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**EDITORIAL**

## Palliative Care — A Shifting Paradigm

Amy S. Kelley, M.D., M.S.H.S., and Diane E. Meier, M.D.  
 N Engl J Med 2010; 363:781-782 | [August 19, 2010](#)

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Palliative care focuses on relieving suffering and achieving the best possible quality of life for patients and their family caregivers. It involves the assessment and treatment of symptoms; support for decision making and assistance in matching treatments to informed patient and family goals; practical aid for patients and their family caregivers; mobilization of community resources to ensure a secure and safe living environment; and collaborative and seamless models of care across a range of care settings (i.e., hospital, home, nursing home, and hospice). Palliative care is provided both within the Medicare hospice benefit (hospice palliative care) and outside it (nonhospice palliative care). Nonhospice palliative care is offered simultaneously with life-prolonging and curative therapies for persons living with serious, complex, and life-threatening illness. Hospice palliative care becomes appropriate when curative treatments are no longer beneficial, when the burdens of these treatments exceed their benefits, or when patients are entering the last weeks to months of life.<sup>1</sup>

Comprehensive palliative care services integrate the expertise of a team of providers from different disciplines to address the complex needs of seriously ill patients and their families. Members of a palliative care team typically include professionals from medicine, nursing, and social work, with additional support from chaplaincy and professionals in nutrition, rehabilitation, pharmacy, and other professional disciplines, as needed. These programs are now available at more than 80% of large U.S. hospitals (those with more than 300 beds), where most Americans receive their care during complex and advanced illness.<sup>2</sup>

Despite the increasing availability of palliative care services in U.S. hospitals and the body of evidence showing the great distress to patients caused by symptoms of the illness,<sup>3</sup> the burdens on family caregivers,<sup>4</sup> and the overuse of costly, ineffective therapies during advanced chronic illness,<sup>5</sup> the use of palliative care services by physicians for their patients remains low. Physicians tend to perceive palliative care as the alternative to life-prolonging or curative care — what we do when there is nothing more that we can do — rather than as a simultaneously delivered adjunct to disease-focused treatment.<sup>6</sup>

In this issue of the *Journal*, Temel and colleagues challenge this prevailing notion of palliative care by presenting the results of a randomized, controlled trial of early palliative care in addition to standard oncologic care for patients with newly diagnosed metastatic non–small-cell lung cancer.<sup>7</sup> A total of 151 subjects were recruited and enrolled in the study at a single academic thoracic oncology practice. Health-related quality of life and mood were measured at baseline and at 12 weeks. In addition to standard oncologic care, patients in the intervention group met with a palliative care clinician at the time of enrollment and at least monthly thereafter. As compared with the standard care group, the intervention group had better quality of life, lower rates of depression, and a 2.7-month survival benefit.

The results of this study show that palliative care is appropriate and potentially beneficial when it is introduced at the time of diagnosis of a serious or life-limiting illness — at the same time as all other appropriate and beneficial medical therapies are initiated. The fact that palliative care improved quality-of-life outcomes is consistent with the results of other studies of both nonhospice and hospice palliative care. The substantial survival advantage observed, though it is supported by other recent studies,<sup>8,9</sup> requires replication.

The specific components of the study's palliative care intervention remain unspecified and hence may not be easily reproducible in other practice settings. For example, the salutary effect of additional time with and attention from health care providers and physicians, as opposed to a specific benefit derived from palliative care itself, was not assessed and is a limitation of the study. The reasons for the 2.7-month survival benefit in the palliative care group — a benefit that is equivalent to that achieved with a response to standard chemotherapy regimens — are unknown but may result from effective treatment of depression, improved management of symptoms, or a reduction in the need for hospitalization. The current study was not designed to address these important questions.

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Despite these limitations, Temel and colleagues are to be commended for overcoming many of the challenges and barriers to conducting a randomized trial of a palliative care intervention.

Future studies of palliative care must begin to test and identify the actual components of palliative care that are provided and received. Such methodologic rigor is necessary to establish the evidence for best practice. Studies of other disease populations beyond patients with cancer and in other settings (e.g., long-term care) are also necessary to identify the ways in which palliative care can be appropriately delivered in diverse patient populations and settings. Finally, although studies have shown that palliative care programs reduce hospital expenditures,<sup>10</sup> additional studies examining the effect of palliative care on overall health care costs need to be undertaken.

The study by Temel et al. represents an important step in confirming the beneficial outcomes of a simultaneous care model that provides both palliative care and disease-specific therapies beginning at the time of diagnosis. This study is an example of research that shifts a long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying. The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this suffering can be effectively addressed by modern palliative care teams. Perhaps unsurprisingly, reducing patients' misery may help them live longer. We now have both the means and the knowledge to make palliative care an essential and routine component of evidence-based, high-quality care for the management of serious illness.

[Disclosure forms](#) provided by the authors are available with the full text of this article at NEJM.org.

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