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Recommendation 1: In patients with serious illness at the end of life, clinicians should regularly assess patients for pain, dyspnea, and depression. (Grade: strong recommendation, moderate quality of evidence.)

Recommendation 2: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage pain. For patients with cancer, this includes nonsteroidal anti-inflammatory drugs, opioids, and bisphosphonates. (Grade: strong recommendation, moderate quality of evidence.)

Recommendation 3: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage dyspnea, which include opioids in patients with unrelieved dyspnea and oxygen for short-term relief of hypoxemia. (Grade: strong recommendation, moderate quality of evidence.)

Recommendation 4: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage depression. For patients with cancer, this includes tricyclic antidepressants, selective serotonin reuptake inhibitors, or psychosocial intervention. (Grade: strong recommendation, moderate quality of evidence.)

Recommendation 5: Clinicians should ensure that advance care planning, including completion of advance directives, occurs for all patients with serious illness. (Grade: strong recommendation, low quality of evidence.)

Palliative care at the end of life involves meeting the physical, psychological, social, and practical needs of patients and caregivers. End of life is defined as a phase of life when a person is living with an illness that will worsen and eventually cause death. It is not limited to the short period of time when the person is moribund (1)

Good clinical care can prevent or alleviate suffering for many patients at the end of life by assessing symptoms and providing psychological and social support to the patients and their families.

The purpose of this guideline is to present the available evidence to improve palliative care at the end of life. This guideline does not address any other settings of palliative care at the end of life. The target audience for this guideline is all clinicians caring for patients needing end-of-life care. The target patient population is everyone with seriously disabling or symptomatic chronic conditions at the end of life. These recommendations are based on the systematic evidence review in the background paper in this issue by Lorenz and colleagues (1)

The Institute of Medicine report identified specific gaps related to end-of-life care, such as pain control in advanced cancer and care for patients with advanced organ failure. High-quality evidence on end-of-life care is limited, and most of the evidence is derived from the literature that focused on patients with cancer; therefore, this guideline does not address many important aspects of end-of-life care. For example, nutritional support, complementary and alternative therapies, and spiritual care were not part of the review. If an end-of-life intervention is not addressed in this guideline, it does not mean that no benefit is related to that particular intervention, but it indicates that the intervention has not been sufficiently studied to demonstrate efficacy. Some important topics in end-of-life care, such as interpersonal and social interventions, may be especially difficult to study. The American College of Physicians' End-of-Life Care Consensus Panel has a series of papers related to ethical issues around end-of-life care that can be accessed from its Web site (http://www.acponline.org/ethics/papers.htm

The literature search for this guideline included studies from MEDLINE and reviews of cancer, congestive heart failure, and dementia from the Database of Abstract of Reviews of Effects from January 1990 to November 2005. Citations from the nonsystematic literature were taken from the review by the National Consensus Project for Quality Palliative Care (4)

The objective for this guideline was to answer the following questions:

1. What are the critical elements for clinicians to address when caring for persons coming to the end of life?

2. What do definitions of the end of life suggest about identifying patients who could benefit from palliative approaches?

3. What treatment strategies work well for pain, dyspnea, and depression?

4. What elements are important in advance care planning for patients coming to the end of life?

5. What elements of collaboration and consultation are effective in promoting improved end-of-life care?

6. What elements of assessment and support are effective for serving caregivers, including family, when patients are coming to the end of life?

This guideline grades the evidence and recommendations using the American College of Physicians' clinical practice guidelines grading system, adopted from the classification developed by the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) workgroup (Table

There is a wide range of critical elements for patients nearing the end of life, as well as for their caregivers. Preventing and treating pain and other symptoms; supporting families and caregivers; ensuring the continuity of care; ensuring respect for persons and informed decision making; attending to well-being, including existential and spiritual concerns; and supporting function and survival duration are general issues that are common for most end-of-life care patients (4 11)

The literature review did not identify any evidence-based tools that have been validated and shown to predict the optimal timing to initiate palliative care services. Decisions to initiate palliative care at the end of life should be individualized on the basis of patient symptoms and preferences.

Twelve studies evaluated various interventions for reducing dyspnea in patients with chronic obstructive pulmonary disease, heart failure, cancer, or all conditions. Evidence was mixed when comparing oxygen therapy with room air. One study showed better oxygen saturation, respiratory effort and rate, and dyspnea with oxygen (19)

Depression

Good evidence supports the effectiveness of long-term use of tricyclic antidepressants or selective serotonin reuptake inhibitors, as well as psychosocial interventions (education, cognitive and noncognitive behavioral therapy, informational interventions, and individual and group support) for treating patients with cancer who have depression (12)

In summary, various processes, such as consulting caregivers, enhancing clear communication, eliciting values, and addressing the emotional context, are important elements for comprehensive advance care planning. Clinicians should help patients and families plan in advance for likely or important clinical decisions.

Studies have shown that the following factors improve utilization outcomes and patient-centered outcomes: multidisciplinary teams involving nurses and social services, continuity of care and service coordination, and facilitated communication.

A meta-analysis of 29 randomized, controlled trials done by McAlister and colleagues (34)

In summary, clinicians should routinely and periodically screen adult caregivers for practical and emotional needs while caring for a patient near the end of life. Periodic screening by caregivers for the patient's supportive needs should be a routine part of care for patients with serious chronic illness.

Symptom control, continuity in care, and reducing caregiver burdens are critical elements of care for managing patients nearing the end of life. In addition, following appropriate treatment strategies for pain, dyspnea, and depression substantially affect patients' end-of-life experiences. Interventions where advance care planning includes trained facilitators (including palliative care providers), involves key decision makers, and addresses care across settings are beneficial for improving care. Further research on potentially beneficial but understudied interventions, and conditions other than cancer, should be a high priority.

Recommendation 1: In patients with serious illness at the end of life, clinicians should regularly assess patients for pain, dyspnea, and depression. (Grade: strong recommendation, moderate quality of evidence.)

Patients needing end-of-life care may present with substantial symptoms, including pain; discontinuity in care; and substantial caregiver burdens. These concerns are critically important for patients and families coping with serious chronic illnesses. Although each patient and family will require individualized assessment and care, the evidence shows that a set of general issues is shared widely among patients needing end-of-life care. These issues include pain and other symptom management, psychological well-being, care coordination and advance care planning, and caregiver burden. The evidence was classified as moderate quality because it was mostly derived from studies of patients with cancer or cancer-predominant populations in addition to being heterogeneous.

Recommendation 2: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage pain. For patients with cancer, this includes nonsteroidal anti-inflammatory drugs, opioids, and bisphosphonates. (Grade: strong recommendation, moderate quality of evidence.)

Clinicians should use specific effective therapies for all patients with acute and chronic pain. Strong evidence supports using nonsteroidal anti-inflammatory drugs, opioids, and bisphosphonates for pain relief in patients with cancer. Bisphosphonates are effective for bone pain relief in patients with breast cancer and myeloma.

Recommendation 3: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage dyspnea, which include opioids in patients with unrelieved dyspnea and oxygen for short-term relief of hypoxemia. (Grade: strong recommendation, moderate quality of evidence.)

Opioids should be considered in patients with severe and unrelieved dyspnea, for example, in cancer and cardiopulmonary disease at the end of life. Clinicians should consider the use of oxygen for hypoxemia for advanced chronic obstructive pulmonary disease. Evidence also supports the use of -agonists for treating dyspnea in chronic obstructive pulmonary disease, but this use has not been studied for end-of-life care.

Recommendation 4: In patients with serious illness at the end of life, clinicians should use therapies of proven effectiveness to manage depression. For patients with cancer, this includes tricyclic antidepressants, selective serotonin reuptake inhibitors, or psychosocial intervention. (Grade: strong recommendation, moderate quality of evidence.)

Clinicians should assess for and manage symptoms of depression in patients with serious chronic diseases. For patients with cancer, strong evidence shows that depression should be treated with generally effective therapies, including tricyclic antidepressants, selective serotonin reuptake inhibitors, or psychosocial interventions. Because the strong evidence is derived only from the studies that included patients with cancer and not for all patients at the end of life, it is classified as moderate on average.

Recommendation 5: Clinicians should ensure that advance care planning, including completion of advance directives, occurs for all patients with serious illness. (Grade: strong recommendation, low quality of evidence.)

All care planning must address certain elements, such as surrogate decision makers, resuscitation, and emergency treatment, and should occur as early as possible in the course of serious illness before the end of life. Care planning must anticipate specific issues for each patient's clinical course, for example, the management of dementia, including tube feeding; whether to initiate or continue chemotherapy in patients with cancer; and whether to deactivate implantable cardioverter defibrillators in patients who have intractable congestive heart failure. Care plans should be reassessed when significant clinical change occurs. Moderate evidence supports the effectiveness of multicomponent interventions in increasing advance directives. Research shows that skilled facilitators and a system focusing on various key decision makers, such as patients, caregivers, and providers, as well as improving shared understanding of values are critical in the planning of care.

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Note: Clinical practice guidelines are guides only and may not apply to all patients and all clinical situations. Thus, they are not intended to override clinicians' judgment. All ACP clinical practice guidelines are considered automatically withdrawn or invalid 5 years after publication or once an update has been issued.

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Evidence for Improving Palliative Care at the End of Life: A Systematic Review
Karl A. Lorenz, Joanne Lynn, Sydney M. Dy, Lisa R. Shugarman, Anne Wilkinson, Richard A. Mularski, Sally C. Morton, Ronda G. Hughes, Lara K. Hilton, Margaret Maglione, Shannon L. Rhodes, Cony Rolon, Virginia C. Sun, AND Paul G. Shekelle Annals 2008 148: 147-159. ABSTRACT

February 8 (CNA reporter Chenqingfang Taipei 8 Mar) from the blood to see radical, energy drink water illnesses, detoxifying colon hydrotherapy,

aromatherapy and other anti-allergy therapy, as well as a variety of pending Certification of expensive tests, orthodox medicine has traditionally been labeled alternative medicine: Now, a group of orthodox academics and the medical community of experts to be the origin of teachers, we should take a scientific attitude look at alternative medicine, the only course, does not grant permits for fear of the use of medicine .

The integrated medicine courses from Chinese medicine acupuncture research Tsuei, chairman of the Foundation launched, lecturer groups including: National Taiwan University Provost Lee, the former director of the physics department at Soochow University, Chen, Han Fu Jen Catholic University College of Yangtze River sound, Professor Hong-Yuan Lee of National Taiwan University s civil engineering department, qigong master Feng-Shan Li, the Department of Health Taipei hospital superintendent Huang Kun-Chang, the British medical treatment of qualified lecturers Cangfen aromatic far, the study of life and death, such as writer bell Lu should be nearly 50 people.

LIN Cheng-Kei one of the lecturers was the heart of Tri-Service General Hospital Medicine and Chief Medical Officer, and later to the United States studying natural medicine. He said that he was mindful of the patient, several patients, they did not see the patient to see one, let him alert, but not medical treatment for an illness, a patient fails to remove heart-cooperation with the physician, treatment less effective, Western orthodox medicine abuse.

LIN Cheng-ji said that now the development of integrated medical North Korea has become clear trend, the United States for example, there are 125 medical schools created 76 alternative medicine courses, the National Institutes of Health has also set up alternative medicine research , in 1998 for nearly 1,600 physicians and researchers, the visit will also show that one-third of the patients receive alternative therapies.

Lecturer one of the Tri-Service General Hospital Community Medicine Dr. Chu-feng said, it is undeniable that Taiwan s alternative medicine in the five-indiscriminately, a mess of the situation, some of the test equipment used by the Department of Health without verification, and some on a business equipment and sell energy from the so-called medical equipment or health food market, one college chaos.

Department of Health inspectors Zheng Yizhengchu lecturer is smart, he pointed out that the market wide variety of alternative therapies, some of which have indeed exist scientifically proven efficacy for the people here who, regardless of the medical staff is not, he does not object to these people accept professional medical knowledge.

However, he stressed that to avoid the creation of a medical or encourage acts of medicine, the course will not close down any license awarded, and he wanted to teach the medical laws and regulations in order to give them understanding of alternative therapies which may involve the laws and regulations, so as to avoid illegal.

About the Author

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