Integration of Palliative Care and Oncology Nursing

Kimberly Chow and Constance Dahlin

Objective: *To describe the evolution of oncology and palliative nursing in meeting the changing landscape of cancer care.*

Data Sources: *Peer-reviewed articles, clinical practice guidelines, professional organization, and position statements.*

Conclusion: *Nurses have been at the forefront of efforts to develop and implement oncology and palliative care programs. Fifty years ago a cancer diagnosis meant a poor prognosis, high symptom burden, and disease uncertainty. Current cancer care has advanced to include palliative care in conjunction with innovative therapies and symptom management.*

Implications for Nursing Practice: *Specialty trained oncology and palliative care nurses are essential in disease and symptom management, psychosocial and spiritual support, and advance care planning.*

Key Words: *oncology nurse, palliative care, primary palliative care, specialist palliative care.*

In 2017, approximately 1.6 million people were diagnosed with cancer in the United States, and approximately 600,920 people were expected to die of their disease.[1] Advances in cancer science and technology continue to increase life expectancy for many of these individuals. However, the consequences of disease-targeted treatments and long-term effects remain a critical focus. Additionally, some cancer types are not curable and have limited treatment options despite the many groundbreaking, innovative therapies.[2] There is a high prevalence of cancer-related symptoms, e.g., (pain, shortness of breath, fatigue, anxiety, and depression), that are often underreported and undertreated.[3–5] This heavy symptom burden requires high-quality symptom management, psychosocial and spiritual support, clear and consistent communication, and early advance care planning.

There is a natural connection between oncology nursing and palliative care nursing. In fact, the two specialties of nursing emerged simultaneously as nurses witnessed patients and their families with multidimensional needs throughout the illness trajectory.[6–10] This article reviews the history of oncology and palliative care nursing and describes how clinical guidelines across both fields have come to support the integration of palliative care into comprehensive cancer care starting at diagnosis. Sustainable models of

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palliative oncology care are described and implications for nursing discussed. A review of the most up-to-date literature using Pubmed, CINAHL, and EMBASE was performed to support findings and recommendations for current and future nursing practice.

History of Palliative Care and Oncology Nursing

The specialties of palliative care and hospice emanated from the care of cancer patients. In the 1950s, St. Christopher's Hospice was founded out of the need to improve the quality of end-of-life (EOL) care for persons with cancer. Hospice care arrived in the US in the late 1970s when Dr. Florence Wald, the dean of the Yale School of Nursing, established the first course for hospice nurses at her institution and led the founding of the Hospice of Connecticut. Since Dr. Wald's pioneering initiatives, nurses have been at the forefront of efforts to develop and implement hospice and palliative care programs across the US.[11–13]

The National Hospice and Palliative Care Organization (NHPCO) defines hospice as a team-oriented care model focused on high-quality, compassionate care that is tailored to the needs and wishes of patients with life-threatening illnesses or injuries.[14] In its earliest years, hospice primarily focused on the care of patients with cancer who had a limited life expectancy, usually fewer than 6 months because of the lack of effective treatments. It was this cancer prognosis upon which the hospice enrollment criteria was developed.[8] Currently, criteria to receive hospice benefits continues to be restricted to patients with a 6-months or less prognosis who are willing to forego disease-directed therapies and shift the focus of care toward comfort at the EOL.

The palliative care movement was led by nurses, doctors, social workers, and other disciplines who believed that limiting hospice care to individuals based on their prognosis restricted the access to care for many seriously ill patients who could otherwise benefit. Instead, there was recognition that specialist care could improve quality of life (QOL), reduce symptoms, and support patients' and families' psychological, social, and spiritual needs upon diagnosis. Thus, palliative care evolved from the traditional hospice model, with the goal of early integration of this philosophy of care into the serious illness trajectory.[15]

Palliative care is defined as "patient and family-centered care that optimizes the QOL by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choices."[16] Palliative care is an umbrella term under which hospice care is a subset. The introduction of palliative care has ensured that patients with any serious illness can receive holistic, patient- and family-centered care across the disease trajectory, starting at diagnosis. The level of support needed is individualized to each patient and his or her situation, with hospice representing a period of intensified palliative care as individuals move closer to death.[15] This early integration is particularly important because technology and innovation within the oncology field have created novel therapies that make prognostication more difficult for clinicians.

Specialty oncology and palliative nursing have developed simultaneously. In the early days of cancer care, chemotherapeutic, surgical, and radiation treatment options were limited, resulting in a heavy symptom burden from pain, nausea, vomiting, diarrhea, mucositis, and neutropenic-related sequelae. The specialty of oncology nursing began in the mid-1960s to identify nurses with the skill-set and expertise to safely administer chemotherapy and manage associated symptoms. Oncology-specific units were created to meet the many unique needs of this patient population.[7] Throughout the history of oncology nursing, the scope of practice has consistently highlighted the importance of balancing appropriate and safe disease management with excellent palliation of symptoms and support for patients and family.[17] In essence, the oncology and palliative nurse's roles grew out of a need to improve the overall quality of care for patients from diagnosis through EOL.

In 1990 the World Health Organization (WHO) published a report on *Cancer Pain Relief and Palliative Care.* This seminal report highlighted the priority to alleviate pain and suffering for cancer patients in the absence of totally effective prevention methods and curative treatment options.[18] In 1997, the Institute of Medicine (IOM) published *Approaching Death: Improving Care at the End of Life*, which was one of the first comprehensive, evidence-based, national reports to call attention to the need for palliative care to play a role in comprehensive cancer care.[19] Shortly after, the