

Early Palliative Care Improves Patient and Caregiver Quality of Life

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Patients receiving early palliative care experience improved quality of life, may live longer, and may have earlier referrals to hospice. Caregivers with loved ones receiving early palliative care experience improved communication, decreased risk of caregiver burnout, and improved bereavement adjustment. Studies have shown that patients who received palliative care at diagnosis lived 2.5 months longer than those who did not; patients who received aggressive resuscitation or intensive care admission near the end of life had worse quality of life; and caregivers were three times more likely to develop depression following patient death for those who did not receive early palliative care.

AT A GLANCE

- Early initiation of palliative care has been shown to improve survival, quality of life, and hospice transition.
- Oncology nurses are in a unique position to provide primary palliative care and facilitate referrals to specialty primary care.
- Oncology nurses can alleviate barriers to early palliative care through standardized tools, continued education, and implementation of nursing interventions highlighted in this article.

KEYWORDS

palliative care; cancer; hospice; quality of life; health education

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In 1990, the World Health Organization Expert Committee on Cancer Pain Relief and Active Supportive Care officially defined *palliative care* but emphasized it as care relegated to those whose disease was not responsive to curative treatment. However, in 2002, the World Health Organization, after learning that this traditional definition was self-limiting and that palliative care is applicable throughout the trajectory of serious illness, redefined *palliative care* as “an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual” (Sepúlveda et al., 2002, p. 94). Despite this update, common practice has relied on the World Health Organization’s (1990) original definition of palliative care, which limits treatment to refractory patients.

The National Consensus Project for Quality Palliative Care (2018) guidelines strongly support best practice as initiating palliative care for seriously ill patients as soon as possible, ideally at the point of diagnosis. This is different from hospice because the Centers for Medicare and Medicaid Services (2024) hospice criteria require the patient to have a prognosis of six months or less if the disease runs its natural course. Hospice falls under the umbrella of palliative care. All hospice is palliative care, but not all palliative care is hospice (Limerick & Sutton, 2020). Palliative care and hospice focus on the management of physical symptoms, emotional and social concerns, and spirituality, but palliative care is appropriate at any age or any stage of illness and can be provided alongside curative or life-prolonging care, whereas the Centers for Medicare and Medicaid Services (2024) hospice criteria require the patient to have a specific prognosis and to forgo curative treatment.

The historical, archaic medical curricula omitted basic palliative care education until the 1990s, when this was introduced at a very superficial level. To date, all practitioners have a rudimentary knowledge of primary palliative care, allowing them to provide initial treatment and recognize the need for referral to specialty palliative care. Specialty palliative care focuses on the management of complex or refractory problems encompassing physical, emotional, social, and spiritual needs, as well as ethical dilemmas or cases of futile care (Quill & Abernethy, 2013).

This coordinated model of generalist-plus-specialist palliative care is supported globally and improves access to patients with unaddressed pain and