EDITOR'S MEMO

We are examining the evolution and delivery of palliative care to patients with pulmonary hypertension (PH) and pulmonary arterial hypertension (PAH) in this issue of *Advances in Pulmonary Hypertension*. This is an important topic since many of our patients have either reached a point at which quality of life is limited (either by the disease itself or by complications of the medications), medical therapy is no longer effective, or transplantation is not an option. Yet, we, like physicians in other areas of medicine, often wait too long to consult our palliative care colleagues, thereby depriving our patients of needed care and relief.

I thank Chris Barnett and Hunter Groninger for serving as guest editors for this issue. They have assembled an outstanding group of contributors and have covered the subject exceedingly well. Using an incredible case (and it *is* a real case) as the starting point, we have tried to demonstrate multiple places at which palliative care might have been appropriate for this patient. I think this case illustrates many of the current problems and misconceptions of palliative care—many of us still think of palliative care as giving up and only consider it at the end of life (see Sean Studer's "Ask the Expert" for a very astute evaluation of this). Whether this reflects our own biases, our inability to admit that sometimes we cannot help patients, or just poor marketing, palliative care is not "just" an end-of-life service—nor should it ever be thought of as such; it needs to be considered much sooner in our care of patients. We should integrate palliative care into our care of PAH patients; it will benefit both our thinking and the care of the patient. Chris, Hunter, and I hope you enjoy reading this issue and that it forces you to contemplate how and when to use palliative care more effectively in your care for these complex patients.

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GUEST EDITORS' MEMO

It is uncommon, if not downright rare, that a novel intervention in health care has the capacity to improve medical care quality and lower its cost at the same time—but such has been the slow but steady path of hospice and palliative care. Although still evolving, the field's evidence base continues to support what its leaders have been speaking and writing for decades: there is a science to pain/symptom management; patient-family-provider communication is an intervention deserving of training that can lead to better clinical outcomes; people with serious illness suffer physically, emotionally, socially, and spiritually—alleviating their distress requires an expert interdisciplinary approach.

Hospice and palliative care—a field that prioritizes patient-centered quality of life as much as or more than longevity—is growing up from childhood into adolescence; its reach now extends from the realms of oncology and geriatrics where it took shape in the United States to other chronic progressive diseases such as heart failure, kidney failure, or advanced pulmonary disease. Pulmonary hypertension, in all its forms, is also such a disease constellation that can inflict great distress on our patients and their families.

The best palliative medicine models of care delivery are highly collaborative. By intention, this special issue aims to practice what it preaches: we have paired experts in pulmonary hypertension with palliative care, to explore how we might align relief of suffering and clarifying goals with cutting-edge disease-modifying therapies earlier and better. We hope that readers will consider looking at the pulmonary hypertension disease experience through a palliative lens to the benefit of those we serve.

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