In this article, we present or review the evidence for providing palliative care concurrently with oncologic care, guideline-based recommendations for screening and incorporation of palliative care, and a case-based discussion to demonstrate palliative care across the continuum of cancer care.

Introduction

"Palliative care is given throughout a patient’s experience with cancer. It should begin at diagnosis and continue through treatment, follow-up care, and the end of life."

—The National Cancer Institute (NCI) fact sheet on palliative care

Approximately 12 million people are living with cancer in the United States, according to Surveillance, Epidemiology, and End Results (SEER) statistics. In 2012, 1.6 million new cases of cancer will be diagnosed. Fortunately, deaths from cancer have been on the decline, with increasing numbers of survivors.[1] Strides have been made in survival for patients with breast, colon, prostate, and lung cancer. Figures 1 and 2 depict a decrease in age-adjusted cancer death rates across all major cancer sites in both men and women, with the exception of lung cancer in women. This trend can also be depicted as number of deaths avoided based on an overall decrease in mortality rate (Figure 3). Because patients with cancer are living longer, often with metastatic disease, cancer is becoming more of a chronic illness with high symptom burden. Additionally, patients who are cured often have significant long-term symptom-related and treatment-related morbidity.[2] For this patient population, it becomes critical to have palliative care integrated from the point of diagnosis.

FIGURE 1

Trends in Death Rates Among Males for Selected Cancers, United States, 1930 to 2008

FIGURE 2

Trends in Death Rates Among Females for Selected Cancers, United States, 1930 to 2008

The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care is
applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications."[3] Due to rapid changes in both the perception and practice of palliative medicine, the Center to Advance Palliative Care (CAPC), a leader in palliative care advocacy and training, recently added to this definition: "Palliative care . . . is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family [with] . . . specialists who work together with a patient’s other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment."[4] Implicit in this evolving definition of palliative medicine is the goal of earlier integration of palliative care for all patients with a serious illness and their families in order to enhance and improve these patients’ quality of care from the time of diagnosis.

![FIGURE 3](image_url)

Total Number of Cancer Deaths Averted From 1991 to 2008 in Men and From 1992 to 2008 in Women

Palliative care is a multidisciplinary approach to care (involving nursing, social work, physician care, chaplaincy); it is focused on the patient and family as the unit of care throughout the trajectory of the illness, from diagnosis to death.[5-8] Treatment is tailored to meet a patient’s and family’s goals and to harmonize with their values. Palliative care given concurrently with oncologic care can improve outcomes and quality of care for patients.

In this article, we present or review the following:
- The evidence for providing palliative care concurrently with oncologic care.
- Guideline-based recommendations for screening and incorporation of palliative care.
- A case-based discussion to demonstrate palliative care across the continuum of cancer care.
- Who provides palliative care?
- Barriers to integrating palliative care and oncologic care.
- The value of palliative care.

Evidence for Integration of Palliative Care With Oncologic Care
Standard anti-cancer therapies prolong survival, relieve symptoms, and improve quality of life. Much of the early data evaluating the effect of anti-cancer treatment on survival and quality of life comes from the advanced non–small-cell lung cancer literature. This is due to both the high burden of symptoms in this disease, and until recently, a relative dearth of active anti-cancer treatment options.

For example, early trials comparing single-agent chemotherapy vs best supportive care (BSC) in these patients showed improved survival and symptom control with chemotherapy.[9-13] Platinum-based multi-agent treatment regimens for non–small-cell lung cancer also improved survival and disease-related symptoms.[14-17] The likelihood of symptom improvement usually correlated with response to therapy. One point worth noting is that the trials described here standardize the treatment arm (chemotherapy or targeted drug) but do not standardize the best supportive care arm. For all practical purposes, these trials compare treatment vs observation.[18-23]TABLE A
Chemotherapy and Quality of Life (QOL) in Advanced Non–Small-Cell Lung Cancer

Similarly, targeted therapies also have the potential to result in dramatic disease responses, and when they do, they offer significant symptomatic improvement. For patients with non–small-cell lung cancer, the addition of erlotinib (Tarceva) or gefitinib (Iressa) in patients with an epidermal growth factor receptor (EGFR) mutation improves survival and quality of life.[24-27] In the Iressa Dose Evaluation in Advanced Lung Cancer (IDEAL) 1 study, 70% of those patients receiving a 250 mg/day dose of gefitinib and who had either stable disease (SD) or a response to therapy (complete response [CR] or partial response [PR]) had improvements in symptoms as measured by the Functional Assessment of Chronic Illness Therapy (FACIT).[28] This was substantiated by data from the IDEAL 2 study: 96% of patients who had a radiographic response had symptom improvement.[29] More recently, the identification of the somatic driver mutation anaplastic lymphoma kinase (ALK) and the development of the targeted drug crizotinib (Xalkori) have added yet another option for patients.[30-33] The foregoing are examples of drugs that have a substantial response rate and are thus able to significantly improve disease-related symptoms and to prolong life.

If anti-cancer treatment improves survival and quality of life (via disease modification), the question that arises next is “What does palliative care add?” The strongest evidence supporting concurrent palliative care and oncologic care is Temel’s landmark study which showed the impact of integrated care.[34] One hundred fifty-one patients with newly diagnosed stage IV lung cancer were randomized to usual oncologic care vs usual oncologic care plus concurrent palliative care. Patients in the usual care arm were allowed to receive palliative care by referral based on patient/healthcare provider request. Patients in the experimental arm were seen by the palliative care team monthly. The initial palliative care visit occurred within 3 weeks of enrollment and lasted a median of 55 minutes. On average, 20 minutes were devoted to symptom control, 15 minutes to discussion of coping, and 10 minutes to understanding the illness.[35] Patients in the concurrent care arm had greater improvements in quality of life and mood, less aggressive care at the end of life, and prolonged survival (8.9 vs 11.6 months, \( P = .02 \)).[34] Additionally, interaction with the palliative care team increased the likelihood that patients would have a realistic view of their prognosis. At baseline, one-third of patients believed that their cancer was curable. An accurate estimation of prognosis was significantly more likely for patients in the intervention arm than for those receiving standard care (82.5% vs 59.6%).[36]TABLE

Other studies have investigated the integration of different components of palliative care into oncologic care and have demonstrated a favorable impact on quality of life, mood, and symptom intensity. These studies show that the addition of palliative care to oncologic care has the ability to improve the patient and family experience in dealing with a serious, life-limiting illness (Table).[37-42] While there are an increasing number of studies that demonstrate the benefit of
palliative care, further investigation is needed to determine which components of a palliative care intervention are essential to achieve specific benefits.

**Guideline-Based Recommendations for Screening and Incorporation of Palliative Care**

Quality initiatives and guidelines advocate an integrated palliative care–oncology model. The vision of the American Society of Clinical Oncology (ASCO) of personalized medicine focusing on patient values and goals relies on the provision of concurrent palliative care.[43] A recent ASCO–European Society for Medical Oncology (ESMO) consensus statement on quality cancer care included "pain management, supportive and palliative care" as one key component of optimal oncology care.[44] Finally, ASCO’s Quality Oncology Practice Initiatives incorporated an array of palliative care measures as quality indicators, including symptom control, attention to emotional well-being, and quality of end-of-life care. These were further expanded in 2011.[45] The increasing data demonstrating the benefits of simultaneous oncology and palliative care led ASCO to publish a Provisional Clinical Opinion on the topic (Table). "Earlier involvement of palliative care also leads to more appropriate referral to and use of hospice, and reduced use of futile intensive care. . . . it is the Panel’s expert consensus that combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden."[46] There was no evidence of harm to patients who received integrated palliative and oncology care.

Finally, in view of rapidly rising healthcare costs, ASCO was challenged to identify practice changes that would improve cost-effectiveness without diminishing quality of care. The first recommendation focused on when NOT to treat the cancer: "Don’t use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment."[47] For these patients, a front-line palliative care approach is recommended.

The National Comprehensive Cancer Network (NCCN) guidelines[48] recommend palliative care always, chemotherapy sometimes, for any patient with:

- Uncontrolled symptoms.
- Moderate to severe distress related to cancer diagnosis or therapy.
- Serious comorbid physical, psychosocial, or psychiatric conditions.
- Life expectancy < 6 months.
- Patient and family concerns over course of disease or decision making and/or request from patient or family for palliative care.

The guidelines recommend frequent palliative care screens to evaluate symptom burden, change in performance status, disease trajectory, or goals of care. Glare et al operationalized these screening criteria into a scored tool and applied this tool in the ambulatory oncology setting. Screening of patients was done by an office practice nurse at an outpatient gastrointestinal clinic who was aware of the medical situation of each patient. Patients were classified according to extent of disease, prognosis, and palliative care concerns. The following were included in the screen: metastatic disease, functional status, presence of complications related to the underlying cancer, presence of comorbid conditions, and presence of palliative care concerns. Of 119 patients screened, 13% (score > 5) met criteria for palliative care referral.[49] This intervention was effective as a simple screen and captured patients who would benefit from specialist palliative care at an earlier than usual time in their disease course.

However, even with guidelines, accurately estimating prognosis remains difficult. Certain physical symptoms may help, because they portend a poor prognosis and may therefore trigger a palliative care referral. These include anorexia, dysphagia, dyspnea, xerostomia, and weight loss. A recent study found that if none of these symptoms were present, patients had a median survival of 6 months, but if all of these symptoms were present the median survival was only 6 weeks.[50] Poor (score of ≥ 3 on the Eastern Cooperative Oncology Group [ECOG] scale) or declining performance status is another indicator for palliative care involvement. Patients with advanced cancer lose the majority of their functional status during the last 2 months of life. Both the Karnofsky Performance Status (KPS) scale and the ECOG performance status scale correlate with survival in cancer patients. A KPS score of 40 or an ECOG score of ≥ 3 are associated with survival of 3 months or less.[50-54]FIGURE 4
Finally, a change in treatment trajectory, determined by either the clinician or the patient, warrants palliative care involvement. Examples include toxicity from treatment (ie, grade IV graft-versus-host disease in a transplant patient), refractory disease (ie, disease that is no longer treatment-sensitive), or a reluctance on the part of the patient to continue with anti-cancer therapy due to the burdens of treatment. Figure 4 depicts the disease trajectory often seen in cancer. Palliative care integration is appropriate at diagnosis, when disease recurs (this is often the first time when people recognize that they are/or may die of their disease—ie, a decision-making point), and when disease becomes advanced or incurable. Individualized assessment of each patient, with attention to both the molecular basis of the cancer and the issues that cause suffering for patient and family, ensures quality integrated care.

A Case That Illustrates the Integration of Palliative Care Into the Continuum of Cancer Care

Mr. J is a 43-year-old man with metastatic prostate cancer. In late 2009, he developed urinary symptoms (increased frequency and poor stream) and sexual dysfunction. Because of persistent symptoms, he underwent evaluation by his physician. In June 2010, a digital rectal examination showed an enlarged prostate. Prostate biopsy demonstrated a high-grade, high-volume cancer, Gleason score 4+5, with perineural invasion and involvement of the bladder neck. At the same time, he was found to have bone metastases. He was started on treatment with bicalutamide and leuprolide (Lupron), which resulted in hot flashes. His wife and two children were quite concerned about his health, and had questions about what was going to happen next.

At the time of diagnosis, a significant symptom burden (both physical and psychological) is often present. [55-58] Mr. J had to deal not only with the psychosocial and emotional impact of a cancer, but also his ongoing urologic issues, sexual dysfunction, and treatment toxicity. Additionally, he had financial concerns due to multiple lost days of work, and worries about supporting his wife and two children. His family was frightened and had questions about his disease trajectory. For a few months he had stable disease and was able to work and interact with his children, aged 9 and 7, but he struggled with continued hot flashes and anxiety about the future for himself and his family.

Palliative care needs for patients in remission or with stable disease include concerns about financial status; and anxiety about recurrence/progression, continued treatment, and disease-related morbidity.

In January 2011, Mr. J presented with increased difficulty with urination. Workup demonstrated further progression in the bones and increased pelvic lymphadenopathy. Chemotherapy was recommended as second-line treatment. Throughout treatment, Mr. J had urinary symptoms (urgency, pain, incontinence) and bone pain. Despite several lines of treatment, his performance status continued to decline. Mr. J’s family was most concerned about his symptoms and was unclear about next steps. The palliative care team was consulted.

Unfortunately for some, disease may progress or recur. Mr. J had an increase in disease burden, and with this came increased symptoms and overall decline in quality of life and functional ability. A KPS of < 50% suggests a survival of weeks to months.[50,54] His wife was tearful, and his children were searching for ways to find meaning and be a part of the family team. His palliative care needs now included coping with a life-limiting illness, balancing treatment toxicity with quality of life, dealing with financial needs, managing increased symptom burden (pain), and beginning to close with friends and family.

Mr. J died of his disease in spring of 2011. He was enrolled in hospice care 1 week before his death, due to lack of anti-cancer options and increased symptoms. Mr. J’s time in hospice is typical of many patients with advanced disease. Often, hospice is
introduced very late in a patient’s course, when symptoms are escalating or when there are no further treatment options.[59-63] While > 30% of all patients admitted to hospice have a cancer diagnosis, > 50% of cancer patients in hospice have a hospice length of stay of under 3 weeks, and 35% of these patients utilize hospice for less than 1 week.[64] In Mr. J’s case, the hospice team became involved at a point of crisis and worked with the family to help the patient with his symptoms and the family with their shock and grief. At the time of death, palliative care shifts to bereavement care, with the goal of caring for loved ones—which in this case included supporting the patient’s wife and children.

What is clear from this example is that while palliative care as a subspecialist service was introduced quite late in the patient’s course, the patient’s palliative care needs were present from the time of diagnosis. This raises the question, "What is the best way to deliver palliative care? Can it be provided by the oncologist, or does it require a specialty service?"

Who Provides Palliative Care?

Ideally, palliative care is multidisciplinary care. The care addresses all aspects of suffering—physical, social, emotional, spiritual, and practical—in order to provide the best experience for the patient and the family. Those included in the team of healthcare providers responsible for providing palliative care at the end of life (hospice care) have been defined by Medicare regulations. The team includes a physician, nurse, social worker, chaplain, bereavement provider, and volunteers. It is not yet clear which team members are essential for the provision of palliative care earlier in the course of cancer therapy. To date, studies of concurrent palliative and oncologic care have not teased out which components of palliative care (personnel and practices) provide what benefit. The terms "primary," "secondary," and "tertiary" describe models of palliative care delivery. Primary palliative care is provided by the patient’s primary team, and usually includes the primary oncologist and his or her team. In the case above, the patient was treated by his primary oncologist with disease-modifying therapy, with the hope of improving symptoms, survival, and quality of life. In addition, referrals to radiation oncology and urology were provided in an attempt to treat symptoms (urinary urgency and bone pain). Care was cancer-focused. What was not recommended, but is critical, is involvement of a social worker and chaplain to address the family’s financial, social, psychological, and spiritual needs. Primary palliative care requires basic skills in pain and symptom management and communication, as well as awareness of the need for input from other disciplines for psychosocial, spiritual, and practical support for the patient and the family.

Secondary palliative care is palliative care provided by a specialist team. These teams are usually multidisciplinary and include trained palliative care professionals. Patients referred to these teams often have more complex palliative care needs (eg, difficulty in controlling pain, challenging psychosocial needs) not easily resolved by the primary team. This was the case with Mr. J. Finally, tertiary palliative care refers to centers and institutions that engage in palliative care education, teaching, and research.[65]

Palliative care is also expanding across settings to service the needs of patients across the continuum of cancer care. Palliative care has slowly evolved from a community-based hospice movement into a multidisciplinary inpatient team model in acute care centers/hospitals.[66] Because oncologic care is primarily an ambulatory practice, development of a model of integration in the outpatient setting is an area of active research. While the most recognized model is demonstrated in the Temel study, that integrated approach is a high-resource model involving a palliative care team (physician, nurse, practitioner) that met the patient on a monthly basis.[34] Criticisms of this model are that these resources (both personnel and timing of visits) may not be practical outside of an academic setting. Other groups have looked at different models of palliative care delivery. For example, Muir et al explored the impact of embedding a palliative medicine physician into a busy oncology practice.[67] Palliative care services were initiated as a one-half-day-per-week clinic, staffed by a board-certified palliative care physician and palliative care fellow. Data were collected on patient satisfaction as well as symptoms (via the Edmonton symptom assessment scale [ESAS]). Of the patients who were able to complete serial surveys, patients reported a 21% improvement in symptoms. An increase in the satisfaction of oncologists with their work was also noted. One criticism of Muir’s model is that it is based on reimbursement, using billable components such as MD-based care, and as a result is not truly team-based care (no social work or nursing components). Another criticism is that the model requires a high volume of visits for sustainability (4 new patient visits, and 10 to 14 follow-up visits in a single half-day); this may not be feasible for many. A third model is one developed by Dudgeon et al, who have initiated a province-wide initiative to routinely
screen and treat symptoms and distress in cancer patients.[68] This large-scale project was launched with an initial goal of screening all palliative care patients and all lung cancer patients in the province of Ontario using the ESAS. During the first 3 years, over 25,000 ESAS screens were completed (60% of all lung cancer patients, and 40% of all palliative care patients). Patients reported their symptoms at each visit and viewed the changes over time, as did their healthcare team. Schemas for referral for symptom/distress management and algorithms for treatment were embedded into the system. This model, with built-in management algorithms, has the potential for widespread application. In a resource-rich setting, computer kiosks can be used to collect the patient reports of symptoms (as in Ontario), while in a resource-poor environment, the data could be collected with paper and pencil. Future endeavors to evaluate models of integration in the outpatient setting are critical to determine the best means of delivery of ambulatory palliative cancer care.[68]

While there has been growth of palliative care services, access in the US is still limited. A survey by CAPC found larger US hospitals (300 beds or more) were more likely than their smaller counterparts to have a palliative care service (85%). Areas of continued need include public hospitals (54% with palliative care), community hospitals (37% with palliative care), and for-profit hospitals (26% with palliative care). Also, the definition and quality of these teams are quite disparate. Palliative care is often an inpatient-only, consultative specialty. Teams may or may not have board-certified practitioners, and may or may not be multidisciplinary.[69,70] A study published in JAMA evaluated integration of palliative care into US cancer centers. The authors found that while palliative care was more likely to be present in National Cancer Institute (NCI)-designated cancer centers, the majority of palliative care services were inpatient-based. Only 59% of NCI-designated cancer centers, and 22% of non–NCI-designated cancer centers, had an outpatient palliative care clinic or team.[71] Growth and expansion of palliative care must include continued investigation of outpatient palliative care delivery as well as inpatient palliative care units and home-based teams.[72,73]

**Barriers to Integrated Palliative Care and Oncologic Care**

In spite of increasing evidence, and guidelines that recommend integrating palliative care with oncologic care, significant barriers to integration remain. These include lack of palliative care education, and negative perceptions of palliative care. The "ignorance-arrogance paradox" postulates that physicians do not recognize what they do not know.[74] Sadly, for pain management, this is as true now as it was 20 years ago.[75-77] For example, a survey of oncology fellows found that only a quarter of fellows could do a basic pain conversion correctly.[78] Fellows had received more training and feedback on procedural skills, such as performance of a bone marrow biopsy, and minimal training in communication and management of symptoms such as depression.[78,79] In addition, there is a shortage of providers trained in the very young specialty of palliative care.[71]

Encouragingly, over the last few years, there has been an increased emphasis on palliative care education and training. There are increasing numbers of palliative care training programs in all disciplines, with mandatory palliative care training requirements for students at multiple levels from medical school to fellowship. There are guidelines for palliative care minimum standards, including a quality framework established by the National Quality Forum as well as the Clinical Practice Guidelines for Quality Palliative Care by the National Consensus Project.[80-83] Notably, 10% of the questions on the certification examination for medical oncology focus on palliative care knowledge.[84] An NCI-funded project to develop and test palliative care training for US oncology fellows has also just gotten underway. Funded palliative care research programs (currently < 1% of the National Institutes of Health budget), palliative care fellowships, and mandatory palliative care training for oncologists are critical for advances in palliative care knowledge and optimization of oncology care.

Another major barrier to the integration of palliative care into all phases of oncology care is the misperception that palliative care is "end-of-life" care.[85-87] Unfortunately, some practitioners still view cancer care as dichotomous, "cure" vs "care." A proxy for this issue is the reluctance of oncologists to discuss advance care planning with their patients and to raise questions about prognosis, hospice, medical decision making, and site of death. A recent study from the Cancer Core Outcomes Research and Surveillance Consortium of over 4000 physicians found that for an asymptomatic patient with a predicted survival of 4 to 6 months, only 65% of physicians would discuss prognosis, 44% would discuss code status, and 26% would discuss hospice. Most physicians would wait until there were no further anti-cancer therapies available before discussing hospice, place of death, and code status.[88] One hypothesis for why physicians feel this way is concern that
these conversations may take away hope and increase depression. Data prove that this is not the case.[89-91] The vast majority of patients want information about their prognosis and disease in order to participate in decision making.[92] It is likely that these discussions do not occur due to lack of physician training in communication skills, as well as a general sense of physician discomfort and sadness.[93,94] As a result, palliative care is often incorporated late in a patient’s course, and hospice even later.[59-63] In addition, patients’ end-of-life preferences are not always honored. While most patients would like to die at home, > 30% die in institutions, and approximately 9% receive ICU-level care at the end of life.[95-100] Earlier access to palliative care and improvements in physician education, particularly in the area of communication, have the potential to improve this.

Palliative Care: A Value-Added Proposition

There is agreement that the rising costs of healthcare are unsustainable in the current US economy. About one-third of all healthcare costs are incurred in the last year of life. This is due to high rates of hospitalization at the end of life and increased time in intensive care settings during hospitalizations.[101-103] The principles and practice of palliative care have been shown to decrease costs and improve quality, via both outpatient and inpatient interventions.[104] In one example, a closed, not-for-profit, group plan–based organization studied an in-home palliative care intervention for patients with a terminal illness (prognosis of < 1 year) and at least one hospital admission in the last 12 months. The intervention, a home-based coordinated interdisciplinary team modeled on a traditional hospice approach, showed that patients in the intervention arm were more satisfied with their care ($P < .05$), more likely to die at home ($P < .001$), less likely to visit the emergency room ($P = .01$), and less likely to visit the hospital ($P < .001$), and as a result had overall decreased costs of care ($P = .03$). Patients did not have to have a prognosis of < 6 months in order to receive this intervention and they could continue receiving curative therapies.[105] An inpatient palliative care consult can also lead to reduced post-hospital discharge costs and improved satisfaction (on the part of both provider and patient). In a multicenter study of 517 patients, those who received an inpatient palliative care consultation had higher scores on the Care Experience scale (inpatient palliative care consultation [IPCS], 6.9, vs usual care [UC], 6.6; $P = .04$) and on the Doctors, Nurses/Other Care Providers Communication scale (IPCS, 8.3, vs UC, 7.5; $P = .0004$), had fewer ICU admissions on hospital readmission (12 vs 21, $P = .04$), and had greater 6-month net cost savings ($4,855 per patient; $P = .001$).[106] For cancer patients hospitalized for at least 5 days who subsequently died, palliative care consultation decreased total and ancillary costs.[107] When palliative care is provided to appropriate inpatients, cost savings of $1,700 to $4,900 per admission (or $250 in direct costs per patient per day) are realized.[108] Other studies have reported similar outcomes, with demonstrated improvement in the cost-efficiency of care when palliative care is integrated into care.[109] Pathway-based cancer care that eliminates futile therapy is another mechanism for reducing costs. Palliative care principles have been incorporated into pathways that included the utilization of expensive drugs (such as erlotinib [Tarceva] and bevacizumab [Avastin]) in the right clinical scenarios as well as the elimination of chemotherapy beyond third-line treatment regimens. The US Oncology Group found that when care is delivered on-pathway vs off-pathway, costs are 35% lower and overall survival is the same.[110]

Changing the Paradigm: Bringing Palliative Care From the Fringes to the Center

Palliative care is coming to the center stage. Despite barriers to integration (access, education, and perception), strides are being made in training, in the establishment of clinical standards, and in research. There is finally momentum driving palliative care/oncology integration, in part due to our changing healthcare environment where "cost" and "quality" are the buzzwords. Critical paths for oncology/palliative care integration include increased research funding, policy initiatives that lead to reimbursement reform, dissemination of palliative care education at all levels of training, and development and evaluation of models for integrated care delivery. Through these avenues, palliative care will become a routine component of standard oncologic care and provide the best patient and family experience.

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