Editorial

Early integration of palliative care in malignant hematology

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Chan *et al.* contributes to the literature in their publication of "*Supportive Care and Symptom Management in Patients with Advanced Hematological Malignancies: A Literature Review*" addressing the significance of tailoring Palliative Care (PC) services for malignant hematology (MH) patients (1). However, evidence-based practices for early implementation of palliative care in MH populations are scarce (1). This scarcity can be attributed to several obstacles such as the difficulty in prognosticating MH, knowledge deficits regarding PC, and general barriers to access PC (2). In order to further contribute to the literature, it is imperative to address the importance of early implementation of palliative care, especially for MH populations.

In 1998, the American Society of Clinical Oncology (ASCO) (3) created an initiative that was committed to the worldwide comprehensive integration of palliative care in oncology by the year 2020 (4). The initiative was based on compelling research which demonstrated that early integration of palliative care improved quality of life (QOL) and satisfaction in persons diagnosed with lung cancer (5). Since this seminal research, palliative care implementation, for any cancer at any stage, has been shown to increase satisfaction and reduced stress (6). Despite these findings, several barriers still exist that make it more difficult to implement palliative cancer care for persons who need it (7). Chief among these barriers is lack of access to palliative care services for hematological malignancies.

Data shows that individuals are not referred for palliative services by their providers until they have reached advanced stages in cancer—at which point hospice care is the primary focus (8). In hematological malignancies, the average time lapsed between an initial PC consult and death is 13 and 46 days for solid malignancies (9). There seems to be a knowledge deficit specific to the goals of palliative versus hospice care, and most believe that palliative care equates to foregoing active cancer treatment (10). It also poses a moral dilemma for providers and patients that mistakenly equate PC services with a loss of hope and reduce efforts towards curative intent (1). Palliative care is distinct from hospice care, and it can be integrated concurrently with curative treatments from the time of diagnosis, through end-of-life supportive care. Palliative care is concerned with reducing symptom burden and improving function and QOL.

Individuals with a MH diagnosis experience an array of symptoms secondary to the nature of their disease and/or its treatments. Poor symptom management in MH can result in further complications or hasten death (11). When compared to non-hematological malignancies, MH patients are twice as likely to die in a hospital (12). M.D. Anderson Cancer Center conducted a study that demonstrated the greatest predictor for poor QOL at end-of-life (EOL) was a hematological malignancy diagnosis (1). Hematologist Oncologists are much more likely to prescribe moderately toxic systemic therapy without proven survival benefit to a

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patient with a prognosis of less than one month of life. In part, it is believed that MH Oncologist believe treatment is the best form of palliation in their patient population. For example, in some instances a packed marrow may cause a patient to become transfusion dependent, therefore, treatment may in fact improve QOL if they can become less dependent on transfusions. This highlights how essential it is for MH patients to have earlier access to palliative care. Prognosticating MH patients is difficult and therefore increasing MH patients' access to PC from the point of diagnosis may actually improve EOL planning, QOL and overall patient understanding of disease trajectory (13).

Individuals with increased access to palliative care experience increased QOL, increased mood scores, and better symptom management (14,15). Early referral to palliative care (within eight weeks of diagnosis for all cancer stages) resulted in better survival, improved QOL—similar to the effects of first-line chemotherapy, reduced hospitalizations, reduced health related expenses and decreased the likelihood of individuals receiving chemotherapy in the last six weeks of life (5,16). Perhaps one possible solution to this disparity of early PC services in MH patients is to provide more specialized PC teams that have a robust understanding of the needs in this specialty.

Specialized interdisciplinary care teams (IDTs) in palliative care for adult oncology populations improved health related QOL and improved overall participant symptoms (11,17). It was also found that regardless of whether a person was receiving chemotherapy or not, persons with cancer receiving palliative care had an increased QOL (6). Therefore, early implementation of these IDT for MH can only benefit the patient's experience throughout their disease trajectory. Providing persons with cancer with psychosocial education regarding palliative care, increases their acceptance of palliative care and overall satisfaction with care (10,18). Better education and palliative symptom management in terminally ill individuals with chronic conditions, such as cancer, was associated with increased satisfaction with care and QOL, and decreased hospital expenses (6,19,20).

The World Health Organization (WHO) is seeking to improve health internationally by incorporating palliative care programs earlier in the illness trajectory, and asserts that palliative services should be available early and based on individuals' needs rather than poor prognosis (21). It is estimated that if palliative services were fully implemented, the US would save approximately $6 billion a year (22). Although 67% of US hospitals have implemented palliative care teams, there is less focus and information available for the implementation of these services at the community level (22,23). This demonstrates an opportunity to improve access to palliative care for hematologic malignancies and a need for earlier implementation of palliative care services starting at community levels.

In conclusion, delayed referrals that result from providers' knowledge deficit may lead to reduced access to palliative care, a QOL issue in the cancer population (5,10). Addressing knowledge deficits regarding the role and purpose of palliative care can help to increase patient access to palliative services (5,24). Previous research indicates that optimal results may be achieved for persons with cancer by granting access to palliative services within eight weeks of initial diagnosis (5,6,20). In order to accomplish earlier referrals, healthcare providers must understand that palliative care services are not limited to terminal patients (12). Patients must also be taught that palliative care is distinct from hospice in that they can co-receive palliative care and curative treatments, whereas with hospice, one cannot receive curative treatment (10,14,25). The WHO and ASCO believe palliative care should be available early to individuals irrespective of stage of disease. The biggest impediment to the application of such programs is knowledge deficits amongst providers and individuals undergoing medical care. This article is meant to acknowledge the contributions to the literature by Chan *et al.* and encourage additional studies regarding the early implementation of PC for malignant hematology (1).

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