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The need to improve palliative care delivery is increasingly evident as the number of those who live in their later years with chronic disease-related impairment continues to rise, and the costs of late life care have become unsustainable. It is estimated that the last year of a person's life consumes around 30% of his or her lifetime Medicare expenditures (1). Fortunately, knowledge about how to deliver palliative care more effectively has also increased, and the American College of Physicians (ACP) has recently published [Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life](#). This guideline is based on a strong research synthesis, specific enough to guide some aspects of practice. The ACP's guideline:

- Based recommendations on a high quality, systematic review of approximately 25,000 documents.
- Did not focus only on randomized controlled trials (RCTs). Instead the research synthesis and guideline use an explicit evidence rating scheme (e.g., GRADE) and the recommendations adhere closely to the strongest evidence.
- Offers specific guidance about what clinicians should do (i.e., use opioids for cancer pain) (2).

One particularly important issue highlighted by the guideline is the relevance of palliative care to all patients living with serious chronic illness, including those living with cancer, advanced heart failure, chronic lung disease, or dementia. Relevance for palliative care isn't an issue of 'recognizable dying' because most patients living with serious impairment are at an elevated risk of dying, even though forecasting the timing of it is very imprecise. Palliative care relevance is related to the needs that patients and their families are struggling with. Those issues are related to disease progression and, while functional decline is more predictable with a disease like cancer, that is often not the case in other conditions (3).

responsibility for symptom management and advance care planning may fall to a "system" rather than an individual provider. Because the ACP's guidelines adhere so closely to evidence, the recommendations provide guidance on symptomatic care and advance care planning that such patients and their families should expect to receive at a minimum. In addition, as a tool to aid implementation, the recommendations in these guidelines have already been embodied in quality indicators that can be used to evaluate current practice (4,5).

However, no guideline can cover all of any topic, and the ACP guideline is no exception. For example, because the evidence base supporting specific interventions for care giving, spiritual distress, or bereavement is limited, these topics are not addressed. Unfortunately, good clinicians can't ignore these issues because they are confronted by them daily and will continue to struggle with them. The ACP review also purposefully did not address with much specificity technical interventions for patients living with cancer (e.g., post-chemotherapy nausea and vomiting prophylaxis), areas which do have a large and specific literature base. Clinicians may be interested in guidance on all of these additional topics, because attention to them can have a big impact on cancer patients' quality of life. For these practitioners, supportive and palliative care standards such as those sponsored by the National Comprehensive Cancer Network, the Multinational Association of Supportive Care in Cancer, and similar leading organizations will provide more useful, specific standards (6,7).

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## **Potential Conflicts of Interest**

Dr. Lorenz took part in the research synthesis used to develop the ACP's guideline "Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life."

Dr. Lorenz is a palliative care staff physician in the VA Greater Los Angeles Healthcare systems and adjunct affiliate staff for RAND Corporation. He has also served on the NCQA

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