The body of research addressing the palliative care—oncology collaboration continues to accumulate; however, sustained efforts are needed to ensure that we are providing the best possible care for our patients.

Palliative care is increasingly recognized as an essential component of quality oncology care. Despite growing evidence to support the role of palliative care in the oncology setting,[1] the integration of this complementary specialty into standard oncology practice has been slow to evolve. In their article, Drs. Ramchandran and Von Roenn describe palliative care and its role in oncology, as well as the challenges faced when integrating palliative care into oncology care. Overcoming these barriers to integration remains a formidable challenge for palliative and oncology practitioners alike and is an area of intense interest and ongoing research.

One of the first barriers mentioned by the authors is the challenge in identifying which components of the palliative care intervention are necessary to produce the benefits experienced by patients and their families. In a table, they list seven randomized trials that have evaluated the use of palliative care in patients with advanced illness. Notably, each palliative intervention was different in terms of setting, personnel, and interventional technique. These variations highlight the lack of a "standardized" palliative intervention. Despite this limitation, it is well accepted that palliative interventions derive much of their success from a fundamentally patient-centered, rather than illness-centered, approach to care. With a patient-centered focus, the physical, psychological, spiritual, and social needs of patients, as well as the needs of their caregivers, are addressed.[2] This comprehensive approach to care requires the expertise of specialists from multiple disciplines, including physicians, nurses, social workers, chaplains, and therapists. The ideal palliative team would have each discipline represented; however, the lack of financial and educational resources often limits the ability to provide such a comprehensive team. Even some of the palliative interventions listed in the Table lacked a true interdisciplinary team, yet were successful. Thus, attempting to integrate palliative care into oncology care is still a worthwhile endeavor even when resources are limited. Consensus projects such as the National Consensus Project (NCP) Guidelines,[3] and the National Quality Forum (NQF) Preferred Practices[4] are working to create an evidence-based standard for high quality palliative care. These tools will help decrease variability in palliative care delivery and guide a more standardized approach to palliative care.

As aptly asserted by Drs. Ramchandran and Von Roenn, oncology care occurs primarily in the ambulatory setting; therefore, developing an outpatient model of integration is critical to the palliative care—oncology collaboration. However, we have limited data to guide this endeavor. Of the examples listed in the article, Muir and colleagues' embedded model represents an achievable outpatient prototype with unique advantages that optimize collaboration. By utilizing the same clinic space and hours, the potential for timely communication among palliative and oncology providers is greatly enhanced. Feasibility of integration is further enabled by eliminating the need for a separate palliative clinic location and personnel. Furthermore, convenience for patients is increased by providing complementary services under one roof, optimally during the same visit. Muir and colleagues demonstrated improvement in patient symptoms as well as high oncologist satisfaction with the embedded palliative care intervention. Each palliative referral saved a significant amount of the referring oncologist's time, which presumably would have been spent focused on palliative issues. A reasonable patient load (two new patients and four to six follow-ups per clinic half-day) was all that was required for palliative consultants to compensate for the clinic time and space used, as well as for their salaries.[5] Although further study is needed, an embedded palliative clinic may provide a realistic solution to outpatient integration in many clinical settings.

Drs. Ramchandran and Von Roenn acknowledge the lack of palliative care education and negative perceptions of palliative care as fundamental barriers to the integration of palliative care into
oncology care. A better understanding of these barriers will help further the paradigm shift described in her article. In a poll commissioned by the Center to Advance Palliative Care (CAPC), over 70% of respondents were "not knowledgeable at all" about palliative care. Despite this lack of public knowledge, once educated on the role and benefits of palliative care, those same respondents were overwhelmingly in favor of using its services: 95% agreed that patients with serious illness and their families should be educated about palliative care, and 92% would consider palliative care for a loved one with a serious illness.[6] In a separate poll, a quarter of physicians indicated they were reluctant to recommend palliative care despite overwhelming agreement with the statement "it is more important to enhance the quality of life for seriously ill patients." This reluctance was out of concern that patients would perceive that their doctors were not doing everything possible to extend their lives.[7] Such sentiments are consistent with CAPC care opinion data indicating that most physicians essentially equate palliative care with end-of-life care.[6] This widespread misunderstanding limits access to palliative care earlier in the disease trajectory, often to the detriment of patients, as illustrated in the case discussion by Drs. Ramchandran and Von Roenn. Improving palliative care education in medical school, residency, and fellowship training, as well as in continuing medical education, is crucial to overcoming the knowledge barrier among providers. Moreover, training physicians to be able to provide "primary" palliative care is essential and is of particular importance in oncology.

As illustrated by Drs. Ramchandran and Von Roenn, the palliative care–oncology integration benefits patients by improving quality of life, symptoms, mood, and caregiver burden—and even extends life in some cases. It has also been shown that oncologists are highly satisfied with palliative care integration into their clinic.[5] This review has addressed some of the major barriers to integration, including lack of standardized palliative interventions and of outpatient integrated models, as well as poor patient and provider understanding of palliative care. We recognize that additional significant barriers exist to ensuring quality palliative care for all patients,[8] including cancer patients. The body of research addressing the palliative care–oncology collaboration continues to accumulate; however, sustained efforts are needed to ensure that we are providing the best possible care for our patients.

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