Editorial

Palliative care is a critical part of gynecologic oncologic care

Claire Hoppenot

Division of Gynecologic Oncology, Baylor College of Medicine, Dan L Duncan Comprehensive Cancer Center, Houston, TX, USA

Correspondence to: Claire Hoppenot, MD. Division of Gynecologic Oncology, Baylor College of Medicine, Dan L Duncan Comprehensive Cancer Center, 7200 Cambridge St, Ste 7A, Houston, TX 77030, USA. Email: Claire.hoppenot@bcm.edu.

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Women with gynecologic cancers have a heavy symptom burden. The symptoms and emotional support needed shifts through diagnosis, chemotherapeutic and surgical treatments, at time of cancer progression and at the end of life. Gynecologic oncologists follow patients through these many phases of care and provide counseling throughout each transition. Palliative care plays a critical role, both within the office of the gynecologic oncologist or as a referral to a palliative care team.

There are many models as to how gynecologic oncologists provide palliative care and refer to palliative care teams. Gynecologic oncologists generally are open to working closely with a palliative care team. A survey of the Society of Gynecologic Oncology (SGO) found that 75% of providers agreed that palliative care should be integrated into cancer care at the time of diagnosis of advanced cancer (1). However, the survey also revealed barriers to palliative care referrals; for example, 80% of gynecologic oncologists felt that many barriers would be reduced with higher access to outpatient palliative care (1).

In a qualitative study of gynecologic oncologists in an metropolitan area, our team has noted patterns of palliative care involvement at the time of a difficult end-of-life clinical diagnosis: a malignant bowel obstruction (2). Most interviewees were in an academic setting and had access to both inpatient and outpatient palliative care. The majority worked closely with palliative care physicians when diagnosing a patient with a malignant bowel obstruction and were likely to consult the palliative care team for symptom management and prognostic counseling. Again, however, barriers to care abounded, including worries about fragmentating care by introducing a new team to the patient and concerns regarding patient selection for access to the limited resource of a palliative care referral. Gynecologic oncologists ranged from desiring more palliative care team involvement (both during and before a malignant bowel obstruction diagnosis) to wanting to limit their involvement in order to streamline care in one set of hands (2).

In their narrative review of palliative care in gynecologic oncology, Salyer and colleagues address most of the concerns that gynecologic oncologists had expressed in the SGO survey and qualitative interviews described above (1-3). They suggest guidelines for when to refer to palliative care, tailored to settings with varied access to palliative care consultations as inpatient, outpatient or both. They also introduce "primary palliative care", which are aspects of palliative care that they argue gynecologic oncologists should be expected to provide; for example, basic management of nausea, constipation, and goals of care conversations (3). They also focus on ways that this training can be achieved.

Salyer and colleagues highlight the importance of training in primary palliative care either through a palliative care fellowship that can be taken back to a gynecologic oncology practice or, at the very least, within the gynecologic oncology fellowship (3). Palliative care education throughout training is not well studied; a scoping review of primary palliative care training throughout residency and fellowship specialties found that specialties most likely to have publications on palliative care training included emergency medicine, general surgery, internal medicine, and medicine-pediatrics,

as well as subspecialists in oncology, nephrology, and pediatric subspecialties (4). They found substantial variation in the amount of time placed on palliative care topics as well as within content. Salyer and colleagues address palliative care training specifically of gynecologic oncology fellows; Accreditation Council for Graduate Medical Education (ACGME) milestones have recently included palliative care skills, however programs vary as to how they address and assess these goals (3).

Research on didactic work in palliative care during training focuses on the two main aspects of primary palliative care: basic symptom management and communication (4). Communication in particular is a critical aspect of palliative care and is difficult to teach through didactic sessions. In the SGO survey on palliative care and gynecologic oncology practice, barriers to referral enumerated by gynecologic oncologists included time constraints, worry about reducing hope and trust, and patients' unrealistic expectations (1). At the same time, patients have highlighted the importance of clarity of information, being allowed to grieve, and sustaining hope in conversations of transitions from curative to end-of-life care (5,6). While not all of these can be achieved with communication skills, communication can facilitate both barriers to referral to palliative care and providing end-of-life counseling.

Our study team conducted a qualitative study of women admitted for malignant bowel obstructions from ovarian cancer; we found many gaps in communication and expectations between women and their primary gynecologic oncologist (7). These included discussion of goals such as future chemotherapy (most patients expected more chemotherapy after the diagnosis of a malignant bowel obstruction while most physicians considered it a contraindication), planning for support after discharge (patients were much more likely to discuss a desire to go home), and frustration at the uncertainty associated with the diagnosis (patients desired more concrete information and physicians struggled with prognostic uncertainty) (7). We suggested that a decision aid, such as proposed by Wieringa and colleagues, could assist in presenting the information on the diagnosis, options, risks/benefits and guide to patient preference deliberation (8). In the setting of malignant bowel obstructions in particular, increased communication, education, and a multi-disciplinary team have been shown to improve patient satisfaction and control of symptoms at a very difficult and critical time in a woman's life (9).

While fellowship can provide didactic training and real-time modeling with mentors, training in communication for such difficult conversations needs to continue beyond fellowship training and early career. Salyer and colleagues provide resources for communication training through SGO, VitalTalk, GyoEdu, best care/worse case scenarios and other forums (3). Palliative care fellowships also provide strong training and have been shown to be feasible along with surgical training such as gynecologic oncology, although they can have challenges particularly around maintenance of certification through the American Board of Internal Medicine (3).

Salyer and colleagues' narrative review provide an important reminder of the importance of palliative care teams throughout the care of gynecologic cancer patients, as well as of the role that we as gynecologic oncologists play in providing primary palliative care to patients. This is particularly true in settings where palliative care referrals are not readily available in either the inpatient or outpatient setting (or both); even when available, palliative care referrals are a limited resource and access is generally limited. Many patients are also already overwhelmed with appointments, and may have difficulty coming in for an extra palliative care appointment, especially in the setting of a high symptom burden. Ultimately, patients have developed a relationship with gynecologic oncologists, and as their primary oncologist, we must be involved in counseling regarding prognosis and hospice transitions. Training in symptom management and especially communication throughout fellowship and beyond is critical to provide the best possible care for patients with gynecologic malignancies.

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Footnote

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