



# Scope of *Annals of Palliative Medicine* based on a review of the disciplinary development and evolving definition of palliative medicine

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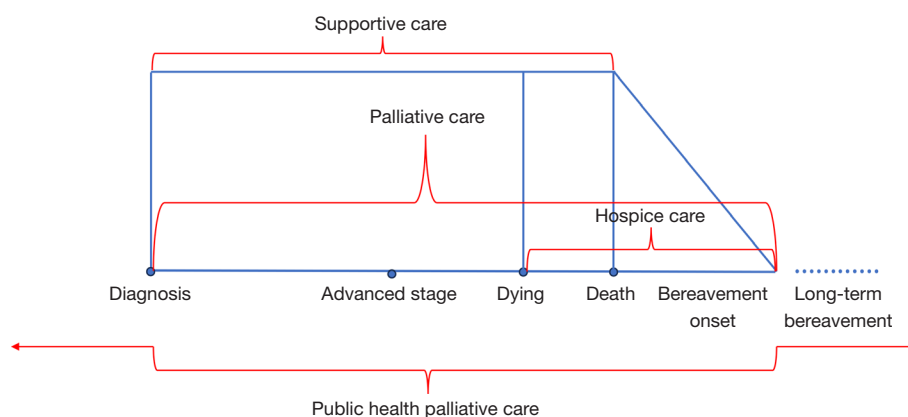
*Annals of Palliative Medicine (APM)* was first established in 2012 and has been indexed in PubMed since 2015 (1) and in Science Citation Index Expanded (SCIE) since 2019 (2). These outstanding accomplishments have been achieved through the joint efforts of our excellent editorial team members, dedicated reviewers, and authors who share their high-quality research. Over the past 11 years, *APM* has adhered to its original mission of “providing up-to-date and cutting-edge information and professional support for health care providers in palliative medicine disciplines to improve the quality of life for patients and their families and caregivers” (3) and has published nearly 3,000 articles in the field of palliative medicine.

However, on February 16, 2023, *APM* received an email from Web of Science informing that they would, for now, defer including *APM*'s articles in Web of Science due to the publication of three articles that they considered to be beyond the scope of palliative medicine (4). After a tracing-back thorough review, the *APM* Editorial Office recognizes that although these three articles have undergone external

peer review, the editorial insight in these three articles was insufficient. Furthermore, the main reason behind this was the editors' different understanding of the scope of *APM*. The *APM* Editorial Office is committed to improving the editorial workflow by strengthening the scope assessment of all articles submitted. In addition, the *APM* Editorial Office has decided to write this editorial, aiming to review the definition and scope of palliative medicine and to further refine and clarify the scope of the *APM* journal.

## History of palliative medicine

When it comes to the origin of palliative medicine, it is inevitable that the discussion of hospice and palliative care is to be included, because palliative medicine has gradually developed from these two concepts. Physician and tuberculosis expert Edward Livingston Trudeau [1848–1915] wrote, “*To Cure Sometime, To Relieve Often, To Comfort Always*”, underscoring the limitations of medicine and that we must accept that medicine cannot cure all



**Figure 1** Relationships between public health palliative care (community partnerships, policies, & actions), palliative care (health & social care services), supportive care (health & social care services) and hospice care (health & social care services).

diseases. Healthcare providers have always recognized and emphasized the humanistic spirit inherent to medical practice, even when facing critically ill patients with little hope of recovery, and doctors should try their best to alleviate their pain or any unnecessary suffering of both the patients and the family caregivers. In 1967, Dame Cicely Saunders opened the world's first hospice care institution in London—to provide hospice care for patients with advanced malignant diseases (5). In 1974, Dr. Balfour Mount was believed to have coined the term “palliative care” to further expand the scope of care. Palliative care was envisioned not only to include hospice care, but also to provide a wider range of care from as early as the time of diagnosis of a serious illness and concurrently with curative or life-prolonging treatment (5) (Figure 1). Later, the development of palliative care in the 20<sup>th</sup> century recognized the needs of patients with other long-term chronic, serious, and life-limiting illnesses. Palliative care has grown tremendously over the past decades and has been officially recognized and integrated into healthcare systems globally (6,7).

## Definition and scope of palliative medicine

### *What is palliative medicine?*

In the decades since the establishment of the discipline in 1987, the scope of palliative medicine has evolved, and there is no one dominant definition of palliative medicine (8-13) (Table 1). Furthermore, as of June 2023, a direct definition of palliative medicine has not been identifiable in Cambridge Dictionary (14), Oxford Dictionaries (15), nor Merriam-Webster-Medical (16). Among the few definitions

of palliative medicine, we found that the definitions have evolved and broadened to reflect the growing scope of the field.

In the 2<sup>nd</sup> edition of the *Oxford Textbook of Palliative Medicine* published in 2003, palliative medicine was defined as “*Palliative medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life. This definition is for the specialty practiced by doctors. When describing the care offered by a team of doctors, nurses, therapists, social workers, clergy, and volunteers, it is more correct to refer to palliative care*” (17). This definition limits palliative medicine to practice solely by physicians and clearly distinguishes between palliative care and palliative medicine based on the boundaries, types, and number of care providers. However, the 3<sup>rd</sup> edition of the *Textbook of Palliative Medicine and Supportive Care* (published in 2021) (18) divides the practice of palliative medicine into three categories: primary palliative care, secondary palliative care, and tertiary palliative care. Specifically, primary palliative care can be provided by any primary care physicians, specialists or healthcare providers, including oncologists, cardiologists, intensive care physicians, etc.; secondary palliative care deals with more complex problems that cannot readily be handled by primary care physicians and often requires consultation from a professional palliative care team supporting a primary care provider; tertiary palliative care specifically deals with situations that cannot be well controlled by primary care providers and treatment that is transferred to an inter-disciplinary palliative care team.

The *APM* journal has been adopting the broadened definitions and scope of palliative medicine. Palliative

**Table 1** Definitions of palliative care

Source	Definition
WHO (8)	<i>“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”</i>
IAHPC (9)	<i>“Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers.”</i>
EAPC (10)	<i>“Palliative care is the active, total care of patients whose disease is not responsive to curative treatment. Palliative care takes a holistic approach, addressing physical, psychosocial, and spiritual care, including the treatment of pain and other symptoms. Palliative care is interdisciplinary in its approach and encompasses the care of the patient and their family and should be available in any location including hospital, hospice, and community.”</i>
NCP (11)	<i>“Palliative care means patient and family entered 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 to facilitate patient autonomy, access to information, and choice.”</i>
CAPC (12)	<i>“Palliative care is specialized medical care for people with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of palliative care doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness’s and can be provided along with curative treatment.”</i>
PHPCI (13)	<i>“Death, dying, loss and care is everyone’s responsibility. A public health approach to palliative care views the community as an equal partner in the long and complex task of providing quality healthcare at the end of life.”</i>

WHO, World Health Organization; IAHPC, International Association for Hospice and Palliative Care; EAPC, European Association of Palliative Care; NCP, National Consensus Project for Quality Palliative Care; CAPC, Center to Advance Palliative Care; PHPCI, Public Health Palliative Care International.

medicine and palliative care are interdependent and, in many ways, interchangeable. Such an idea is consistent with *APM*’s mission to *“provide up-to-date and cutting-edge information and professional support for healthcare providers in palliative medicine disciplines to improve the quality of life for patients and their families and caregivers”* (3), which exemplifies the fact that *APM* not only provides support and content for physicians, but also provides support for a more expanded group of palliative health and social care providers and participants. Such a view embraces the notion that palliative healthcare is best provided by a team of interdisciplinary professionals in partnership with the community (19).

*Table 1* summarizes some of the definitions from various international palliative care organizations (8-13). These definitions are highly consistent in their goals for palliative care, all aiming at improving symptom management and quality of life. There is also a basic agreement on the interventions involved. Furthermore, it is emphasized consistently that palliative care is interdisciplinary and requires teamwork. However, there are subtle differences in the wording of which populations and stages of diseases

palliative care efforts are focused on. The International Association of Hospice & Palliative Care (IAHPC) definition covers the most inclusive population across patients, families, and caregivers (9). The other definitions generally focus more on emphasizing patients and families. In terms of disease stages, the World Health Organization emphasizes life-threatening illness (8), whereas IAHPC, National Consensus Project for Quality Palliative Care and United States-based Center to Advance Palliative Care are broader, emphasizing not only life-threatening illness but also other serious illnesses (11,12). The European Association of Palliative Care approaches the scope of disease from the perspective of any disease not responsive to curative treatment (10). In addition, the Public Health Palliative Care International highlights the equal responsibility of different players (e.g., citizens and professionals) and settings (e.g., schools, workplaces, neighborhoods) in society in providing quality social care for end-of-life experiences throughout the life course (13).

Despite the many definitions, we can see that the scope of palliative medicine and palliative care have continued to evolve. By thorough review and synthesizing the meanings

in *Table 1*, we can observe that:

- ❖ Palliative care is an active total and specialized care for individuals across all ages with serious health-related suffering due to severe illness, and especially of those whose disease is not responsive or amenable to curative treatment and/or have life-threatening illness or are at the end of life.
- ❖ The goal of palliative care is to improve the quality of life and relieve suffering of such patients, and that of their families and caregivers.
- ❖ Palliative care is interdisciplinary and is provided by a team of palliative care physicians, advanced practice providers, nurses, pharmacists, dietitians, social workers, spiritual care providers, volunteers, and other specialists who work together with the patient's primary care physicians or specialists to provide an extra layer of support.
- ❖ Palliative care focuses on anticipating, preventing, and treating physical, psychosocial, social, and spiritual suffering while at the same time maximizing the conditions for the promotion of health and wellbeing at the end of life.

#### ***How are palliative medicine/palliative care, hospice care and supportive care related?***

Despite the fact that the definition and scope of palliative medicine are becoming more comprehensive, the frequent use of hospice care and supportive care interchangeable with palliative medicine or palliative care creates confusion in the healthcare community. *Figure 1* briefly summarizes the relations among these different distinctions.

In terms of hospice care, the field has generally reached a consensus that it is considered a subarea of palliative care (20). As mentioned, "*Hospice care is often related to a prognosis of six months or less and focused on care at the end of life, while palliative care can be provided to patients at any time, at any stage of illness*" in conjunction with curative or disease modifying therapy (10). However, people's understanding of the newly emerging term supportive care differs. Some experts believe that supportive care can be used interchangeably with palliative care to describe palliative treatment services (21). Others believe that although supportive care programs provide services that overlap with palliative care, supportive care does not necessarily focus on end-of-life care, which is typically prioritized by palliative care (20,22). *Figure 1* reflects the latter of the two views on supportive care.

#### ***How are palliative medicine/palliative care and public health palliative care related?***

According to the mission statement of Public Health Palliative Care International (13), "*the experiences of death, dying, loss and care is everyone's responsibility. A public health approach to palliative care views the community as an equal partner in the long and complex task of providing quality healthcare at the end of life*". Under this understanding of palliative care, community is the primary support for patients, families, caregivers, and palliative care services through policy and practices inside the civic sector—from neighborhoods, schools, workplaces and faith groups, to public activities such as festivals, public education, community development and engagement, to civic policy development, to partnerships between communities and health and social care professionals. Community partnerships are crucial to the success of the dual palliative care goals of quality and continuity of care (23). This public health model stresses the importance of social supports before diagnosis, alongside the journey of serious illness and death, and in the long-term future of bereavement and caregiver supports.

The challenges of communication, patient and family support, and ongoing bereavement and caregiver support are best addressed within the immediate contexts of the everyday life of the patient, their family, and their caregivers (24). Palliative care problems that have their sources (and solutions) within the social world—loneliness, social isolation, financial troubles, job loss, lost school days, stigma and social rejection, or premature deaths and suicide—are amenable to prevention, harm reduction, and early intervention. Public health interventions in palliative care are integral to addressing this social epidemiology and underpin and support the more explicit work of clinical palliative care services by physicians and clinical teams. Furthermore, palliative care is not solely about symptomatic control of illness and disease, but it is also the promotion of health and wellbeing in patients, families, and caregivers even at the end of life. The promotion of health and wellbeing is recognized by modern public health to be without clinical boundaries as people living with disabilities, aging, injury, chronic illness, and life-threatening or life-limiting illness have a right to health and wellbeing (25). Public health palliative care supports this approach through its advocacy of prevention sciences for addressing the social morbidities associated with dying, aging, death, and grief and bereavement. These are experiences and challenges

not only within the final six months of life but that extend throughout the whole lifespan, long before diagnosis and well after the initial onset of bereavement.

### Scope of APM

From our comprehensive review of the literature, and based on the guidelines of international governing bodies, it is evident that palliative medicine not only includes hospice care services and supportive care services but also overlaps with the equally important community-oriented emphases of public health palliative care. It covers specialized medical care for individuals across all ages with serious health-related suffering during potential treatable critically-ill patients, and it also encompasses care for those whose disease is not responsive or amenable to curative treatment, including those with life-threatening illness or who are at the end of life. Palliative medicine is also inclusive of traditional public health considerations especially when these concern social troubles and challenges as well as the goals of health and wellbeing at the end of life.

Given such a broad and general scope of palliative medicine, we would like to define the areas that the *APM* journal will focus on in the future to provide clearer guidance to authors, readers, reviewers, and editors.

The *APM* journal is a comprehensive journal focused on palliative medicine, and the scope of *APM* encompasses supportive care, palliative care, hospice care and public health palliative care. We will specifically solicit articles pertaining to serious or life-threatening diseases to focus on the supportive, palliative, hospice, and public health aspects of medicine and care related to these conditions.

Below are eight sections of *APM*:

- ❖ *Palliative medicine and palliative care for incurable cancer*: including, but are not limited to advanced lung cancer, advanced breast cancer, advanced colon cancer, advanced pancreatic cancer, advanced liver cancer, advanced gastrointestinal cancer, advanced cervical cancer, incurable hematological malignancies, and multiple metastatic cancer.
- ❖ *Palliative medicine and palliative care for serious or advanced diseases*: including, but are not limited to dementia, multiple sclerosis and other neurodegenerative diseases, severe aortic stenosis or heart failure, acquired immune deficiency syndrome, chronic or end-stage lung disease, chronic or end-stage liver disease, chronic or end-stage kidney disease, and other uncontrolled situations requiring

intensive care.

- ❖ *Symptom management in palliative medicine and palliative care*: including, but are not limited to pain assessment and management, difficulty in swallowing, nausea and vomiting, constipation and diarrhea, anorexia and weight loss, hiccups, ulcers, difficulty in breathing, coughing, lymphedema, difficulty in urinating, fatigue and weakness, sleep disorders, bleeding, and thrombotic complications.
- ❖ *Psychiatric, psychological, social, and spiritual issues in palliative medicine and palliative care*: including, but are not limited to depression, fear, anxiety, loss of dignity, delirium, social and cultural differences, loss of meaning and purpose, existential issues, and bereavement.
- ❖ *Public health in palliative medicine and palliative care*: including, but are not limited to evidence-based advanced care planning, role of community support and engagement, challenges of equity, diversity and inclusion, challenges of continuity of care, caregiver and bereavement social support, public education and civic policy development, job and financial losses, and religious and cultural meaning.
- ❖ *Teamwork and education in palliative medicine and palliative care*: including, but are not limited to the professional roles, collaboration and training of physicians/nurses/pharmacists/nutritionists/radiologists/physiotherapists/social workers/spiritual care providers/volunteers, discussions on prevention and management of burnout and compassion fatigue among healthcare providers.
- ❖ *Ethics and policy in palliative medicine and palliative care*: including, but are not limited to human rights, ethical dilemmas, euthanasia, do not resuscitate orders and family decision making, and withholding and withdrawing life-sustaining treatment.
- ❖ *Communication in palliative medicine and palliative care*: including, but are not limited to communication skills with patients and families, difficult conversation scenarios, truth-telling and consent, and communication in multicultural contexts.

### Summary and next steps

In summary, palliative medicine has developed into a discipline with a broad scope, encompassing both hospice care and supportive care for patients who are critically ill and who are or are not terminal. In addition, palliative



medicine covers palliative care at all stages of various serious and life-threatening diseases and end-of-life situations. The scope of the *APM* journal includes all domains of palliative medicine and focuses on the above eight sections. Looking backward, *APM* had published three articles that went beyond the scope of this refined definition of palliative medicine, reflecting areas for future improvement in the editorial workflow. Moving forward, *APM* will strengthen its editorial training and will add a mandatory review process to ensure that the submitted articles are relevant to the scope of the journal. *APM* will also continually reassess the scope of palliative medicine with its increasing emphasis on symptom management and supportive care given by palliative care and the more expanded healthcare providers. Finally, we would like to take this opportunity to express our gratitude to all editorial teams, reviewers, authors, and readers for their support of *APM*. We trust that the clarification of the journal's scope and the enhancements in editorial policy will contribute to the further development of *APM* as a premier journal in the field of palliative medicine.

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