Message from the Editor-in-Chief

Early palliative care and integration of palliative care models in modern oncology practices

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The current issue of *Annals of Palliative Medicine* features a collection of manuscripts dedicated to early palliative care (1). The guest editors for this focused issue, Jan Gaertner, Stephen Lutz and Edward Chow, who leaders of the Palliative Radiotherapy Column for *Annals of Palliative Medicine* (2,3), have assembled articles from leading palliative medicine physician, nurses, and allied healthcare providers for this early palliative care issue.

Palliative care is increasingly being integrated into oncology practice (4) and recognized as a critical component of modern oncology care (5). Randomized studies have demonstrated a benefit to early implementation of palliative care to improve quality of life across a number of patient-reported and outcome-reported metrics and to enhance patient satisfaction (6,7). Davis *et al.* conducted a systematic review of randomized trials of palliative care to more conclusively assess the benefits of early palliative care in this issue of *Annals of Palliative Medicine* (8). The authors report on 15 randomized trials of outpatient palliative care and 13 randomized trials of palliative home care and generally found significant advantages to patients randomized to early palliative care that included less depression, improved quality of life for both patients and caregivers, reduced aggressive care at the end of life, higher rates of completing advanced directives, fewer hospitalizations, reduced hospital length of stay, reduced medical costs, and improved patient and family satisfaction (8). However, existing trials to date have been heterogenous both in terms of patient populations studies and in terms of interventions on the control arm and timing of early palliative care. The definition itself of early palliative care is not without considerable confusion (9,10). While the comprehensive review by Davis is supports the continued integration of early palliative care with oncology care, their findings highlight the need for better designed and executed studies to determine the best time to intervene and what model of care might be best.

Hui and Bruera describe several contemporary such models to allow for successful integration of palliative care with oncology (11). Integration in this context, with the addition of specialist palliative care to routine oncology care as opposed to routine oncology care alone, is an increasingly investigated practice (4). How this integration should occur, however, is not well defined and will certainly differ across practice types according to the size and existing resources of a health system, patient population, patient needs, and existing level of palliative care provided by oncologists and primary care physicians. Instituting practice changes and mobilizing monetary resources to enable these changes to occur, however, are never easy, particularly with the changing face of medicine and evolving dynamics of payer reimbursement and increasing healthcare costs.

Hui and Bruera also describe the levels of integration from linkage to coordination to full integration, and they formulate models to aid stakeholders in the evaluation of the feasibility, efficacy, and effectiveness of integration across practice settings. In doing so, they also allow for an easier comparison of the relative benefits and merits of the different models. Through their description and analysis of the time-based model, provider-based model, issue-based model, and system-based model, the authors provide a roadmap for centers to optimize patient access to supportive care, with a clear goal of improving the quality of life for patients (11).

Additional models, including the inpatient palliative care

model, home based palliative care model, and outpatient clinic palliative care model, are detailed by Zhi and Smith (12). They also provide a great review of the literature on available data demonstrating the benefits of early palliative care. However, more progress is needed and several barriers to early integration remain (13). Zhi and Smith further chronicle continued challenges and barriers preventing providers from delivering optimal and integrated care for patients. Some of the barriers are, in part, attributable to oncologists, who may have limited training in palliative care (14), concerns about losing patients (12), limited time available to discuss and implement palliative care measures (15), and limited access to palliative care teams (12). Additional resource and public exposure barriers are described, highlighting the importance of improving the general population's understanding of the differences between palliative care and hospice care (16). Potential strategies to overcome each barrier are also detailed (12).

International models are also described in this issue of *Annals of Palliative Medicine*. As readers will see, while there are certainly different methods of integrating early palliative care in different regions of the world, many pillars of each model and common barriers to implementation are shared between countries. Yeung *et al.* describe the current state of palliative care in Hong Kong and detail how palliative care is mostly provided by public hospitals under the direction of internal medicine or clinical oncology physicians (17). In Hong Kong, clinical oncologists have both medical oncology and radiation oncology training, and these oncologists can complete post-fellowship training in palliative medicine. This model allows for a combined specialty in which clinical oncologists with palliative training provide both therapeutic oncologic interventions and palliative interventions, as opposed to focusing solely on palliative medicine. While this model is training intensive and taxing to providers in a population with a high need to cancer interventionists, this combined specialty model allows for easy facilitation of early integration of palliative care.

Fassbender and Watanabe next discuss the state of palliative care in Canada (18). The increasing use of palliative care and the early integration of palliative medicine with oncology are detailed. Of note, the authors describe many of the same barriers to early palliative care that are seen in the United States that are detailed in the manuscripts by Hui and Bruera (11) and by Zhi and Smith (12). Several novel solutions to these barriers have already been implemented in Canada.

Fitch *et al.* describe international nursing perspectives on palliative care (19). Nurses are the largest workforce in healthcare globally and have a great influence over both the palliative and medical management of patients. Although nurses can play critical roles in delivering care and reducing suffering for patients and their families and caregivers, several barriers that are shared with oncologists as well as unique barriers to nurses have posed challenges to enabling the widespread role of nurses in early palliative care (19,20).

The last article in this impressive collection of early palliative care manuscripts tackles the issue of resource allocation (21). Gaertner *et al.* provide estimates of the costs associated with early palliative care of both specialist approaches and generalist approaches. With the specialist model, in which specialist palliative care and routine care are concurrently pursued, the authors review several studies (22,23) in which early palliative care has been demonstrated to be associated with cost savings for inpatients. However, they also highlight the generally limited funding methods for widespread utilization of the specialist model for integrative palliative care worldwide. Conversely, for the generalist approach, palliative care is optimally strengthened as a part of standard care. Costs inherent to this approach are heterogenous and inclusive of teaching of general palliative care competencies, routine symptom assessment, and the mandatory implementation of advanced care planning in care trajectories. Despite the difficulties in cost calculations, cost savings with this model are still likely if the adoption of palliative care results in less utilization of futile diagnostic and therapeutic procedures at the end of life and less aggressive care due to improved communication of treatment goals (22,24). Clearly, much more work is needed to be able to provide reliable cost estimates. However, the work by Gaertner *et al.* is a highly noteworthy effort at assessing this difficult topic.

Although the currently employed palliative care model may be the specialist model in some regions or health systems and the generalist model in others, more widespread implementation of each model will require additional upfront expenditures. However, these costs should be considered in the context of cost-saving that can be achieved with early palliative care implementation. In contrast to the two separate models, however, early palliative care is likely best achieved with a combined effort across medical disciplines and early integration of specialist palliative care services. Such an integrated approach can reap the rewards of cost savings, improved patient quality of life, and even improved clinical outcomes for patients.

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Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

References

1. Gaertner J, Lutz S, Chow E. Early palliative care: philosophy vs. reality. Ann Palliat Med 2015;4:87-8.
2. Simone CB 2nd. Current focus and future advances for Annals of Palliative Medicine. Ann Palliat Med 2014;3:37-8.
3. Simone CB 2nd. Annals of Palliative Medicine is indexed in PubMed. Ann Palliat Med 2015;4:46-7.
4. Hui D, Kim YJ, Park JC, et al. Integration of oncology and palliative care: a systematic review. Oncologist 2015;20:77-83.
5. Simone CB 2nd, Jones JA. Palliative care for patients with locally advanced and metastatic non-small cell lung cancer. Ann Palliat Med 2013;2:178-88.
6. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 2010;363:733-42.
7. Zimmermann C, Swami N, Krzyzanowska M, et al. Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial. Lancet 2014;383:1721-30.
8. Davis MP, Temel JS, Balboni T, et al. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. Ann Palliat Med 2015;4:99-121.
9. Hui D, Nooruddin Z, Didwaniya N, et al. Concepts and definitions for "actively dying," "end of life," "terminally ill," "terminal care," and "transition of care": a systematic review. J Pain Symptom Manage 2014;47:77-89.
10. Gaertner J, Lutz S, Chow E, et al. Integrating palliative care and oncology: towards a common understanding. Ann Palliat Med 2015;4:3-4.
11. Hui D, Bruera E. Models of integration of oncology and palliative care. Ann Palliat Med 2015;4:89-98.
12. Zhi WI, Smith TJ. Early integration of palliative care into oncology: evidence, challenges and barriers. Ann Palliat Med 2015;4:122-31.
13. Simone CB 2nd. The state of oncology in 2014 and the role of palliative care for advanced and metastatic malignancies. Ann Palliat Med 2014;3:123-5.
14. Schenker Y, Crowley-Matoka M, Dohan D, et al. Oncologist factors that influence referrals to subspecialty palliative care clinics. J Oncol Pract 2014;10:e37-44.
15. Simone CB 2nd, Vapiwala N, Hampshire MK, et al. Palliative care in the management of lung cancer: analgesic utilization and barriers to optimal pain management. J Opioid Manag 2012;8:9-16.
16. Parikh RB, Kirch RA, Smith TJ, et al. Early specialty palliative care--translating data in oncology into practice. N Engl J Med 2013;369:2347-51.
17. Yeung R, Wong KH, Yuen KK, et al. Clinical oncology and palliative medicine as a combined specialty—a unique model in Hong Kong. Ann Palliat Med 2015;4:132-4.
18. Fassbender K, Watanabe SM. Early palliative care and its translation into oncology practice in Canada: barriers and challenges. Ann Palliat Med 2015;4:135-49.
19. Fitch MI, Fliedner MC, O'Connor M. Nursing perspectives on palliative care 2015. Ann Palliat Med 2015;4:150-5.
20. Vachon ML. Reflections on Compassion, Suffering and Occupational Stress. In: Malpas J, Lickiss N, editors. Perspectives on Human Suffering. Dordrecht: Springer, 2012:317-36.
21. Gaertner J, Maier BO, Radbruch L. Resource allocation issues concerning early palliative care. Ann Palliat Med 2015;4:156-61.
22. Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Aff (Millwood) 2011;30:454-63.
23. May P, Garrido MM, Cassel JB, et al. Prospective Cohort Study of Hospital Palliative Care Teams for Inpatients With Advanced Cancer: Earlier Consultation Is Associated With Larger Cost-Saving Effect. J Clin Oncol 2015. [Epub ahead of print].
24. Gaertner J, Drabik A, Marschall U, et al. Inpatient palliative care: a nationwide analysis. Health Policy 2013;109:311-8.

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