

A Identificação de Doentes com Necessidades Paliativas nas Enfermarias de Medicina Interna: Colocar os Doentes Vulneráveis no Centro dos Cuidados

The Identification of Patients with Palliative Needs in Internal Medicine Wards: Placing Vulnerable Patients at the Center of Care

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Recently, Martins presented the results of the application of the Palliative Care Screening Tool (PCST) regarding a group of patients admitted to an Internal Medicine ward over a three-month period, identifying and characterizing those with palliative needs (PN).¹ Although many individuals with chronic diseases, in advanced stages, need palliative care (PC), there are difficulties as far as the effective access to this type of specialized follow-up is concerned. Two common misconceptions regarding PC are: i) its preferential indication for cancer patients; ii) the late referral of individuals, mainly at the terminal phase of their lives. It is notoriously harder to acknowledge PN in patients with non-cancer pathologies, culminating in limited access of these to PC of excellence.² However, even in cancer patients there is a clear clinical delay respecting early referral to PC.³ To better train health professionals there are instruments allowing the early identification of patients with PN and assisting in the PC planning. Examples are: the “Gold Standards Framework - Proactive Identification Guidance” (GSF-PIG); the “RADboud indicators for Palliative Care Needs” (RADPAC); the “Supportive & Palliative Care Indicators Tool” (SPICT); and the

“Necessidades Paliativas” (NECPAL), some of them already translated and validated in Portugal, particularly the last two instruments. Such tools allow the identification of a larger number of patients as they include mortality predictors (such as functional status and quality of life) and specific indicators related to the disease *per se*.² By making exclusive use of the health professional’s perception of the patient’s PN, and by not including those predictors and indicators, there may be up to two thirds of cases where the need for PC is not recognized.² Using the PCST, a simple and easy scale, Martins showed that PN existed in 54% of the hospitalized patients.¹ Its application in a Brazilian Geriatric and Convalescent Hospital identified 86% of patients with PN.⁴ Although there may be differences in the population of both studies contributing to the disparity of results, these figures may also suggest the need for an adequate translation, cultural adaptation, and validation of these instruments. It should be said that Martins’ version did not undergo a process of cross-cultural validation in Portugal. In addition to the identification of patients with PN, it is also important to understand the extent to which this knowledge may change healthcare professionals’ attitudes towards care in hospital settings. Several studies in the field of General Practice have shown that teaching early identification of patients with PN leads to changes in the follow-up plan of these patients, with repercussions on the number of hospitalizations (towards a reduction) and the place of death (according to the patient’s preferable choice).⁵ The identification of patients with PN is crucial for a greater availability of PC to the general population. Nonetheless, it will be part of a longer process, which should include a comprehensive training schedule to provide clear benefits to a larger number of patients. The negative connotation that the term “palliative” implies, together with the lack of clinical expertise in health communication and the fear of conveying a poor prognosis, can lead healthcare professionals to procrastinate this type of care.³ In Internal Medicine, while training residents, it is pertinent to have a mandatory internship in Palliative Medicine. Only by providing such will hospitals become centers of humanization where clinical relationships stand out, centripetal to the

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vulnerable human person, where “curative” and “palliative” will not be mutually exclusive, but complementary parts of an integrated continuum of care. ■

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