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Palliative Care in Routine Clinical Practice

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TRANSCRIPT

Hello everyone!

This is Dr. Arulmozhi, Associate Professor, from Department of Community Medicine.

Today, I want to talk about something that is deeply connected, to the way that we care for patients. It is a critical aspect of healthcare, but often introduced too late. And that is **palliative care**.

When we hear the words *palliative care*, many of us immediately think of cancer patients, their final days of life, or situations where all curative treatment has been stopped and nothing more to be done. But palliative care is much more than that.

We need to understand that **palliative care is not only for cancer patients.**

It is for anyone living with a **serious, chronic, progressive, or life-limiting illness**—including heart failure, COPD, chronic kidney disease, stroke, dementia, diabetes, tuberculosis, HIV, and many others., irrespective of **their diagnosis or stage of illness.**

So, what is palliative care?

It is about **helping people to live as well as possible while living with serious illness**. It focuses not only on pain and physical symptoms, but also on emotional, social, spiritual, and family needs.

And importantly, **palliative care can be provided alongside curative treatment.**

What is the biggest challenge that we face in palliative care?

It is the Late referral.

Because palliative care is considered only when the patient is nearing the end of life.

By the time they reach palliative care, they may have already experienced months of pain, breathlessness, fatigue, anxiety, or loss of independence.

So, when we see a patient, we should ask not only:

"What disease does this person have?"

but also:

"What is this illness doing to this person's life?"

Are they in pain?
Are they breathless?
Are they struggling with daily activities?
Are they anxious or lonely?

Do they need frequent hospital visits?
Is the family struggling to cope?

If yes, **consider palliative care.**

So when we start palliative care early, it can lead to better **symptom control, improve quality of life** not only for patients but also for caregivers, help patients and families make informed decisions, and reduce treatments that may no longer provide meaningful benefit. In some cancer settings, it has also been associated with improved survival.

So, **palliative care is not giving up—it is about improving the quality of life.**

Palliative care is definitely a **multidisciplinary team effort** involving doctors, nurses, psychologists, social workers, physiotherapists, spiritual-care providers, and community workers.

And we can start right from our **routine OPD**. We can screen the patients proactively.

When we see a person with chronic or multiple illnesses, just take a moment, to look beyond the diagnosis and investigations.

Ask:

"Is this person suffering?"

If yes:

"What can I do to relieve that suffering?"

It may be a medication like morphine, a referral, teleconsultation—or simply listening.

And palliative care does not stop at the hospital. For many patients, especially older adults and those with chronic illnesses, most of their life happens at home.

Community-based care and trained volunteers can provide companionship, support caregivers, identify problems early, and connect patients with the healthcare team.

Let's get trained in palliative care—and train caregivers and community volunteers—to provide compassionate, continuous care both at home and in the hospital.

Our responsibility is to ensure that people **live as well as possible, for as long as possible, with comfort, dignity, and support.**

Thank you for listening. Stay compassionate, and let's focus on **patient-centred care.**

Signature of the Resource Person

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