administration of anticancer drugs. As compared to cancer patients, patients with COPD have a high symptom load and poor quality of life, yet they often get fewer hospice and palliative care treatments, less pharmacological therapy, and more life-sustaining care. In order to analyse the practises of life-sustaining

*Corresponding author: James Baker, St. Benedicts Hospice, Specialist Centre for Palliative Care, Sunderland, United Kingdom, E-mail: jamesbk@nhs.net

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treatment, including the treatment and progress of patients after their POLSTs were written, this study aimed to identify the POLST-related characteristics of patients with lung diseases, including both lung cancer and non-malignant lung diseases like COPD. This was done in an effort to support the implementation of a system for choosing life-sustaining therapy based on the features of patients with lung cancer and non-malignant lung illnesses.

Conclusion

The coronavirus disease 2019 (COVID-19) pandemic may be to blame for the current study's finding of a greater percentage of self-determination than in prior research. During the COVID-19 pandemic, when medical facilities restricted family care by limiting visits and partially prohibiting carer engagement on-site out of concern for infection, research participants made decisions on life-sustaining therapy. So, it is possible that patient-centered decision-making, which directly informs patients about their situations and assists them in making decisions, has increased and evolved. The present study, however, had some limitations because it was a retrospective examination of medical data and could not go into great detail about how the POLST decision-maker was chosen. The ability to identify specifics of the procedures and considerations that went into decisions about life-sustaining treatment was limited in this retrospective study based on medical records, and its generalizability was also constrained because the data were only collected and analysed from one hospital. Caution is required when interpreting the data because non-malignant lung disorders include COPD and some acute illnesses including sepsis and pulmonary embolism. Healthcare professionals should be more invested in providing patients with non-malignant diseases with life-sustaining care and work to create an all-encompassing system.

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Conflict of Interest

Author declares no conflict of interest.

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