



End-of-life Care, Comfort Care, and Hospice: Terms and Concepts

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Purpose: This study aims to clarify and standardize the terms and concepts associated with end-of-life care, specifically within the contexts of hospice and palliative care. **Methods:** We reviewed references pertaining to hospice and palliative care, including definitions of end-of-life care and comfort care. Two meetings were held with members of the medical terminology committee of the Korean Society for Hospice and Palliative Care, along with experts in the field, to establish a consensus on the terms used. In the first round, six experts participated, and in the second round, eight experts engaged in online meetings to brainstorm, exchange opinions, and review and discuss reference materials concerning terms related to hospice and palliative care. **Results:** Legal definitions do not always align with those used in clinical medical settings. Although it is challenging to define the period precisely, end-of-life care encompasses all diseases, including age-related infirmities, typically spanning 6 months to 1 year. Hospice care, in contrast, includes certain non-cancerous terminal diseases as well as terminal cancer, covering a period of 3 to 6 months. Comfort care generally refers to the care provided approximately 7 days before death. **Conclusion:** A conceptual understanding of terms related to end-of-life care must be reached through cultural and social consensus. Furthermore, end-of-life care should not be limited to cancer but extended to all diseases. In the future, the scope of end-of-life care should expand to encompass care for bereaved families, evolving into a more comprehensive concept of comfort care.

Key Words: Hospice care, Palliative care, Terminal care

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INTRODUCTION

Advances in science and medicine have uncovered previously unknown pathophysiological conditions of diseases, enabling the curing of diseases and extension of life, thereby gradually increasing life expectancy. This rise in life expectancy, coupled with a declining birth rate, is contributing to an aging society. As living beings, humans are inherently destined to face death. Despite our efforts to maintain health and enhance life's

value, we cannot completely halt the progression of aging or disease, and daily life progressively becomes more challenging. It is noted that the concept of hospice in Korea was first introduced at Gangneung Calvary Hospital [1]. Therefore, many people ultimately rely on hospitals or nursing homes, including hospice care, toward the end of their lives.

As a result, improving the quality of end-of-life care services has emerged as an important task, particularly as mortality rates from diseases requiring such care have risen significantly

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in Organization for Economic Co-operation and Development countries between 2001 and 2017 [2]. This trend is also evident in Korea, where public interest in the discontinuation or withholding of life-sustaining treatment has grown following high-profile cases such as the Boramae Hospital incident and the Severance Grandmother Kim incident. These events led to the enactment of the 2016 “Hospice/Palliative Care and Life-Sustaining Treatment Decisions for Patients in the Dying Process” (hereinafter referred to as the “Life-Sustaining Treatment Decision Act”). Following this, hospice palliative care services were expanded to include terminal illnesses beyond cancer. However, the provision of care remains predominantly focused on terminal cancer patients [3]. Specifically, regional cancer centers lack hospice wards for the hospitalization of terminally ill patients who do not have cancer, forcing these patients to receive care in general wards during their end-of-life process.

Because terms and concepts related to end-of-life care are often understood and applied based on personal judgment, and due to the lack of academic or social consensus, communication with patients in the medical field can be challenging, leading to confusion in treatment.

The provision of end-of-life care, which should be established through cultural and social consensus, often takes priority over legal definitions. Furthermore, legal definitions of terms may not align with those used in clinical medical settings, particularly in hospice care. Therefore, we have decided to organize the terms and concepts associated with end-of-life care in the context of hospice and palliative care, including relevant time periods.

METHODS

To clarify and standardize terminology related to hospice and palliative care, we conducted a comprehensive review of textbooks, academic references, and definitions in the Life-Sustaining Treatment Act enacted in Korea, including terms such as palliative care, hospice, end-of-life care, and comfort care [4–10]. This process involved organizing two meetings with experts.

The first meeting was attended by six individuals: five members from the medical terminology committee of the Korean Society for Hospice and Palliative Care, and one researcher

engaged in a hospice terminology-related project. Their objective was to outline and draft the conceptual definitions of terms associated with hospice and palliative care.

The second meeting featured a more diverse panel, including a member of the Medical Terminology Committee of the Korean Society for Hospice and Palliative Care, a researcher engaged in a hospice terminology-related project, a legal expert with a PhD in law, two physicians, two nurses practicing in hospice and palliative care, and a social worker. This group reviewed the outcomes from the first meeting and gathered opinions through consultations on the legal concepts and terminology related to the requirements and targets of hospice and palliative care as outlined in the Act on Decisions on End-of-Life Treatment. Both meetings were conducted online to enhance brainstorming, discussion, and the review of reference materials.

RESULTS

The terminal stage is defined as a period during which the patient’s function is significantly impaired, serious complications are present, and the likelihood of death from the disease is very high. The concepts of “end of life,” “hospice,” and “comfort care” (care in the last days of life) are similar, yet they vary by country in terms of duration and the diseases they encompass. “End of life” may involve chronic disease progression, acute disease, or terminal cancer unresponsive to chemotherapy. This period can range from several years to several months before death, with variations also seen in the financial aspects of care (Table 1). End-of-life care is administered by a general medical team and can be applied to patients with all diseases, including age-related infirmities. The care targets the patient and can be provided in hospitals, nursing homes, or at home, depending on the patient’s and their family’s financial and social circumstances. Essentially, end-of-life care pertains to the terminal stages of all diseases and should be recognized as a comprehensive concept. Hospice care is provided to patients with terminal cancer or terminal illnesses and their families 3–6 months before death. In Korea, care services vary and include inpatient, home-based, and advisory services. This care can be delivered in hospitals, nursing hospitals, nursing homes, and private homes. It involves hospice specialists and

Table 1. Concepts of End-of-life Care, Hospice Care, and Comfort Care.

Category	End-of-life care	Hospice care	Comfort care/ Care in the last days of life
Period (before death)	6~12 months	3~6 months	7 days
Care givers	General medical care team	Hospice team	General medical care team
Diseases	All diseases	Cancer and some other diseases	All diseases
Caring subject	Patient	Patient and their family	Patient
Care place	Hospital, home, nursing home	Hospital, home, nursing home	Hospital, home, nursing home
Service contents			
Symptom control	○	○	○
Interdisciplinary approach		○	
End-of-life care	○	○	
Bereavement care		○	

multidisciplinary teams and includes bereavement care. Diverse opinions exist regarding the timing of death and end-of-life care. While it is impossible to predict the exact timing of death accurately, predictions are made based on physical signs, changes in consciousness, breathing patterns, and urine output. Comfort care is applicable to all diseases, including age-related infirmities. It is defined in various ways, ranging from several days to several months. However, it is widely believed that general medical staff should be the primary caregivers, with symptom control as the main focus of care, ideally starting about one week before death.

DISCUSSION

As interest in topics such as hospice and palliative care, care for terminally ill patients, and well-dying has grown, the Life-Sustaining Treatment Decision Act was enacted, subsequently revised, and implemented. Despite this, definitions of relevant terms continue to vary among individuals, and opinions on these matters remain diverse. Therefore, considerable research on end-of-life care is currently underway [11,12]. Although the Life-Sustaining Treatment Decision Act provides a definition, many aspects are left to the discretion of medical staff, leading to variations in interpretation among individual medical practitioners.

The concept of palliative care originated from the modern hospice movement and was further developed by the World Health Organization (WHO) to address the challenges faced by patients and their families dealing with pain and a range of physical, psychosocial, and spiritual issues associated with life-

threatening illnesses. It is defined as a medical specialty aimed at improving quality of life by early detection, prevention, and relief of pain through proper assessment and treatment, representing a broader scope than traditional hospice care. Hospice and palliative care primarily evolved to serve terminal cancer patients. In Korea, however, conditions such as AIDS, chronic obstructive pulmonary disease, and liver cirrhosis also qualify for hospice care. The definition of the dying process remains vague, spanning from several months to a few weeks. This ambiguity complicates the completion of legal documents in the medical field [3].

The definition of end-of-life care extends beyond specific diseases, encompassing a broader range of concepts and financial support that vary from country to country. It is considered a more comprehensive concept than hospice care. The demand for end-of-life care is growing due to an aging population and shifts in the causes of death [12].

Comfort, derived from the Latin word “confortare,” encompasses a range of meanings including to fortify, corroborate, provide, console, relieve, take care, help, and assist. It is a complex and multidimensional construct, characterized as a subjective, positive, and individual experience. This experience can occur in contexts related to an individual’s illness and/or treatment, with the ultimate goal being to improve patient care [13]. The term “patients receiving comfort care” refers to individuals experiencing acute deterioration of chronic organ failure due to cancer, chronic disease, or an accident, with no prospects for recovery. These patients do not improve despite receiving treatment, their symptoms rapidly worsen, or they are expected to die within a few days or during the current

hospital stay. This definition also includes patients with slowly progressing terminal illnesses, such as those with brain damage and dementia [14,15].

“Comfort care” refers to a holistic approach designed to prevent and manage pain for both the patient and their family during the dying process. The duration of end-of-life care can vary widely, ranging from a few days to several months. Nonetheless, guidelines for end-of-life care typically focus on the month preceding death, although there is a prevalent view that it should last about a week [14].

Even in the UK, where hospice care was first introduced in the 1960s, a national end-of-life care strategy was announced in 2008. This strategy laid the foundation for providing hospice and palliative care to all terminally ill patients, thereby ensuring end-of-life care for everyone [16].

In emergency rooms and intensive care units, effective communication about comprehensive comfort care among medical staff, patients, and their families is a crucial factor in the treatment of terminally ill patients [17,18].

In Korea, the rise in life expectancy and evolving family dynamics have led to an increase in single-person households and older adults living alone. Consequently, there is an anticipated growth in the need for end-of-life care. This will necessitate greater financial support for end-of-life care. Additionally, enhanced publicity and legal support are essential to address the challenges posed by the discontinuation of life-sustaining treatment for these individuals, as currently outlined in the Life-Sustaining Treatment Decision Act [3].

CONCLUSION

The definitions of terms in the Life-Sustaining Treat-

ment Decision Act and those commonly accepted by medical professionals vary slightly. Although it is challenging to define these periods precisely, the concept of end-of-life care generally encompasses all diseases, including age-related infirmities, typically covering a period of about 6 months to 1 year. Hospice care, on the other hand, includes certain non-cancerous terminal diseases as well as terminal cancer, with a duration ranging from 3 to 6 months. Comfort care is usually considered to be appropriate for the final 7 days before death and is deemed increasingly necessary for all diseases, including cancer. Looking ahead, it is suggested that the management of bereaved families should be more comprehensively integrated into end-of-life care, which should be viewed as an expanded concept of comfort care.

CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

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Conception or design of the work: JSH, HJK. Data collection: JSH. Data analysis and interpretation: JSH, HJK. Drafting the article: JSH, HJK. Final approval of the version to be published: all authors.

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