available for questions and responsive to intense emotional reactions that sometimes occur. A short condolence card or letter is almost always appreciated. If possible, efforts should be made to follow-up with family members and caregivers deemed at risk for complicated bereavement and grief.

PROSPECTUS FOR THE FUTURE

Palliative care became an officially recognized subspecialty within the United States in 2006. Physicians from 10 specialties can be board certified in hospice and palliative medicine including: family medicine, internal medicine, emergency medicine, pediatrics, physical medicine and rehabilitation, anesthesiology, psychiatry, neurology, radiology, and surgery. As patients live longer with chronic illness, there will be an increasing need to fully integrate palliative care providers and programs within hospitals, nursing homes, and the outpatient setting; and to ensure that all primary care providers and non-palliative specialists develop the skill sets needed to provide basic palliative care. There is a compelling need for research to better define the optimal timing, setting, and delivery of palliative care to improve the quality of life and lessen the suffering of patients and families with advanced illness.

SUGGESTED READINGS

Goldstein NE, Morrison RS, editors: Evidence-Based Practice of Palliative Medicine, Philadelphia, 2013, Elsevier.

Moryl N, Coyle N, Foley KM: Managing an acute pain crisis in a patient with advanced cancer: “This is as much of a crisis as a code”, JAMA 299:1457–1467, 2008.

National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, ed 3, Pittsburgh, PA, 2013. http://www.nationalconsensusproject.org.

Quill TE, Abernethy AP: Generalist plus specialist palliative care–creating a more sustainable model, N Engl J Med 368:1173–1175, 2013.

Quill TE, Holloway RG, Shah MS, et al: Primer of Palliative Care, ed 5, Glenview, 2010, American Academy of Hospice and Palliative Medicine.