

Clinical oncology and palliative medicine as a combined specialty—a unique model in Hong Kong

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Abstract: The importance of early integration of palliative care (PC) into oncology treatment is increasingly being recognized. However, there is no consensus on what is the optimal way of integration. This article describes a unique model in Hong Kong where clinical oncology and palliative medicine (PM) is integrated through the development of PM as a subspecialty under clinical oncology.

Keywords: Clinical oncology; palliative medicine (PM); palliative care (PC); integration; subspecialty

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Introduction

In recent years, there is increasing awareness of the importance of early integration of palliative care (PC) into oncology management. Studies have demonstrated that besides improvement in symptom control and quality of life, there is also survival gain (1-3).

Nevertheless there is no universal consensus on how to integrate and what constitutes successful integration (4). In a systematic review (5), it is shown that integration exists in very heterogeneous forms, e.g., the presence of PC units or inpatient consultation teams, or existence of PC guidelines, clinical care pathways etc.

Specialist training and service delivery models are among the factors influencing the integration. In this article, we will briefly describe a unique system in Hong Kong, where clinical oncology and palliative medicine (PM) is integrated through the development of PM as a subspecialty under clinical oncology.

PC in Hong Kong

PC in Hong Kong is mostly provided by public hospitals, under the Hospital Authority. Heterogeneity exists regarding the system of care and delivery model. Some palliative units are independent hospice centers while others are subunits under hospital departments, notably medical or clinical oncology departments. Doctors leading the service include physicians of internal medicine and clinical oncologists.

The first hospice in Hong Kong, the Nam Long Hospital, was established in 1967 by a non-profit organization. In 1982, the first PC team was set up in Our Lady of Maryknoll Hospital, and this heralded the hospice movement in Hong Kong. Subsequently, more and more PC units were established, and a more structured approach was adopted.

The early PC units are mainly under the care of specialists of internal medicine who are the forerunners of

hospice service in Hong Kong. PM was first established as a specialty under the Hong Kong College of Physicians in 1998.

Later due to service need, the oncologists gradually developed PC service, mainly as an in-house service under the umbrella of clinical oncology department. With growing service demand and training needs, together with increasing recognition of PM as a specialized service, PM was established as a subspecialty under clinical oncology in 2002.

Clinical oncology and PM as combined specialty

The specialty of Clinical Oncology in Hong Kong follows the UK system. It embraces both Medical Oncology and Radiation Oncology and is under the auspices of the Hong Kong College of Radiologists (HKCR). Since the establishment of the PM Subspecialty in 2002, those who intend to acquire training can join the training program organized by the PM Subspecialty Board of HKCR. This is mainly a post-fellowship training for clinical oncologists who have passed the intermediate oncology examination (Part II of Fellowship examination).

Trainees need to undergo a 4-year training program in a clinical oncology center accredited for the purpose. The training program consists of a minimum of 2 years of PM training in conjunction with a minimum of 2 years of higher clinical oncology training. Trainees also have to participate in regular academic meetings and submit course work which includes audits, case portfolios and a thesis. Finally they have to pass the subspecialty board examination.

This subspecialty training is optional and the participation is on voluntary basis. Since the establishment of the subspecialty, three board examinations have been held in 2006, 2009 and 2013. As at April 2015, there are 34 clinical oncologists (out of a total of 112 clinical oncologists in Hong Kong) who have acquired the PM qualification and become dual specialists (CO-PM specialists). The majority of them are serving in clinical oncology centers in public hospitals.

Integrating PM and oncology in clinical service

There are altogether six public oncology centers in Hong Kong. They offer full range oncology service covering medical oncology, radiation oncology and PC. With establishment of PM subspecialty, structured multidisciplinary PC teams were set up, headed by clinical

oncologists who have acquired dual qualification (CO-PM specialists). Wide spectrum of palliative service is offered which include inpatient care, outpatient clinics, ambulatory services, home hospice care etc. Apart from serving the patients under oncology department, the team also offers inpatient consultation service for other departments in the hospital.

Nearly all the CO-PM specialists are participating in both clinical oncology and PC service instead of devoting all the time in PM. How they allocate the time between clinical oncology and PM is subject to their department's service need and working system.

On the other hand, the PC units under PM specialists of the internal medicine stream are mostly under medical departments of public hospitals, or as independent centers separate from main hospitals. There is constant collaboration between the oncology PC teams and internal medicine PC teams. Such arrangement helps to bridge over service gaps and supplement service capacity. Some patients may be under the care of both teams, for example, palliative home care service being under the internal medicine team, while PC clinic in the regional hospital under the oncology team.

Merits

In the context of integrating PC into oncology care, there are various ways of achieving this goal, e.g., by consulting an external PC team. However, the most direct way is that the oncologist is also a PM specialist. They will integrate the concept of PC in their day to day oncology service, applying this approach to patients of both early and late stage cancer.

Regarding infrastructure support, having an in-house PC unit within clinical oncology department is a good way to facilitate integration of palliative service. This concept is in-line with the approach advocated by the European Society for Medical Oncology (ESMO) program of Designated Centre of Integrated Oncology and Palliative Care. At present there are three oncology centres in Hong Kong accredited as ESMO Designated Centre under such scheme.

In this way, oncology and PC has become a one-stop service. Each oncology department has oncology specialists with PM qualification. PC is available within the same department without the need for external referral. There is continuum of care at the interface of transition from active oncological treatment to PC. The early introduction of PC in the earlier phase of oncology management is feasible

and easily achievable. Symptom control and psychosocial care can be better instituted. This is especially important nowadays since with the emergence of new cancer drugs and targeted therapy, the oncology treatment phase is prolonged, and the boundary between active oncological treatment and PC is less distinct.

Moreover, the patient would not feel abandoned by having to undergo a process of being transferred to another team for PC. In addition, patients on PC not infrequently have the need for oncology treatment e.g., palliative radiotherapy. The decision for such treatment in frail patient is often a matter of fine judgement, taking into account the logistics of treatment such as number of treatment fractions and volume of irradiation. Generally speaking, clinical oncology and PM as a combined specialty is a cost effective service model as patients do not need to have cross specialty referral.

Challenges and barriers

Nevertheless there are challenges and potential barriers to this model. It is quite a demanding task for clinical oncologists to acquire the additional training and qualification of PM, on top of the basic PC training offered in the clinical oncology training program. It needs high motivation and effort. In the training program under HKCR, we try to build a positive proactive atmosphere, to cultivate peer learning environment and to foster the passion and interest of the oncologists in PC. The continuing trend of young oncologists joining our PM training suggests that this can be a practical and sustainable approach.

There are also practical problems regarding clinical service delivery. The workload of oncology departments in public hospital in Hong Kong is constantly high and increasing. To cover the wide range of service from curative to palliative to end-of-life care is always a taxing exercise. To balance the needs among various oncology treatment and palliative service is constantly a difficult decision. Resource and manpower constraints are among the core difficulties

and limitations.

Conclusions

Clinical oncology and PM as a combined specialty is a unique model which can facilitate early integration of PC. The doctor is both an oncologist as well as PM specialist. It works in a complementary manner with the PM specialty under internal medicine. With appropriate infrastructure support including setting up of PC team and service structure, this can be a cost effective approach for service delivery.

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Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

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