
FROM THE EDITOR

Thoughts on the goals of psychosocial palliative care

As the discipline of Palliative Medicine matures, it has become apparent that concepts of adequate palliative care must be expanded in their focus beyond pain and physical symptom control to include psychiatric, psychosocial, existential, and spiritual domains of end-of-life care *and perhaps even culminating in a peaceful acceptance of death* (Breitbart et al., 1998). Providing pain and physical symptom control remains the basic goal of care for most palliative care practitioners. This is the case because such symptoms are indeed compelling sources of distress, and practitioners have the tools and the skills to effectively manage these symptoms. We have made progress in the diagnosis and treatment of psychiatric disorders, such as delirium, anxiety, and depression, in the terminally ill, but effective clinical approaches to existential despair are only now beginning to be developed, tested, and disseminated to clinicians. In developing a set of goals for psychosocial palliative care, perhaps a useful first question is one that asks “What should the clinical goals of general palliative care be in the broadest of senses?”

The goals of medicine practice in general are to *prolong, protect and preserve* life. How are these goals relevant to the overall goals of palliative care? *Prolonging* life is not typically a clinical goal of palliative care. Paradoxically, recent studies suggest that patients who are cared for in hospice survive longer than terminally ill patients who are cared for in usual medical settings (Connor et al., 2007). *Protecting* patients from harm appears to be a reasonable goal of palliative care. However, too frequently, discussions of prognosis or dying are avoided in order to “protect” patients from perceived distress. Rarely, there are patients who can predictably be harmed by such discussions, due to psychiatric illness or emotional fragility. The vast majority of patients are, in fact, benefited by being given the opportunity to discuss their concerns regarding dying and being able to deal with the realities that lie before them.

What does it mean to *preserve* life? Preserving life, as a goal of palliative care, means to do all that is possible for a patient to maintain the essence of who they are, their sense of identity, meaning, and dignity, during the last phase of life and the dying process. This can be accomplished through symptom control, tenor of care, facilitating connectedness to loved ones, to work and creative endeavors, and to focusing on tasks of life completion and legacy. In palliative care then, the clinical goals are *rarely* to *prolong* life, *often* to *protect* life, *but always* to *preserve* life.

Compassion is an important element of all palliative care clinical interactions; particularly those that may help preserve life in the face of death. Compassion may be defined by the following practices: *hospitality, presence, and listening*.

Hospitality refers to the nature and tenor of the clinician–patient interaction. It requires that the clinician communicate to the patient the sense that we are related, we are both human beings facing the same existential concerns and realities of human existence (e.g., mortality). A deconstruction of the hierarchical dynamic that so often characterizes the doctor–patient interaction must take place, creating what Martin Buber termed an “I–Thou” interaction. Of note, hospitality is the source of the terms “hospital” and “hospice.” *Presence* refers to the state of mind and focus of the clinician. During the clinician–patient interaction, the patient is given our full attention. We are completely absorbed and connected to that patient and his or her story and not distracted by other individual concerns (e.g., the chapter I have not yet written that is overdue). The hospital title of “Attending Physician” confirms the importance of attention and *presence* in patient care. Finally, *listening*. In true listening the patient’s words are heard, but more importantly the clinician responds in such a way to indicate that the patient has also been understood. Empathy is at the core of *listening*.

There is an evolution taking place regarding the nature and scope of the clinical goals of psychotherapeutic or counseling interventions in the palliative care setting. Most psychotherapists and counselors

Corresponding author: William Breitbart, Department of Psychiatry & Behavioral Sciences, 641 Lexington Avenue, 7th floor, New York, NY 10022. E-mail: breitbaw@mskcc.org.

would agree that, until recently, there were two basic constructs that were universally accepted as the basis of counseling interventions with a dying patient: *support*, and *nonabandonment*. *Supportive counseling* is, at its essence, allying with a patient's defenses and coping strategies, and supporting or reinforcing them. So the patient who is dying and is using denial in the face of the proximity of death would be supported by the therapist in this way of coping. We all find ourselves allying with hopes, even unrealistic ones, expressed by patients and families in the dying process. However experienced clinicians also create possibilities for patients to discuss death and dying by gentle questioning. *Nonabandonment* or *presence* (in both the physical sense and the more abstract form, as described above as an act of compassion) is a second basic principle of counseling the terminally ill. The therapist makes a commitment to escort or accompany the patient through the course of treatment and the dying process. There is power in the presence of the therapist in accompanying the patient on this too often lonely path. The question many of us are asking in recent years (e.g., Yalom, 1989) is, "Can we accomplish something *more ambitious* (emphasis added, p. 127) in psychotherapy with the terminally ill?"

The "more ambitious" goal of psychotherapy with the terminally ill is to help patients come to a sense of acceptance of a life lived and thus, ultimately an acceptance of death (i.e., being able to face death with a sense of peace and equanimity). Many suggest such a goal of care is not achievable by all and perhaps inappropriate for many. I would suggest that tasks of life completion are achievable and essential to offer at this phase of life. Acknowledging or facing death (i.e., the finiteness of life) can, for many, be the impetus for transformation. Facing death forces one to turn around and face life, the life one has lived.

When one examines the life one has lived and struggles to accept that lived life, one is faced with a number of challenges and tasks of dying. Facing death can enhance the process of pursuing a sense of coherence, meaning, and completion of one's life (Steinhauser et al., 2000). It allows for realization that the last chapter of one's life is the last opportunity to live to one's full potential, to leave behind an authentic legacy, to connect with the beyond, and to transcend life as we know it (Byock, 1996). The goal is to preserve the idea that there is still life to be lived, still time to become, so that one can die with a sense of peace, equanimity, and acceptance of the life one lived. The paradox of the end of life dynamic is that *through acceptance of the life one has lived comes acceptance of death*.

REFERENCES

- Breitbart, W., Chochinov, H.M., Passik, S.D. (1998). Psychiatric aspects of palliative care. In *Oxford Textbook of Palliative Medicine*, 2nd ed., Doyle, D., Hanks, G.W., & MacDonald, N. (eds.), pp. 216–247. New York: Oxford University Press.
- Byock, I. (1996). The nature of suffering and the nature of opportunity at the end of life. *Clinics in Geriatric Medicine*, 12, 237–251.
- Connor, S.R., Pyenson, B., Fitch, K., et al. (2007). Comparing hospice and nonhospice patient survival among patients who die within a three-year window. *Journal of Pain and Symptom Management*, 33, 238–246.
- Steinhauser, K.E., Christakis, N.A., Clipp, E.C., et al. (2000). Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA*, 284, 2476–2482.
- Yalom, I.D. (1989). *Love's executioner and other tales of psychotherapy*. New York: Basic Books.

WILLIAM BREITBART, M.D., F.A.P.A., F.A.P.M.
Editor-in-Chief