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When Complete Symptom Relief Is neither Possible nor Preferred: A Theoretical Account of Acceptable Discomfort, Competing Priorities, and Patient-Defined Goals in Palliative Nursing

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Abstract

To develop a theoretical account of how palliative nurses can interpret residual symptom burden when complete symptom relief is either unattainable or conflicts with a goal that the patient values more highly. Original non-empirical theory development informed by palliative nursing theory, symptom-management scholarship, patient-preference research, goal-concordant-care literature and evidence concerning serious-illness decision-making. Peer-reviewed nursing, palliative-care and preference-sensitive-care literature published between 2017 and 2024 was critically selected to examine symptom experience, multidimensional assessment, treatment burden, functional priorities, clinician understanding of patient goals, temporal preference change and safety limits surrounding severe or refractory suffering. The analysis distinguishes incomplete symptom relief caused by ineffective or inadequate care from residual discomfort that a patient knowingly accepts because further relief would threaten cognition, meaningful activity, interaction, independence or another higher-priority goal. Patient-Defined Acceptable Discomfort Theory treats acceptability as relational, purpose-dependent, revisable and clinically bounded rather than as a numerical symptom threshold. Symptom intensity remains important, but it cannot independently establish whether care has achieved the patient's goal. Palliative nursing requires a concept of successful symptom management that can accommodate both vigorous relief of unwanted suffering and carefully negotiated acceptance of some residual burden. Such acceptance is ethically and clinically defensible only when the patient's priority is adequately elicited, feasible alternatives are considered, preferences remain revisable and unacceptable or refractory suffering is not relabelled as tolerable merely because complete relief is difficult.

Keywords: Palliative nursing, Symptom management, Patient preferences, Acceptable discomfort, Goal-concordant care, Person-centred care

Introduction

Palliative nursing is often evaluated through the reduction of pain, dyspnoea, nausea, anxiety and other distressing symptoms. Relief is indispensable, yet person-centred palliative care is also concerned with identity, self-determination, relationships and what makes life worth sustaining under serious illness [1]. A symptom score can therefore describe one clinically important aspect of experience without fully establishing whether the patient's most important goal has been achieved.

This distinction becomes visible when symptom treatment itself carries consequences that matter to the patient. A systematic review of goals used in cancer pain management found that conventional approaches do not consistently capture broader dimensions such as functioning or other patient-valued outcomes [2]. Direct

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qualitative evidence is more revealing still: some palliative-care patients described choices between stronger analgesia and preservation of cognition, clarity, work, hobbies or a familiar sense of self [3]. These accounts do not imply that pain should remain untreated. They demonstrate that the value of additional relief can depend on what must be surrendered to obtain it.

Preference research similarly shows that people approaching the end of life do not evaluate care through a single outcome. Older people with life-limiting illness make trade-offs among attributes of care rather than simply maximizing one clinical objective [4]. Across discrete-choice studies, pain relief remains highly valued, but preferences also differ according to other characteristics of care, personal circumstances and the outcomes patients are asked to consider [5]. Complete symptom elimination therefore cannot be assumed to dominate every competing priority in every clinical circumstance.

A second difficulty concerns whether clinicians know which outcome a patient currently values most. Serious-illness research shows that clinicians do not invariably identify their patients' prioritized goals correctly [6]. In palliative cancer pain, patients have articulated functional goals whose significance would be missed if management were evaluated solely through pain intensity [7]. A person may seek enough analgesia to walk to a garden, remain alert for conversation or continue an activity that carries identity and meaning, even when a lower symptom score is pharmacologically possible.

This article develops Patient-Defined Acceptable Discomfort Theory (PDADT) to account for that clinical territory. The theoretical problem is not whether symptom relief matters; it plainly does. The problem is how nursing judgment should interpret residual symptoms when the patient would have to sacrifice a more highly valued goal to obtain further relief. PDADT consequently distinguishes clinically unacceptable suffering, which continues to require active assessment and relief, from preference-sensitive residual discomfort, which may be voluntarily tolerated under defined and revisable conditions. The theory is intended to clarify this distinction without turning acceptability into a universal symptom threshold or legitimizing undertreatment.

Background

Fundamental nursing care provides a useful starting point because symptom management occurs within a relationship rather than as an isolated technical intervention. The Fundamentals of Care Framework integrates physical and psychosocial needs with the nurse–patient relationship and the context in which care is delivered [8]. Related nursing models similarly emphasize attentiveness, relational engagement and the integration of apparently ordinary care activities with the patient's broader experience [9]. In palliative practice, these perspectives make it difficult to define successful symptom control entirely through a clinician-selected numerical endpoint.

Contemporary palliative quality measurement reinforces this broader view. Patient-reported quality includes whether people feel heard and whether they receive help that reflects what they actually need [10]. Multidimensional assessment work likewise demonstrates that the initial palliative encounter encompasses considerably more than symptom severity, extending across physical, psychological, social and other domains relevant to serious illness [11]. These approaches provide essential information for nursing judgment, although neither a patient-reported outcome measure nor a needs-assessment tool independently establishes how much residual symptom burden a particular patient would willingly accept.

The meaning of a symptom is also relational and temporal. Family caregivers may encounter substantial difficulty managing symptoms near the end of life, creating circumstances in which patient preference, caregiver capability and service resources interact [12]. Psycho-existential symptoms can improve, persist or newly emerge during palliative care, showing that the clinical meaning of an earlier preference cannot always be projected unchanged into a later phase of illness [13]. Similarly, analyses of patient-reported outcome data indicate that relationships among symptoms vary with phase of illness and clinical state [14]. A decision that is tolerable today may therefore cease to be tolerable after a change in disease, function, cognition, medication effect or personal priority.

Recognition of preference-sensitive discomfort must nevertheless begin from the fact that substantial symptom improvement is often achievable. In specialist inpatient palliative care, patients with cancer pain can attain personally defined pain-management goals [15]. Any theory of acceptable discomfort would become clinically dangerous if it encouraged nurses to presume that persistent symptoms merely reflect patient choice. The first question remains whether the symptom can be relieved safely and in a manner compatible with the patient's goals.

The distinction is particularly important at the severe end of symptom experience. Research on decision-making before continuous palliative sedation shows that patient involvement can vary across cases and stages of decision-making [16]. International palliative-sedation guidance places refractory suffering, intolerability, proportionality and respect for autonomy at the centre of ethically defensible practice [17]. Although routine symptom negotiation must not be conflated with palliative sedation, this literature identifies a necessary boundary: suffering that remains unwanted, intolerable or refractory cannot simply be renamed "acceptable" because complete control is challenging.

PDADT therefore requires two questions to remain separate. The first is clinical: What symptom relief is possible, proportionate and safe? The second is preference-sensitive: Among feasible options, what balance of symptom

burden and treatment consequence best protects what this patient values now? Confusing these questions risks either undertreating suffering or overriding patient priorities in pursuit of an apparently optimal symptom score. The distinction is summarized in **Table 1**.

Table 1. Competing conceptions of symptom relief in patient-defined palliative nursing goals

Conception of relief	What counts as success	Patient-valued object primarily protected	Nursing question that becomes decisive	Principal failure mode	Interpretation within PDADT
Symptom elimination	The symptom is absent or minimized as far as clinically achievable	Immediate comfort	Can the symptom be reduced further safely?	Assuming lower intensity is always the dominant goal	Appropriate when the patient wants maximal relief and treatment consequences are acceptable
Intensity-targeted relief	A predefined or negotiated reduction in symptom intensity is reached	Reduced distress	Has the intended reduction occurred?	Treating a score as a complete representation of success	Useful as one outcome, but insufficient when function, cognition or other goals compete with further reduction
Function-preserving relief	Symptoms are controlled enough to permit a valued activity or capability	Mobility, participation, independence or meaningful activity	What level of relief enables the activity the patient is trying to protect?	Reducing symptoms further at the cost of the capability that made treatment worthwhile	Residual burden may be acceptable when it is explicitly tolerated to preserve a higher-priority function
Cognition-preserving relief	Distress is reduced without unacceptable loss of alertness, clarity or interaction	Consciousness, communication, identity or presence	How does additional treatment affect the mental state the patient values?	Assuming sedation, confusion or cognitive blunting is an acceptable price for every increment of relief	The preferred balance is patient-specific and requires reassessment as illness and treatment effects change
Relationally negotiated relief	Treatment reflects an adequately elicited patient priority within feasible clinical options	Voice, participation and relational trust	Have the patient's priorities been understood rather than inferred?	Substituting clinician or family preference for the patient's own goal	Acceptability depends partly on the integrity of the goal-elicitation process
Safety-constrained relief	Residual burden exists only after serious suffering, reversible causes and proportionate options have been appropriately considered	Protection from preventable or intolerable suffering	Is the apparent trade-off genuinely voluntary, or is the patient accepting symptoms because relief is inaccessible, ineffective or poorly offered?	Calling inadequate treatment, refractory distress or constrained choice "acceptable discomfort"	The safety boundary overrides preference-sensitive interpretation when suffering remains unwanted or clinically unacceptable

Note: PDADT = Patient-Defined Acceptable Discomfort Theory.

Data sources

PDADT was developed through a critically selected evidence base rather than a systematic-review design. The literature was chosen to test the theory's component assumptions and counterarguments across five intersecting areas: palliative and nursing theory; symptom and pain-management goals; patient preferences and functional priorities; goal-concordant and priority-aligned decision-making; and clinical or methodological limits on how patient goals can be measured. Evidence was retained when it clarified a construct, contradicted an emerging proposition, exposed a measurement problem or established a boundary on interpretation.

A central methodological problem is that goal concordance is not a single directly observable outcome. Multiple approaches have been used to determine whether serious-illness care reflects patient goals, each capturing somewhat different information [18]. Even within the same patient, ratings and rankings of goals can produce different representations of what is most important [19]. PDADT therefore cannot treat a single recorded

preference, conversation checkbox or concordance measure as definitive evidence that residual symptom burden is genuinely acceptable.

The literature on multimorbidity contributes an adjacent but informative body of evidence. A systematic mixed-studies review found that patients and clinicians can prioritize treatment and health outcomes differently, with patients often attaching particular importance to lived function and everyday experience [20]. In older adults with multiple chronic conditions, care organized around explicitly elicited priorities was associated with changes in treatment decisions and reduced treatment burden [21]. Implementation research further shows that clinicians may use actionable functional goals, serial therapeutic trials and negotiation when disease-specific objectives conflict with what matters most to a patient [22]. These studies are not direct validation of PDADT in palliative nursing; they instead demonstrate plausible decision processes through which competing goals can be made explicit.

Guiding principles for multimorbidity similarly encourage decisions that consider patient priorities alongside anticipated benefit, harm and treatment burden [23]. This is conceptually relevant because additional symptom treatment can itself impose burden. Yet another assumption also requires restraint: patient goals should not be presumed to fluctuate simply because serious illness progresses. Longitudinal work involving patients and surrogate decision-makers found substantial stability in end-of-life preferences despite major contextual disruption [24]. Reassessment is therefore necessary because preferences *may* change, not because instability should be assumed.

Taken together, the data sources support a theory in which symptom burden, treatment consequences and patient-defined priorities are distinct inputs to nursing judgment. They also impose a methodological limit: observed symptom severity does not reveal preference, documented preference does not necessarily establish current preference, and clinician interpretation does not substitute for adequately elicited patient goals.

These relationships require a nonlinear representation because preference, treatment effect, symptom experience and safety constraints influence one another rather than forming a simple treatment pipeline. **Figure 1** depicts the evidence-informed decision field that will later support the formal propositions of PDADT.

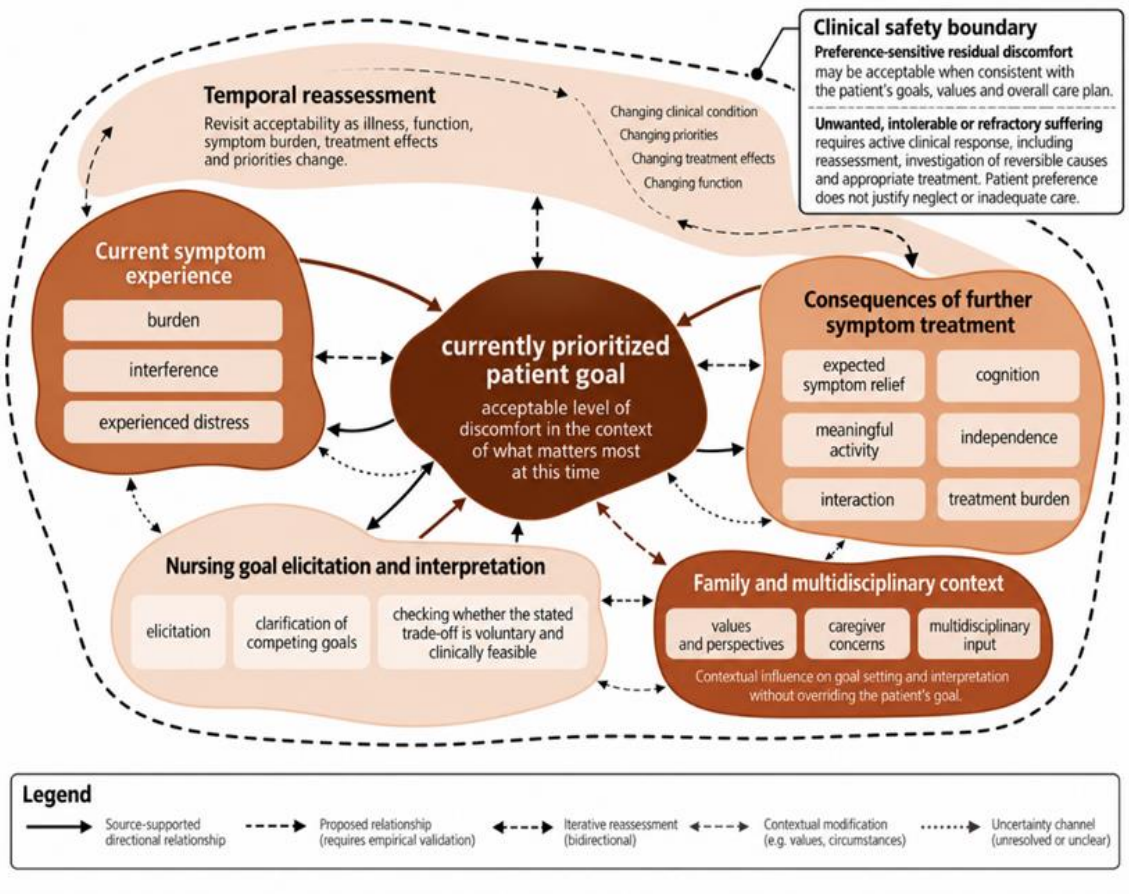


Figure 1. Conditional negotiation field for patient-defined acceptable discomfort in palliative nursing

Overview of the issues

The conceptual problem becomes clearest when a symptom-management decision contains more than one legitimate clinical objective. Decisions surrounding palliative sedation illustrate an extreme version of this complexity: research across European settings shows that decisions develop iteratively and may involve patients,

relatives and clinicians to differing degrees [25]. In less extreme symptom-management situations, qualitative work with patients and carers has likewise shown that effective management extends beyond symptom intensity to quality of life, preferences and medication-related consequences [26]. The relevant nursing question is therefore not simply whether another intervention could reduce a symptom, but what that intervention would alter in the life the patient is trying to preserve.

This interpretation places considerable weight on communication, but communication itself requires a defined purpose. Serious-illness scholarship continues to debate which measurable outcome should count as the most important product of these conversations [27]. Systematic approaches to outpatient palliative assessment can identify multidimensional needs and create opportunities for responsive care [28], yet the presence of a documented need does not establish how competing needs should be ranked. Assessment is an input to negotiation, not its endpoint.

The same caution applies to palliative-care involvement and documented goals. Among hospitalized patients with cirrhosis, receipt of palliative consultation was not independently associated with improvement in several measured outcomes after adjustment, illustrating how context, illness severity and confounding complicate straightforward claims that adding palliative involvement automatically produces better downstream outcomes [29]. In intensive care, researchers have shown that patient goals can sometimes be reconstructed from electronic records, but relevant information may be distributed across multiple notes [30]. Documentation can therefore support continuity without necessarily reproducing the patient's current hierarchy of goals.

From these issues emerge four distinctions central to PDADT.

First, residual symptom burden and treatment failure are not synonymous. A symptom may remain because relief is incomplete, because further treatment is ineffective, because treatment effects are unacceptable to the patient, or because the patient chooses to preserve a valued capability that more aggressive treatment would threaten. Only the latter situations enter the preference-sensitive territory addressed by PDADT, and even then only after feasible relief has been considered.

Second, symptom tolerance is not an intrinsic patient trait. Describing a person as having "high tolerance" risks converting a situational trade-off into a stable characteristic. The relevant object is instead the relationship between a current symptom burden and the goal protected by accepting that burden. A patient may tolerate pain to remain cognitively clear during an important conversation and later request stronger relief when that priority changes. The symptom has not changed its biological character; the meaning of the trade-off has changed.

Third, patient-defined does not mean clinically unconstrained. A patient may legitimately prioritize alertness, mobility, communication or autonomy, but nursing practice remains responsible for detecting reversible causes, explaining options, assessing treatment effects and responding to suffering that the patient no longer wishes to endure. Preference-sensitive care is therefore neither passive acceptance nor automatic deference. It is an active process in which the patient's values and professional obligations are held together.

Fourth, goal concordance must be temporally revisable without assuming volatility. Earlier preferences deserve respect, yet changing disease, capacity, family circumstances or treatment effects can alter what matters. Conversely, repeated reassessment should not imply that a stable preference is provisional simply because clinicians expect it to change. The theoretical task is to preserve the patient's authority to revise a trade-off while also respecting continuity when the patient continues to endorse it.

These distinctions shift the endpoint of symptom-management reasoning. The decisive question is not whether the lowest possible symptom intensity has been reached. It is whether the remaining symptom burden reflects an informed, feasible and revisable balance between relief and another goal that the patient presently values more highly, while remaining above the clinical floor below which suffering is unwanted, unsafe or insufficiently treated.

Table 2 converts these clinical tensions into the proposed theoretical propositions that will be developed formally in the next section.

Table 2. From symptom-management tensions to proposed Patient-Defined Acceptable Discomfort Theory propositions

Proposed theoretical proposition	Clinical tension from which it arises	Nursing interpretive consequence	Condition requiring reassessment or escalation	Theoretical status
Meaning-conditioned tolerability	Identical symptom intensity can interfere differently with what different patients value	Interpret burden in relation to what the symptom prevents, disrupts or allows the patient to continue doing	The symptom becomes more distressing, more intrusive or newly incompatible with the patient's priorities	Proposed PDADT relationship

Competing-goal proposition	Additional symptom reduction may compromise cognition, function, interaction or another valued state	Ask what is gained and what is surrendered by further treatment rather than assuming every increment of relief has positive net value	A less burdensome treatment becomes available, the trade-off changes, or the protected goal loses priority	Proposed PDADT relationship
Goal-recognition requirement	Clinicians and families may misunderstand or incompletely represent the patient's highest-priority goal	Confirm the goal through direct elicitation whenever possible and distinguish patient preference from professional or family inference	Preference is unclear, contested, poorly documented or affected by impaired decision-making capacity	Proposed PDADT requirement
Relational negotiation proposition	Palliative decisions occur within nurse–patient, family and multidisciplinary relationships	Use nursing assessment and communication to clarify feasible choices while protecting the patient's decisional authority	Conflict, coercion, unrealistic expectations or disproportionate caregiver/service burden alters the decision context	Proposed PDADT relationship
Temporal revisability proposition	Symptoms, treatment effects and priorities can change, while some preferences remain stable	Reassess proportionately without presuming either instability or permanence	Disease trajectory, function, cognition, treatment response or expressed values materially change	Proposed PDADT relationship
Clinical-safety floor	Residual discomfort may represent voluntary trade-off, inadequate treatment or refractory suffering	Establish whether the burden is genuinely accepted after appropriate assessment and feasible relief options have been considered	Suffering becomes unwanted, intolerable, refractory, unsafe or attributable to remediable undertreatment	Boundary condition of PDADT

Note: PDADT = Patient-Defined Acceptable Discomfort Theory.

Conceptual findings

The evidence supports a distinction between successful communication, successful symptom reduction and successful attainment of the patient's preferred balance among competing goals. These outcomes can overlap, but they are not interchangeable. In outpatient oncology, structured serious-illness communication did not produce uniform improvement across all targeted patient outcomes [31]. Communication-priming interventions can nevertheless increase attention to goals-of-care discussions [32]. For PDADT, this means that eliciting a goal is necessary to preference-sensitive symptom management, while the occurrence of a conversation alone cannot establish that subsequent treatment is goal concordant.

A similar distinction applies to symptom measurement. Electronic patient-reported outcome collection can be implemented at substantial scale in palliative oncology and provides clinically useful information about symptom experience [33]. Yet a severity value cannot reveal whether a patient would accept, reject or deliberately retain some of that burden in order to preserve alertness, mobility, communication or another valued state. PDADT therefore treats symptom measurement as an essential input to clinical reasoning rather than as an independent rule for determining treatment success.

The level of analysis must also remain explicit. Methodologies for estimating serious health-related suffering can quantify population-level palliative-care need and identify large service gaps [34]. Such information is crucial for health-system planning, but it cannot determine whether an individual patient regards a particular residual symptom as acceptable. Population burden, clinical severity and personally acceptable burden are related but analytically distinct constructs.

From this evidence base, PDADT proposes six connected propositions.

Proposition 1: Acceptability is meaning-conditioned. Residual discomfort has no fixed clinical meaning apart from its relationship to what the patient is trying to preserve. A symptom may be experienced as unacceptable when it prevents conversation, movement or sleep, yet the same or even greater intensity may be voluntarily tolerated when stronger treatment would threaten a goal judged more important. The theory therefore rejects a universal numerical boundary between acceptable and unacceptable discomfort.

Proposition 2: Treatment benefit is relational to competing goals. The value of further symptom reduction depends partly on its consequences. Additional analgesia, sedation or other symptom-directed treatment may produce greater comfort while also altering cognition, function, interaction or treatment burden. A clinically effective intervention can therefore be misaligned with the patient's current priority even when it lowers symptom intensity.

Proposition 3: Acceptable discomfort requires valid goal attribution. Residual burden cannot be described as patient-defined merely because clinicians believe the patient values another goal. The relevant preference should

be directly elicited when possible and distinguished from assumptions made by relatives or professionals. When capacity is impaired, preference reconstruction requires greater caution because inferred wishes carry different evidentiary status from contemporaneous patient choice.

Proposition 4: Acceptability is revisable rather than permanent. A patient's willingness to tolerate discomfort applies to a particular clinical and personal context. Reassessment becomes necessary when symptom character, functional effect, treatment response, cognition or expressed priorities change. Revisability should not be confused with presumed instability: a preference can remain stable and still retain the right to be reconsidered.

Proposition 5: Negotiation occurs within relationships but preserves patient authority. Nurses, physicians, relatives and services influence which options are visible and feasible. Their contributions can clarify consequences, detect risk and support deliberation. They do not, however, convert a professional or family preference into a patient-defined goal merely through agreement or documentation.

Proposition 6: A clinical-safety floor constrains preference-sensitive interpretation. PDADT applies only when residual discomfort reflects an informed and clinically defensible trade-off. Untreated reversible causes, inaccessible treatment, inadequate assessment, coercion, severe unwanted suffering or refractory distress cannot be reframed as acceptable discomfort. Patient-defined tolerability supplements the obligation to relieve suffering; it does not cancel it.

Together these propositions define acceptable discomfort as a conditional relationship among symptom burden, treatment consequence, personal meaning and a currently prioritized goal. The construct therefore differs from symptom tolerance, stoicism, treatment refusal and simple preference reporting. Its theoretical value lies in explaining why a residual symptom can sometimes coexist with successful palliative nursing while, in another context, an apparently similar residual symptom represents inadequate or unwanted care.

Results and Discussion

PDADT addresses a recurrent problem in palliative practice: the assumption that successful symptom management can always be inferred from the greatest technically achievable reduction in symptoms. Existing evidence does not support such a simple endpoint. Some patients prioritize pain relief strongly, and specialist palliative services can help patients achieve personally defined pain goals [15]. At the same time, qualitative evidence shows that others explicitly weigh analgesia against cognition, activity or identity [3]. The theory accommodates both situations by locating success in the patient's informed goal rather than privileging either maximal treatment or deliberate symptom endurance in advance.

This distinction has direct implications for nursing assessment. Patient-reported symptom measures remain indispensable because they identify burden and change over time. Multidimensional palliative assessment also helps reveal psychological, social and practical needs that a symptom score cannot capture [11]. The additional question posed by PDADT is whether further symptom reduction would support or undermine what the patient is currently trying to accomplish. That question should arise only after ordinary clinical responsibilities—assessment of cause, available treatment and safety—have been addressed.

The theory consequently requires attention to the difference between preference and constraint. A person may appear to "choose" residual discomfort because medication causes unacceptable cognitive effects. That situation can represent a genuine trade-off. A superficially similar choice may instead arise because adequate medication is unavailable, side effects have not been treated, communication is poor or the patient believes requesting greater relief would burden staff or family. These states should not be collapsed into the same concept. Family caregivers may themselves experience substantial difficulty managing symptoms [12], reinforcing the need to examine whether environmental and relational constraints are shaping what appears to be voluntary acceptance.

Temporal interpretation is equally important. Symptom relationships and psycho-existential needs can vary during illness [13]. Patient-reported symptom patterns can also depend on phase of illness [14]. PDADT therefore treats the acceptable-discomfort judgment as time-bound. Nursing reassessment should be responsive to meaningful change rather than performed as a ritual assumption that preferences are continuously unstable. Evidence that end-of-life preferences may remain stable across major contextual changes provides an important counterweight to excessive re-questioning [24].

Clinical safeguards become especially important as suffering intensifies. Decision-making literature surrounding palliative sedation shows that patient participation, family roles and professional judgment can vary considerably [16]. Current international guidance emphasizes refractory suffering, intolerability, proportionality and autonomy when sedation is considered [17]. PDADT does not extend sedation criteria to routine symptom management. The relevance of this literature is narrower: it demonstrates that severe suffering requires explicit safeguards and that neither patient preference nor professional judgment alone eliminates the need for careful proportionality and clinical assessment.

The model also clarifies what goal-concordant care can and cannot establish. Existing measurement approaches operationalize concordance differently [18]. Goal ratings and rankings may yield differing representations of patient priorities [19]. Documentation therefore deserves interpretation rather than automatic acceptance. A

preference recorded several weeks earlier, a family statement, a numerical symptom score and an explicit bedside choice are not epistemically equivalent. PDADT requires nursing judgment to preserve those distinctions.

Evidence from priority-aligned care offers useful but limited support for this reasoning. Patients and clinicians may emphasize different treatment outcomes [20]. Explicit priority elicitation can influence decisions and treatment burden in older adults with multiple chronic conditions [21]. Clinicians have also used functional goals and serial therapeutic trials to manage competing priorities [22]. These findings make the proposed mechanisms plausible, but they do not constitute direct validation of PDADT in palliative nursing. Transfer from multimorbidity care must remain cautious because illness trajectory, urgency, capacity and family involvement can differ substantially near the end of life.

The same caution applies to communication. Structured conversations can improve aspects of serious-illness communication, but improvement in communication processes does not ensure improvement in every patient outcome [31]. Communication priming can increase goals-of-care discussion [32]. PDADT therefore treats conversation as a mechanism for clarifying priorities rather than as an outcome sufficient in itself. A high-quality conversation that leaves the patient's symptom–goal trade-off unresolved has not completed the theoretical task.

For nursing practice, the most immediate implication is a change in the question used to interpret residual symptoms. Instead of asking only, "Can this symptom be reduced further?", nursing judgment may also need to ask, "What would further reduction cost this patient, and is the patient choosing that trade-off?" This addition should never weaken efforts to relieve suffering. Its function is to prevent a different error: imposing a clinician-defined optimum that unintentionally removes an activity, mental state or relationship the patient values more than an additional increment of symptom relief.

Research is needed before PDADT can support formal clinical tools. Initial work should establish whether patients and nurses understand the construct consistently and whether it can be distinguished empirically from undertreatment, resignation, treatment refusal and ordinary symptom tolerance. Longitudinal studies should examine whether acceptable-discomfort judgments remain stable when symptom burden or treatment effects change. Measurement work should test whether combining symptom severity with explicitly elicited patient priorities adds clinically meaningful information beyond standard patient-reported outcomes. Electronic PRO systems demonstrate that repeated symptom measurement is feasible [33], but the additional preference and meaning constructs proposed here require separate validation.

The theory also needs testing across populations and health systems. Current supporting evidence is weighted toward adult serious illness, cancer, older people and comparatively well-resourced palliative settings. Population-level estimates show that serious health-related suffering is distributed globally and that palliative need extends far beyond those contexts [34]. Cultural expectations concerning endurance, family authority, disclosure and clinician responsibility may alter how apparent acceptance should be interpreted. PDADT should therefore be evaluated across diverse cultural, socioeconomic and service settings before its propositions are treated as broadly transferable.

Finally, the theory does not imply that every palliative encounter requires an explicit negotiation about acceptable discomfort. When treatment is effective, well tolerated and aligned with the patient's wishes, the conceptual distinction may add little. Its greatest value arises when symptom relief and another meaningful goal pull in different directions. In those situations, naming the trade-off can protect both sides of palliative nursing: the obligation to relieve suffering and the obligation to respect the patient's own account of what makes relief worthwhile.

Conclusion

Complete symptom relief is neither universally attainable nor universally preferred when further treatment compromises something the patient values more highly. Patient-Defined Acceptable Discomfort Theory provides a bounded account of this problem by distinguishing unwanted or clinically unacceptable suffering from residual symptom burden that a patient knowingly and revisably accepts to protect another goal.

Acceptability is therefore not a symptom score, personality trait or permission for undertreatment. It is a conditional relationship among experienced burden, treatment consequences, personal meaning, feasible alternatives and the patient's current priorities. Nursing judgment remains responsible for assessment, relief of avoidable suffering, clarification of goals and recognition of changes over time.

The theory proposes a more patient-defined endpoint for selected symptom-management decisions while retaining a firm clinical-safety boundary. Its propositions now require empirical validation before they can support formal measurement instruments or clinical decision rules.

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