TABLE 10-1 TEN LEADING CAUSES OF DEATH IN THE UNITED STATES AND BRITAIN

	United States			Britain	
Cause of Death	Number of Deaths	Percentage of Total	Number of Deaths Among People ≥65 Years of Age	Number of Deaths	Percentage of Total
All deaths	2,468,435	100	1,798,276	499,331	100
Heart disease	597,689	24.2	477,338	141,362	28.3
Malignant neoplasms	574,743	23.3	396,670	142,107	28.5
Chronic lower respiratory diseases	138,080	5.6	118,031	27,132	5.4
Cerebrovascular diseases	129,476	5.2	109,990	35,846	7.2
Accidents	120,859	4.9	41,300	11,256	2.3
Alzheimer's disease	83,494	3.4	82,616	8859	1.8
Diabetes mellitus	69,071	2.8	49,191	4931	1.0
Nephritis, nephritic syndrome, nephrosis	50,476	2.0	41,994	4102	0.8
Influenza and pneumonia	50,097	2.0	42,846	26,138	5.2
Intentional self-harm	38,364	1.6	6008	3671	0.7

Source: National Center for Health Statistics (data for all age groups from 2010), *http://www.cdc.gov/nchs*; National Statistics (England and Wales, 2012), *http://www.statistics.gov.uk*.

many serious conditions are being treated at home or on an outpatient basis. Consequently, providing optimal palliative and end-of-life care requires ensuring that appropriate services are available in a variety of settings, including noninstitutional settings.

HOSPICE AND THE PALLIATIVE CARE FRAMEWORK

Central to this type of care is an interdisciplinary team approach that typically encompasses pain and symptom management, spiritual and psychological care for the patient, and support for family caregivers during the patient's illness and the bereavement period.

Terminally ill patients have a wide variety of advanced diseases, often with multiple symptoms that demand relief, and require noninvasive therapeutic regimens to be delivered in flexible care settings. Fundamental to ensuring quality palliative and end-of-life care is a focus on four broad domains: (1) physical symptoms; (2) psychological symptoms; (3) social needs that include interpersonal relationships, caregiving, and economic concerns; and (4) existential or spiritual needs.

A comprehensive assessment screens for and evaluates needs in each of these four domains. Goals for care are established in discussions with the patient and/or family, based on the assessment in each of the domains. Interventions then are aimed at improving or managing symptoms and needs. Although physicians are responsible for certain interventions, especially technical ones, and for coordinating the interventions, they cannot be responsible for providing all of them. Because failing to address any one of the domains is likely to preclude a good death, a well-coordinated, effectively communicating interdisciplinary team takes on special importance in end-of-life care. Depending on the setting, critical members of the interdisciplinary team will include physicians, nurses, social workers, chaplains, nurse's aides, physical therapists, bereavement counselors, and volunteers.

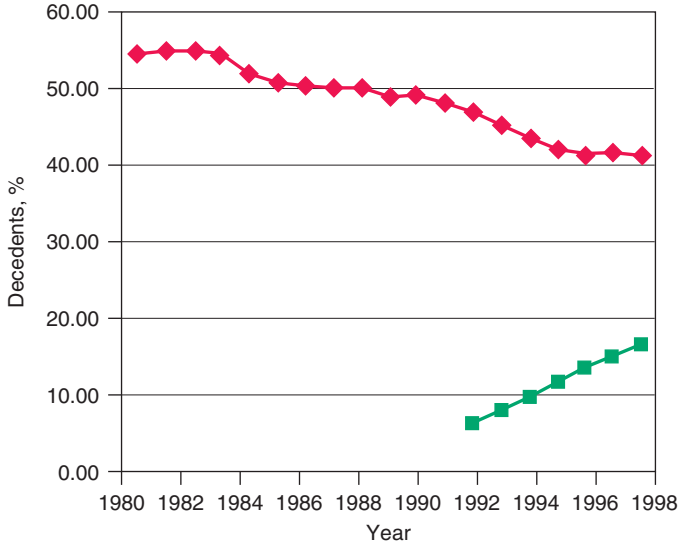

FIGURE 10-1 Graph showing trends in the site of death in the last two decades. ◆, percentage of hospital inpatient deaths; ■, percentage of decedents enrolled in a hospice.

ASSESSMENT AND CARE PLANNING

Comprehensive Assessment Standardized methods for conducting a comprehensive assessment focus on evaluating the patient's condition in all four domains affected by illness: physical, psychological, social, and spiritual. The assessment of physical and mental symptoms should follow a modified version of the traditional medical history and physical examination that emphasizes symptoms. Questions should aim at elucidating symptoms and discerning sources of suffering and gauging how much those symptoms interfere with the patient's quality of life. Standardized assessment is critical. Currently, there are 21 symptom assessment instruments for cancer alone. Further research on and validation of these assessment tools, especially taking into account patient perspectives, could improve their effectiveness. Instruments with good psychometric properties that assess a wide range of symptoms include the Memorial Symptom Assessment Scale (MSAS), the Rotterdam Symptom Checklist, the Worthing Chemotherapy Questionnaire, and the Computerized Symptom Assessment Instrument. These instruments are long and may be useful for initial clinical or for research assessments. Shorter instruments are useful for patients whose performance status does not permit comprehensive assessments. Suitable shorter instruments include the Condensed Memorial Symptom Assessment Scale, the Edmonton Symptom Assessment System, the M.D. Anderson Symptom Assessment Inventory, and the Symptom Distress Scale. Using such instruments ensures that the assessment is comprehensive and does not focus only on pain and a few other physical symptoms. Invasive tests are best avoided in end-of-life care, and even minimally invasive tests should be evaluated carefully for their benefit-to-burden ratio for the patient. Aspects of the physical examination that are uncomfortable and unlikely to yield useful information can be omitted.

Regarding social needs, health care providers should assess the status of important relationships, financial burdens, caregiving needs, and access to medical care. Relevant questions will include the following: *How often is there someone to feel close to? How has this illness been for your family? How has it affected your relationships? How much help do you need with things like getting meals and getting around? How much trouble do you have getting the medical care you need?* In the area of existential needs, providers should assess distress and the