

Haematology and palliative medicine: moving forward

Pam McGrath

Griffith Health Institute, Griffith University, Brisbane, Queensland, Australia

Corresponding to: Pam McGrath, Senior Research Fellow, Griffith University, PO Box 1307, Kenmore, Brisbane, Queensland 4069, Australia. Email: p.mcgrath@griffith.edu.au.

Abstract: The documentation of details on the provision of medical care for haematology patients in the palliative care setting not only provides useful baseline information for clinical consideration and debate, but signals that the scholarship in this area has come of age. Previously the research literature predominantly centred on the question of whether palliative medicine could or should be integrated into the care of haematology patients. The assumption is now in the affirmative and the concern becomes how best to effectively achieve this end.

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Cheng and associates (1) are to be congratulated for their contribution to the emerging literature on the integration of palliative care and haematology. Their paper, *Intensive palliative care for patients with haematological cancer dying in hospice: Analysis of the level of Medical Care in the final week of life*, provides an important new dimension to the literature in this area. The documentation of details on the provision of medical care in the palliative care setting not only provides useful baseline information for clinical consideration and debate, but signals that the scholarship in this area has come of age. The focus for research literature has taken an important step forward. Previously the research literature predominantly centred on the question of whether palliative medicine could or should be integrated into the care of haematology patients. The assumption is now in the affirmative and the concern becomes how best to effectively achieve this end. The sharing of descriptive clinical information on the provision of medical care in the palliative setting extends the analysis of integration to considerations of what is present practice and how this can be refined.

The modern discipline of palliative medicine originated from the inspiring leadership of Dame Cecily Saunders in her work with St Christopher's Hospice in London (2). For decades, the benefits of palliative care were almost exclusively provided to cancer patients. It is only in recent

years that attention has turned to the diversity of non-cancer diagnostic groups (3). However, the historical prioritisation of cancer care at the centre of palliative medicine did not guarantee those diagnosed with a haematological malignancy were assured of referral, timely or otherwise. For decades, a key concern has been that patients with a haematological malignancy were most likely to end life amid escalating technology in the curative system without access to palliative care (4-6). Although progress in this area is slow (7,8), there are now indications that haematology patients are on the palliative care agenda (1,9). Recent research indicates that the major obstacle to integration of palliative care and haematology is not to do with clinical characteristics of this patient population, but rather the attitudes of health professionals providing the care (10). There are special considerations for haematology patients with regards to palliative care such as the rapid change to a terminal trajectory, whether to include the administration of blood products during end-of-life care, and for a small minority, the possibility of catastrophic bleeds (10). However, these challenges can be addressed by a proactive haematology/oncology subculture with a positive attitude towards the integration of palliative care (11). In short, the debate has shifted and the focus is now on the *how to* rather than the, *is it possible?* The challenge is now for research to examine and inform the clinical complexity of

palliative care in regards to haematology patients.

As a seminal paper in the area of clinical description of haematology patients receiving palliative care, Cheng and associates' article (1) understandably raises more questions than it provides answers. Whilst the patient diagnoses listed in the article (acute myeloid leukemia, lymphoma and myeloma) represent the most common haematological malignancies (12), experienced haematology professionals will have a plethora of questions to ask about the patient characteristics. The description of a very short median time from first diagnosis to death, even factoring in advanced age, does not resonate with the available clinical and epidemiological literature. There has been impressive progress in haematology with therapeutic success and subsequent prolongation of life for patients with myeloma and lymphoma (13,14). Indeed, non-Hodgkin lymphoma is listed as one of the four cancers with the greatest gains in recent years (15) and myeloma and non-Hodgkin lymphoma are documented as having the largest absolute increase in survival (12). The median time from first diagnosis should be noted in terms of years, not months. For example, the five-year survival rate for non-Hodgkin lymphoma is 71% and 87% for Hodgkin lymphoma (16). Whilst incidence, prevalence, and survival are clearly documented in the literature, the research on the complexity of clinical issues associated with palliative medicine and haematology is only in its infancy. Cheng and associates' article (1) points to a range of clinical interventions associated with the acute care setting such as blood sampling, granulocyte colony-stimulating factor (G-CSF) injections, total parenteral nutrition (TPN), blood product transfusions, and antibiotic administration administered to the patients in the palliative care setting. Questions need to be asked about whether the referrals were about providing palliative care philosophy and practice to the patients or simply transferring their acute care to a palliative care setting. At best, the literature is now just starting to articulate the haematology-specific clinical issues that need to be addressed. Articles on end-of-life care of haematology patients are presently available on a continuum of topics such as catastrophic bleeds, inclusion of general practice in care, and blood product administration (17-20). However, there is insufficient research to provide definitive answers. Research is not as yet, able to inform consensus or best practice in the area of haematology and palliative care. As Auret and associates (21) indicate, at present there is not even a consensus on basics such as when and why haematologists should refer patients to palliative care. However the important point is that a start has been

made. This is an exciting frontier where practice-based research can make a significant difference. Hopefully Cheng and associates' article (1) will be a catalyst for debate that will foster this new direction in research at the interface of haematology and palliative care.

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