

Comfort Care, Whatever Does That Mean?

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by Michael Pottash (@mpottash)

Comfort Care, whatever does that mean? *This is the important question asked by my colleagues **Anne Kelemen and Hunter Groninger** in the September 2018 issue of JAMA Internal Medicine.* The term is ubiquitous and its interpretation influences how patients with end stage illness are cared for at the end of their lives. In their article they argue that *the language of Comfort Care is confusing and easily misunderstood.* They suggest improving the understanding around end of life care and moving to a less ambiguous term for care of the dying. I worry that any term to describe dying care will always be problematic.

So what is Comfort Care? One common definition comes from Blinderman and Billings, writing in the New England Journal of Medicine, defining it as “the most basic palliative care interventions that provide immediate relief of symptoms in a patient who is very close to death.” Another is from the National Institute on Aging, describing Comfort Care as “care that helps or soothes a person who is dying ... to prevent or relieve suffering as much as possible and to improve quality of life while respecting the dying person’s wishes.” *Both definitions are simple enough, and yet lack any specifics or direction for clinicians. This leaves the practice of Comfort Care up for interpretation.*

Kelemen points out the pitfalls in operationalizing this vague term. First, it promotes a dangerous misconception that clinical care is binary and that patients must choose between focusing on comfort or not. Second, Kelemen cites a study demonstrating that while the term is ubiquitous, clinicians don’t actually know what it means. This leads to ambiguity around what kinds of medical interventions constitute Comfort Care and to a wide disparity in which medical interventions clinicians apply under the circumstance. Worse, some seem to think that it means methodically titrating up an opioid infusion: “Nearly half [of surveyed physicians] expressed a belief that Comfort Measures Only care is itself an indication for more aggressive opioid administration than for other patients, regardless of clinical condition. This is of concern because it seems to obviate the critical need for nuanced assessment that drives symptom management.” Administration of inappropriately high dose opioids will hasten death; this is at best bad medicine and at worst euthanasia.

Blinderman agrees:

“However, the term is often used in a misleading or imprecise manner — for example, when such care is automatically considered equivalent to a do-not-resuscitate order and, perhaps even without discussion with the patient, is extrapolated to mean the exclusion of a full range of palliative measures appropriate for a dying patient. *Rather than simply writing orders for “comfort care” (or “intensive comfort measures,” the term that we prefer), the medical team should review the entire plan of care and enter explicit orders to promote comfort and prevent unnecessary interventions.*”

A Pallimed post by Drew Rosielle from 2016 made a similar protest:

“One, it amplifies the already irksome and unnecessary dichotomy we have set up in medicine between 'cure' and 'comfort'... *What we are trying to do in palliative care is to reduce the gap between the two, to help our patients feel better as they live longer...* Two, it's confusing for patients and should never be said in front of them. I've seen it lead to stupid miscommunication many times. Like someone asking a patient 'Do you want comfort care?' 'Do you want us to focus on keeping you comfortable?' and the patient saying 'Yes of course' *not realizing that the clinician was actually saying 'Should we stop efforts to prolong your life and *only* provide ongoing interventions to alleviate symptoms/provide comfort?'*”

To summarize: *Comfort Care is confusing to patients and families, no one knows how to provide it, and it can be harmful.*

Here is the kicker from Kelemen:

“End-of-life care plans must be specific to the patient and family, reflecting their values and goals for that critical event and universal experience. To highlight this, *we coach colleagues and families to consider every therapeutic intervention—for example, each medication, laboratory test, imaging study—and evaluate whether that intervention promotes the goal of alleviating symptom burden during the dying process.* If it does (eg, oxygen administration in hypoxia), we continue it; if not (eg, the ubiquitous statin therapy), then perhaps it could be discontinued after reassuring communication with patients and families.”

Let’s treat dying patients as we would treat any patients: as thinking clinicians. Continue treatments that meet the goals of the patient and family, and discontinue treatments that do not. If the goals of the patient and family are to prioritize symptom management over life prolongation then ask the question of every test, intervention, or medication: Does this promote quality of life? Some life-prolonging interventions can be continued without impacting quality, if the patient so chooses. This will all depend on the patient’s preferences and the clinical context. That is why it is impossible to create a Comfort Care algorithm, bundle, or pathway - clinical reasoning is still required.

While my colleagues believe that we should use clearer language or work towards a unified understanding of Comfort Care, *I would argue that we should get rid of it altogether. Do we need a term for taking care of dying patients in the hospital?* If it does not indicate a clinical pathway or answer an urgent clinical question, then what is its benefit? Rather, in my experience, I have only seen it cause confusion, miscommunication, and unethical medical practice. Kelemen has identified a crucial blind spot in our collective medical practice, one that I fear is a symptom of a general misunderstanding and discomfort with how to care for the dying. *Let’s teach our trainees to continue reasoning through clinical decisions to the end of a patient’s life, and to provide good medical care even if all that entails is sitting at the bedside to hold their patient’s hand.*

Disclosure:

- Anne Kelemen and Hunter Groninger are dear friends and colleagues.
- Michael Pottash MD MPH is a Palliative Medicine Physician at MedStar Washington Hospital Center and Assistant Professor of Medicine at Georgetown University School of Medicine.

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