Who is not comfortable with the term “palliative care”—patient, family, or surgeon?

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Palliative care is an approach that improves quality of life for patients and their families facing life-threatening illness through prevention and relief of suffering.¹ It helps reduce symptom burden, addresses psychologic and spiritual distress, provides support to both patient and family, and assists in establishing goals of care through difficult communications. It is interdisciplinary care and is offered concurrently with other life-prolonging measures, such as cardiothoracic surgery.

In his article in this issue of the *Journal*, Katz² emphasizes the importance of this interdisciplinary care in cardiothoracic intensive care unit and suggests that the term “supportive care” be used instead of “palliative care” to allow patients, families, and providers to focus on recovery as a primary goal of cardiothoracic surgery. Indeed, a study in an academic cancer center showed that the name change from “palliative care” to “supportive care” was associated with more and earlier referrals.³

Acknowledging the suggestion by Katz,² we would like to raise the point that recovery and palliation are not mutually exclusive. Palliative care is *not* synonymous with end-of-life care; rather, it is inclusive of both supportive and end-of-life care by definition. Regardless of the underlying disease (cancer or cardiothoracic surgery) or the trajectory of illness (recovering or deteriorating), as long as a patient’s suffering is serious enough, it has to be addressed. Furthermore, the primary goal of some surgeries may be palliative in nature, because many patients choose to undergo surgery to improve their daily symptoms and quality of life (eg, ventricular assist devices, valve repairs). For these patients, “recovery” may be measured by how “palliated” their symptoms are.

Importantly, those who feel uncomfortable with the term “palliative care” may be cardiothoracic surgeons, rather than patients or families. A study in pediatrics showed

The authors at a family meeting.

Central Message

The true benefit of palliative care will appear only after medical providers in a cardiothoracic ICU, including surgeons, understand that recovery and palliation are not mutually exclusive.

See Article page 2030.

that although parents initially responded more favorably to the term “supportive care” than to the term “palliative care,” the difference disappeared after they received proper explanation.⁴ The current challenge in cardiothoracic surgery appears similar to that in oncology 10 years ago, when many oncologists felt uncomfortable making a referral to palliative care.⁵ Now, after multiple studies have showed the benefit of palliative care, including improved survival,^{6,7} recent clinical guidelines from the American Society of Clinical Oncology recommend early incorporation of “palliative care” with active treatment as the standard of care.⁸

The use of the term “supportive care” might help open the door to more and earlier integration of this patient-centered interdisciplinary approach to care for our cardiothoracic surgical patients. Its true benefit, however, will appear only after cardiothoracic intensive care unit care providers, including surgeons and intensivists, understand and trust the importance of such therapy. This requires a process of educating providers, which needs to be supported by rigorous research on the benefits of palliative care in the cardiothoracic intensive care unit. Katz² provides a valuable perspective on a very important yet underappreciated therapy through which we can improve the care for our patients and families at their most vulnerable moment.

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