A meeting point between palliative and supportive care

European professionals involved in the care of patients in the palliative phase of an illness may ask themselves: what difference can there be between the terms 'palliative care' and 'supportive care'?

Are we looking at the same thing, or are they two different, even contradictory, ideas? If one looks beyond the terminology, it will quickly become apparent that the care-related and human objectives involving patients and their families are very similar, if not identical.[1,2]

It is a willingness to adapt the structures to a specific environment (organising specialist oncology centres), a willingness to share a common European culture, research development and validation of practices, rather than a renunciation of the spirit cultivated by the founders and pioneers of palliative care.

The link that can be made between the two options is found in the method of care and the philosophy behind it. Whether we talk of palliative or supportive care largely depends on the medical decision upon which it is based. The essential thing, for everyone, is to offer total and optimal care of patients on both a scientific and human level.

Inevitably, the concept of medical decision in palliative and supportive care leads us first and foremost to the relationship between doctor and patient. In this relationship, two people are brought together with a very specific objective: one has to relieve, and indeed cure, the other.

The relationship seems to be one of dependence – the patient expects something from the doctor. The relationship can be defined as a relationship of strength: one person dominates the other through asking something of him.

The decision marks the end of a deliberation process. This is the moment of choice.[3] Once the deliberation is over, we move from the desire to do to the act of doing. The aim of deliberation is to allow the person(s) responsible for taking the decision to identify the criteria that will allow the most appropriate course of action to be carried out.

Making a medical decision has its own specific difficulties when conversation is not enough in itself to allow establishment of suitability between desire, power and the act of doing the patient good.

These difficulties are linked to a complex and unique human situation and to the uncertainty of medicine, which cannot, despite its scientific processes, claim any kind of absolute certainty.

As soon as one appeals to values beyond the realm of scientific knowledge, the question of moral authority in medicine arises. Science has no answer to the criteria which clarify this type of moral choice. Morality can be too dogmatic, too personal to provide this clarification. We are, therefore, looking at a critical situation, which calls on ethics to help in the realms of practice and reasoning.

It appears that the way suggested by Ricoeur4 can be applied in our daily practice. First, from a specifically ethical view (wishing to take the decision that is most suited to the patient's wellbeing). Second, this ethical viewpoint is confronted with the moral obligation based on values, standards and laws, either established by us or indoctrinated into us, giving us our unique identity. Finally, we are brought into a crisis situation armed with our ethical views and the capacity to discern objectively what must be done and can be done, and to make a consistent decision without causing additional suffering.

In both supportive and palliative care, it is a matter of dialogue not only with patients and their families but also with all of the medical team. It demands time and recourse to knowledge that is outside the purely medical field.

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Marcel Louis Viallard, UMSP Evaluation and Treatment of Pain, Centre Hospitalier Bretagne Atlantique, Vannes and Editor-in-Chief of Médecine Palliative, *France*

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