Physicians begin the New Year with an ever-growing challenge: effectively treating the millions of aging Americans with advanced chronic illness. Today’s patients are living longer with diseases that once proved rapidly fatal. Coupled with the “aging boom,” this results in an increasing number of patients who need not only treatment for their illnesses, but also care for their pain and other symptoms; help with daily living needs; caregiver support; and assistance coordinating complex medical care over the course of many years.

These patients’ needs are acute and immediate; numerous studies show most seriously ill patients have insufficiently controlled pain and symptoms. They also need assistance communicating with their healthcare providers and navigating the medical system. The healthcare system has no choice but to be more responsive to these most vulnerable patients: healthcare institutions are expected to meet accreditation standards that mandate high-quality pain and symptom management, effective communication and coordination of care, and other quality standards.

So who will deliver this care? Most patients will look to their primary care physicians. Yet in a busy office practice or hospital, these high expectations can be hard to meet without an innovative and systematic approach. Fortunately, the rapidly growing field of palliative care provides just that—effective, evidence-based management of the patient with advanced and/or chronic illness. This month, the first of a 2-part series, “Principles of Palliative Care,” highlights the clinical fundamentals of this level of care and clarifies when this care is most appropriate.

Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and their families through expert family/patient-physician communication, pain and symptom management, psychosocial support, and effective coordination and use medical services, resources, and care models.

Palliative care is both a way of practicing medicine and an area of specialization. A primary care physician may provide palliative care as part of a patient’s treatment, or a team of palliative care experts may be consulted if a practice or hospital has a formal palliative care program.

The impact of palliative care is significant, broad, and well-documented: palliative care markedly reduces patients’ pain, symptoms, and stress levels. It increases patient and family satisfaction and relieves caregiver burden. Palliative care programs reduce fragmentation of care and lead to better planning, resulting in more appropriate use of medical resources and shorter intensive care unit and hospital lengths of stay. This means palliative care is affordable: most programs pay for themselves, which makes them attractive to administrators. They also are attractive to clinicians with seriously ill patients, because palliative care teams provide around-the-clock on-call services, handle repeated and intensive patient-family communications, manage complex symptoms at the bedside, and help to successfully carry out the care plan of the patient’s primary physician.

In recent years, this strong track record has led an increasing number of physician practices—and over 20% of US hospitals—to establish palliative care programs. Further growth of palliative care programs will be required to meet patient need. Unfortunately, there are obstacles and myths that must be addressed first:

1. The cure vs comfort fallacy. Many physicians and patients opt for palliative care only after curative or life-prolonging care has been completed or suspended. This approach to medical care results in much unnecessary suffering. In fact, palliative care is provided throughout a serious illness, simultaneously with all other appropriate medical treatment, including curative treatment.

Offering palliative care does not require a patient to choose between receiving treatment for his or her disease or treatment for its symptoms; thus it is distinct from hospice care. In fact, palliative care often improves a patient’s tolerance of and response to treatment. One recent study showed that cancer patients...
receiving palliative care during chemotherapy were more likely to complete their cycle of treatment, stay in clinical trials, and report a higher quality of life than similar patients who did not receive palliative care. Presumably, these results were due to expert management of physical and psychosocial distress during active therapy.

2. **Medical education in palliative care.** Another barrier is lack of physician training in basic palliative care, including expert care of pain and symptoms. While medical education reform addressing these gaps is underway, most practicing physicians do not have sufficient training in these areas. I went through 9 years of medical education without a single lecture on pain management. This lack of education leads to physician worries about over-prescribing and poor understanding of appropriate pain and side effects management. As a result, most patients, especially minorities and lower-income patients, do not receive effective pain relief.

3. **Mismatch between the structure of the healthcare system and the needs of patients and families.** The fundamental orientation of our medical system is a problem. It has historically been structured and financed to provide acute, episodic care rather than effective, coordinated management of advanced chronic illness. The fragmented delivery of care results in frequent hospital admissions, long lengths of stay, frustration and fatigue on the part of physicians, and a large burden for caregivers.

The best way to ensure that patients receive the palliative care they need, when they need it, is to establish a palliative care program in a practice or hospital. A program can take the form of a consult service, inpatient “scatter” beds, a dedicated inpatient unit, outpatient services, or a combination of these options. The administrators can choose the type of program that best meets patients’ needs and matches the resources available as well as the “culture” of the healthcare organization. These programs ensure more patients will have access to palliative care services, and they address many of the problems outlined in this column. The presence of a team of palliative care experts leads to referrals earlier in a patient’s illness; it increases the palliative care knowledge of the clinicians it serves; and it enables the staff to coordinate patient treatment, greatly reducing the fragmentation of care.

With or without help from a formal palliative care team, it is important for clinicians to become proficient in the basic principles of good palliative care, as described in this issue of the Journal: strong patient-family communication about the goals of care; vigorous management of pain, other symptoms, and side effects; strong psychosocial support; and effective identification and coordination of the array of medical and social services that offer help in the community. There are a growing number of resources available for physicians who would like to develop skills in these areas, or for those who want to start a palliative care program. They are summarized in the sidebar to this column.

The investment of effort required to begin providing palliative care is small in comparison to the enormous rewards reaped. Patients, physicians, and healthcare organizations find that palliative care improves not only the quality of the care provided, but also dramatically improves the job satisfaction level of those who provide the care. Most importantly, it reinforces the unique role of primary care physicians and the primacy of their relationships with their patients. After all, this is why we went to medical school in the first place—to take the best possible care of our patients. Despite the challenges of the practice of modern medicine, palliative care, and the skills it brings to bear on caring for our sickest patients, is a reminder of the many rewards and privileges of being a physician.