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EDITORIAL

Palliative and respiratory care: Preparing the future

What do Obstructive pulmonary disease, interstitial lung disease, neuromuscular disease, Lung cancer, Asthma, Obstructive sleep apnea and Obesity hypoventilation syndrome have in common? They all affect the respiratory system. They are chronic and progressive conditions and they are, for the most part, incurable.

Advances in Medicine in recent decades have led to increased life expectancy, including for patients with respiratory conditions. Unfortunately, curative treatment isn't always possible and it may not mean that there is any increase in quality of life. Diagnostic and therapeutic decisions may not be in line with the patients' real needs, and may inflict greater suffering.[1,2] Patients with incurable disease are frequently highly symptomatic and suffer loss of functional ability, which should justify a shift in our goals of care, regardless of prognosis, focusing on comfort, dignity and quality of life. This supports the rising importance of Palliative care, a specialized field of Medicine, with tools that could and should be learned by all doctors.

Particularly in Respiratory care, there is, without a doubt a call for greater education, which should begin with basic training in Palliative care, because so many respiratory conditions are, as previously stated, chronic and incurable.[3,4] The initial training process should begin during Respiratory specialty training, which we feel currently has a gap in knowledge to be filled.

Palliative care interventions in respiratory conditions include management of symptoms such as dyspnoea, fatigue, cough, haemoptysis and increased respiratory secretions.[5] Management of dyspnea has been object of particular interest in the past few years. Pharmacological and non pharmacological therapies are available to relieve dyspnoea, however there is still a general fear of implementing some of these measures, mainly due to lack of knowledge of their benefits and risks,[6] particularly regarding opioid use. Opioids remain first line recommendation with grade 1 level of evidence for the relief of respiratory distress in advanced lung diseases if other measures such as bronchodilators, diuretics, corticosteroids and other soothing measures are insufficient.[4]

Education in Palliative care would add value to the current respiratory training programme, both professionally and personally. Communication skills are honed, the patient is assessed globally, interpreting signs and symptoms beyond the respiratory system, with the aim of treating symptoms properly. There is a focus on multi disciplinary team work and special care taken to avoid futile measures. Medical care becomes more patient-centered with a focus on patient preference and views. The familyś role is paramount and their presence, role and views taken into account during this approach which aims to validate the person as a whole; their relationships and what matters to them becomes just as central as the disease which afflicts them.

Palliative patients often present with considerable complexity, not only because of the presence of multiple co morbidities and the severity of their main disease, but also due to the many dimensions that influence patient suffering. Frequently there is no readjustment in goals of care, so that the main purpose becomes quality above quantity of life, with the latter being something that should not be achieved at any cost.[1] This readjustment of goals is still perceived by some as ''giving up'', which adds to the stigma attached to palliative care. It should be seen as the exact opposite; investment in whatever is most suitable for the patient and their family; this is what is recommended by the World Health Organization (WHO).

Palliative care is defined by the WHO as an approach that improves quality of life for patients and their families when facing issues relating to life-threatening illness, through the prevention and relief of suffering by means of early identification and treatment of pain and other symptoms, and also issues in the physical, psychosocial spiritual fields.

This definition is a tall order; its major goal to act on global human suffering and provide comfort and dignity, both to the patient and their family.[1] After a placement in a Palliative care unit, during their respiratory training programme the author argues that education in this field is paramount for appropriate care of patients with advanced lung disease. Considering current international recommendations for doctors and their training, our present reality with increased prevalence of chronic and advanced disease and the desire to improve the patient experience,[4,5] we believe that an integrated placement in Palliative care should be part of the Respiratory specialty training.

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Conflicts of interest

The authors have no conflicts of interest to declare.

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