Palliative care improves the quality of life for patients with a life-threatening illness and for their families. It aims to relieve suffering by identifying, assessing, and treating pain and other physical, psychosocial, and spiritual problems. Palliative care can be provided whether an illness is potentially curable, chronic, or life-threatening; is appropriate for patients with noncancer diagnoses; and can be administered in conjunction with curative-aimed therapies at any stage of the illness. Hospice is a type of palliative care provided when curative treatment is no longer beneficial or desired, and when life expectancy is measured in months or less. It supports patients and their families while focusing on symptom relief and comfort.

Despite documented benefits, palliative care is underutilized in the management of advanced or terminal illnesses. It is estimated that more than 1 million deaths (or 45% of all deaths in the United States) in 2011 occurred in patients who were in a hospice program. Although this represents a gradual upward trend, 36% of those patients died or were discharged within seven days of admission, and nearly two-thirds (63%) received hospice care for less than one month.

**Benefits**

Hospice care provides better symptom management and quality of life compared with usual (cure-directed) care (Table 1). Studies show that patients who receive hospice care have improved quality of life, with less depression and symptom burden; feel more in control; are able to avoid risks associated with treatment and hospitalization; and have decreased costs with improved utilization of health care resources. Benefits also extend to caregivers, family, and friends, which demonstrates greater satisfaction with the quality of care and attention to caregiver needs.

**Barriers**

Several factors may account for the underutilization of hospice care, including confusion about terminology, misperception about its intent and scope, concerns about cost and insurance coverage, and potential mistrust because of perceived economic motives (Table 2). A lack of physician comfort with end-of-life conversations, including the fear of depriving patients of hope, can also create a barrier to hospice referrals.

Uncertainty about prognosis poses an additional challenge for physicians. Studies show that although the physician–patient
relationship provides a meaningful context for addressing end-of-life issues, the degree of uncertainty about prognosis directly correlates with the longevity of this relationship. Insufficient training for physicians and nurses, including a lack of familiarity with various prognostic tools, may also have a role.

A more subtle barrier surrounds the psychology of decision making. Patients tend to be overly optimistic, believing that prescribed treatments will cure even incurable diseases. For physicians, the fear of causing harm by failing to do something may overshadow the fear of actively doing something harmful (i.e., therapeutic optimism).

Best Practices
To achieve the goal of improved hospice utilization when appropriate, some guidelines recommend that palliative care be incorporated into standard-of-care treatment approaches. One validated model that has been proven effective in patients with terminal illness includes the following actions: stating the prognosis at the first visit; appointing someone in the physician’s office to ensure that advance directives are discussed; scheduling a hospice information visit within the first three visits; and offering to discuss the patient’s prognosis, coping strategies, and goals of care at each transition.

Physicians should contextualize decisions around goals of care, which preserves hope and optimism but reorients treatment toward appropriate aims. Palliative care should be part of a broader continuum of care, thereby avoiding abrupt changes in the medical course. Family physicians are well-positioned to discuss advance care planning during routine office visits; several increasingly nuanced approaches are available to facilitate this discussion.

Family physicians should be familiar with disease trajectories of common chronic illnesses, as well as tools that aid in prognostication. There are several validated tools that rely on performance status in conjunction with other clinical indicators (e.g., Palliative Prognostic Score, Flacker Mortality Score, Charlson Comorbidity Index for End-stage Renal Disease). The Patient-Reported Outcome Mortality Prediction Tool has had promising results in predicting six-month
mortality in older adults, but still requires validation for routine clinical use. Institutions should also consider implementing protocols that trigger hospice referrals based on specific clinical features (e.g., repeated or lengthy hospitalization, decline in cognitive or functional status, unacceptable pain, emotional distress), and palliative care utilization should be a key quality measure. Physician and nursing education must continue to incorporate these elements in clinical training.

We should be careful to avoid blaming the patient or the physician for the ways in which end-of-life care is approached. For an illuminating perspective, see a video on end-of-life communication at http://www.youtube.com/watch?v=a2lh_1cBnWw. A physician's desire to cure is often coupled with frustration over futility, and a patient's desire to live is balanced with a concern for comfort. These competing goals can create tensions among the patient, family, and physician. Adequate access to palliative measures, including early palliative care given in conjunction with curative therapy as part of a broader, guideline-directed management strategy, is one way that family physicians can balance these tensions.

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REFERENCES

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<tr>
<th>Organization</th>
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<tr>
<td>American Academy of Hospice and Palliative Medicine <a href="http://www.aahpm.org">http://www.aahpm.org</a></td>
<td>National professional organization for physicians and other health care professionals specializing in hospice and palliative medicine</td>
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<td>Eastern Cooperative Oncology Group Performance Status</td>
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