As the population of aging Americans increases, our nation will inevitably face a healthcare crisis. To meet the increased demands on our healthcare system, we have an opportunity to provide the highest levels of quality care while functioning within the available resources. One such opportunity exists within the philosophy of palliative care. Palliative care services enable individuals with life-limiting illnesses the opportunity to partner with their healthcare providers and receive aggressive management of physical and psychosocial symptoms.

Palliative care, as defined by the US Centers for Medicare and Medicaid Services and National Quality Forum includes “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice (Department of Health and Human Services Centers for Medicare and Medicaid Services, 2008).” This philosophy of care incorporates an interdisciplinary team of board-certified physicians, nurses, social workers, pharmacists, dietitians, and integrative therapists to treat adult and pediatric illnesses such as cancer, neurological disorders, advanced liver and renal disease, and cardiac and respiratory failure. For neonates, children, and adolescents, palliative care includes care for illnesses such as congenital conditions and for developmental and intellectual disabilities.

Palliative care differs from hospice care in that it allows individuals with life-limiting illnesses to seek curative or life-prolonging measures. It can be provided to patients from the point of diagnosis of a life-limiting illness through recovery or into end-of-life care.

In addition to an increased demand for healthcare services, there is also, at end-of-life, a rising cost of care due to a growing population of older adults, the increasing prevalence of chronic illnesses, and the improvement of technology in healthcare. Approximately 25 – 30% of Medicare program benefits are spent providing care at the end of life (Hogan, Lunney, Gable, & Lynn, 2001; Zhang et al., 2009; Peres, 2011). However, there is no positive relationship between spending and quality of care at the end of life (Wennberg, Fisher, Goodman, & Skinner, 2001). For palliative care to be fully embraced, a culture shift within the current United States healthcare environment is necessary. Patients need to be encouraged to participate in their care and treatment decisions, and quality of life should be a primary goal of all medical care. There should be open communication about a patient’s prognosis, not only between healthcare providers and patients but also among the patient’s team of providers. Such communication allows the patient to make better informed decisions and allows the providers to have the same mental model when making treatment decisions.

To shift the culture on a community level, palliative care should be discussed in settings outside of hospitals and medical practices. There is a need to expand the use of available palliative care services and to broaden the community’s awareness of the benefits of these services. Understanding and accepting palliative care at the community level will make it a more acceptable option in the healthcare setting.

Palliative care increases the quality of care for patients and improves the healthcare system by focusing on patient- and family-centered care and not on costs of services. By promoting palliative care, we are advocating for enhanced quality of life and healthcare for everyone.

**References**


