Palliative medicine is specialized medical care for people with serious illness. Serious illness is one with high risk of mortality that negatively affects quality of life or function or is burdensome in symptoms, treatments, or caregiver stress. Palliative care improves symptom management and addresses the needs of patients and families, resulting in improved patient and caregiver quality of life and reduced symptom burden and health care utilization. Hospice is palliative care for patients with a prognosis of 6 months or less and is appropriate when goals are to avoid hospitalization and maximize time at home for patients who are dying.

Clinicians working with seriously ill patients need the skills to effectively communicate with patients and their families throughout the trajectory of illness. Common communication tasks that arise in the care of seriously ill patients include advance care planning, delivering serious news, discussing prognosis, eliciting values, and medical decision making. Clinicians often use goals of care conversations to facilitate these tasks. Similar to other procedures, goals of care conversations require a systematic, evidence-based approach to ensure quality and value. This article provides a framework that clinicians can follow to effectively communicate with seriously ill patients and families and promote patient-centered care.

Prognostication in Serious Illness

Prognostication is a vital aspect of decision making because it provides patients and families with information to establish realistic and achievable goals of care, is used in determining eligibility for certain benefits, and helps in targeting interventions to those likely to benefit. Prognostication consists of 3 components: clinicians use their clinical judgment or other tools to estimate the probability of an individual developing a particular outcome over a specific period of time; this prognostic estimate is communicated in accordance with the patient’s information preferences; the prognostic estimate is interpreted by the patient or surrogate and used in clinical decision making.
Recognizing and Managing Polypharmacy in Advanced Illness

Shaida Talebreza and Mary Lynn McPherson

Older adults, particularly those late in life, are at higher risk for medication misadventure, yet bear the burden of increasing polypharmacy. It is incumbent on practitioners who care for this vulnerable population to use one or more approaches to deprescribe medications that impose a greater burden than benefit, including medically futile medications. It is essential that health care providers use compassionate communication skills when explaining these interventions with patients and families, pointing out that this is a positive, patient-centric intervention.

Pain Management in Patients with Serious Illness

Kimberly Angelia Curseen, Jabeen Taj, and Quintesia Grant

Managing pain in patients with serious illness can be complex. However, pain is often a prominent symptom in patients with malignant and nonmalignant serious illness and providers have to be adept at balancing effective pain management and safety. Clinicians should start with a standard pain assessment that lays important groundwork for developing a tailored multimodal approach to pain management. It is important to identify physical causes of pain and also existential causes. Opioids are not always appropriate but are still an important tool for managing pain. Basic opioid management and safe practices are essential when managing this population.

Management of Gastrointestinal Symptoms (Nausea, Anorexia and Cachexia, Constipation) in Advanced Illness

Monica Malec and Joseph W. Shega

Anorexia and cachexia, nausea and vomiting, and constipation are gastrointestinal symptoms that commonly accompany serious illness. Basic science and clinical research continue to improve the understanding of their pathophysiology. Thorough assessment necessitates history, physical examination, and laboratory and diagnostic testing. Pharmacologic management attempts to counteract or reverse the underlying pathophysiologic mechanisms that accompany each symptom, which may benefit from a multimodal approach to achieve adequate control. Future improvements in management require investments in clinical research to determine the efficacy of novel agents along with comparator studies to better understand which treatments should be used in what sequence or combination.

Management of Respiratory Symptoms in Those with Serious Illness

Cynthia X. Pan, Brigit C. Palathra, and Wing Fun Leo-To

Respiratory symptoms are common in patients living with serious illness, both in cancer and nonmalignant conditions. Common symptoms include dyspnea (breathlessness), cough, malignant pleural effusions, airway secretions, and hemoptysis. Basic management of respiratory symptoms is within the scope of primary palliative care. There are pharmacologic and nonpharmacologic approaches to treating respiratory symptoms. This article provides clinicians with treatment approaches to these burdensome symptoms.
Cannabis for Symptom Management in Older Adults

Cari Levy, Emily Galenbeck, and Kate Magid

The purpose of this article is to present evidence on the efficacy and safety of medical cannabis as a therapy for symptom management in palliative care. This article provides an overview of the evidence on the risks and benefits of using medical cannabis for the indications of chronic pain, cancer-related pain, cancer cachexia, dementia, and Alzheimer’s disease. Currently, there is insufficient evidence to determine the effectiveness and safety of cannabinoids for most reviewed indications, with the exception of chronic pain. Future research is required before palliative care clinicians can make evidence-based decisions on the integration of medical cannabis as adjunct therapies.

Delirium at the End of Life

Meera Agar and Shirley H. Bush

Delirium is a prevalent acute neurocognitive condition in patients with progressive life-limiting illness. Delirium remains underdetected; a systematic approach to screening is essential. Delirium at the end of life requires a comprehensive assessment. Consider the potential for reversibility, illness trajectory, patient preference, and goals of care before proceeding with investigations and interventions. Management should be interdisciplinary, and nonpharmacologic therapy is fundamental. For patients with refractory and severe agitation or perceptual disturbance, judicious use of medication may also be required. Carers and family should be seen as partners in care and be involved in shared decision making about care.

Management of Grief, Depression, and Suicidal Thoughts in Serious Illness

Kanako Y. McKee and Anne Kelly

The varied physical, social, and psychological stressors that accompany advanced disease can be burdensome and cause intense emotional suffering, hindering the ability of patients and families to cope in day-to-day life and negatively affecting quality of life. This article addresses key concepts for the assessment and management of commonly encountered types of psychological distress in serious illness including grief, prolonged grief, major depressive disorder, death contemplation, and suicidal ideation.

Management of Urgent Medical Conditions at the End of Life

Benjamin M. Skoch and Christian T. Sinclair

Medical emergencies at the end of life require recognition of patients at risk, so that a comprehensive assessment and plan of care can be put in place. Frequently, the interventions depend on the patient’s underlying prognosis, location of care, and goals of care. The mere presence of a medical emergency often rapidly changes an estimated prognosis. Education of the patient and family may help empower them to adequately handle many situations when clinicians are not available.
Options of Last Resort: Palliative Sedation, Physician Aid in Dying, and Voluntary Cessation of Eating and Drinking

David A. Gruenewald and Gregg Vandekieft

Some patients with terminal and degenerative illnesses request assistance to hasten death when suffering is refractory to palliative care, or they strongly desire to maximize their autonomy and dignity and minimize suffering. Palliative sedation (PS), voluntarily stopping eating and drinking (VSED), and physician-assisted death (PAD) are possible options of last resort. A decision to choose PS can be made by an informed surrogate decision maker, whereas intact decision-making capacity is required to choose VSED or PAD. For all palliative treatments of last resort, the risk of harm is minimized by the use of checklists, and establishment of policies and procedures.

Burnout and Self Care for Palliative Care Practitioners

David J. Horn and Catherine Bree Johnston

Burnout is common in physicians who care for patients with serious illness, with rates greater than 60% in some studies. Risk factors for burnout include working on small teams and/or in small organizations, working longer hours and weekends, being younger than 50 years, burdensome documentation requirements, and regulatory issues. Personal factors that can protect against burnout include mindfulness, exercise, healthy sleep patterns, avoiding substance abuse, and having adequate leisure time. Institutional and work factors that can buffer against burnout include working on adequately staffed teams, having a manageable workload, and minimally burdensome electronic health record documentation.