
INTEGRATING PALLIATIVE CARE INTO ACTIVE CANCER TREATMENT

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OBJECTIVES: *To describe the evidence that palliative care, provided concurrently with disease-modifying treatment early in the course of a cancer diagnosis, can improve quality of life, length of survival, symptom burden, mood, and utilization of health services.*

DATA SOURCES: *Current research, the National Consensus Guidelines for Quality Palliative Care, and the American Society of Clinical Oncology Provisional Opinion on Integrating Palliative Care into Standard Oncology Care.*

CONCLUSION: *Despite recommendations and evidence, only a subset of cancer centers and community-based oncology clinics currently implement palliative care into ambulatory disease-focused cancer care.*

IMPLICATIONS FOR NURSING PRACTICE: *Oncology nurses can improve access by becoming knowledgeable about generalist palliative care and by advocating for local and national practice change.*

KEY WORDS: *Palliative care, Quality cancer care, Symptom management, Oncology nursing*

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0749-2081/3004-836.00/0.

<http://dx.doi.org/10.1016/j.soncn.2014.08.002>

INTEGRATING palliative care services into standard oncology care for patients diagnosed with advanced disease or those with heavy symptom burden is the recommendation of the American Society of Clinical Oncology for quality cancer care.¹ Palliative care is “patient and family-centered care that optimizes quality of life (QOL) by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.”² Services are provided by an interdisciplinary team of doctors, nurses, and other specialists who work with a patient’s other physicians to provide additional support.³

Palliative care offers the best patient outcomes when it is initiated at the time of a life-limiting diagnosis, continues across the disease trajectory, the dying process, and death.³⁻⁶ Recent evidence has demonstrated that palliative care, provided concurrently with disease-modifying treatment early in the course of advanced cancer, can improve QOL, length of survival, symptom burden, mood, and utilization of health services.³⁻⁹ This evidence has promoted the use of palliative care services at National Cancer Institute (NCI)-designated cancer centers and in non-NCI designated cancer programs.^{1,3,9} Much work is needed to increase the availability of these services to all patients with cancer and to dispel the myths that palliative care is something that is reserved for end of life (EOL).^{3,10}

Cancer statistics continue to be staggering. More than 14 million patients and families in the US are living with cancer at some point along its disease trajectory. More than 1.6 million patients are expected to be diagnosed in 2014 and 585,720 cancer-related deaths from cancer are estimated—the equivalent of about 1,600 deaths each day.¹¹ With the aging population, the numbers continue to rise and by the year 2050, the number of patients in the US with newly diagnosed cancer is expected to increase to 2.6 million.¹¹

Because of the advances in cancer treatment, many with metastatic disease are living longer, but are also in active treatment longer, which increases the potential for burdensome side effects.⁵ Many patients suffer from pain and symptoms related to the disease and/or its treatment; this suffering can persist even after the cancer is controlled. Addressing the impact cancer and its treatment has on the QOL of patient and family is equally as important as treating the cancer. Early integration of palliative care into standard oncology care provides patients and families with both improved QOL and the best opportunity for increasing length of life.

HISTORICAL BACKGROUND

The integration of palliative care services into cancer care in the US began as dedicated units, consultative services, and hospital-based practices in the early 1990s.¹² Palliative care was developed to address the gap in care for patients who were not ready for hospice, or did not qualify for hospice services, but needed aggressive symptom management and attention to the physical, psychological, social, and spiritual domains of QOL.

Most of the palliative care referrals at that time were for patients nearing the EOL or with heavy symptom burden and these “late” referrals to palliative care did not allow time for patients and families to benefit from all the services of a quality palliative care team (PCT).

Clinically, it was evident that patients should be offered earlier referral so palliative care advocates began to address the barriers to early referral. Expert panels, such as the National Quality Forum developed guidelines for quality palliative care and professional organizations such as The American Society of Clinical Oncology (ASCO), The Hospice and Palliative Nurses Association, the Oncology Nursing Society (ONS), and the National Comprehensive Cancer Network (NCCN) have supported the integration of these guidelines into practice. The model of care shifted from recommending palliative care to those with advanced cancer who were no longer receiving disease-focused treatment but not yet ready for hospice, to integrating palliative care at the time of diagnosis and providing services across the cancer care continuum.^{1,4,7} Figure 1 depicts the newer model of palliative care integrated across the disease trajectory.¹³

MODELS OF PALLIATIVE CARE

Many cancer centers and clinics state that they have palliative care services, but the structure, processes, and outcomes for the programs are very diverse.¹⁴ Some claim to have a consultative model in place, but the majority of programs are limited to inpatient services, with fewer programs offering outpatient services.¹⁴ Consultative

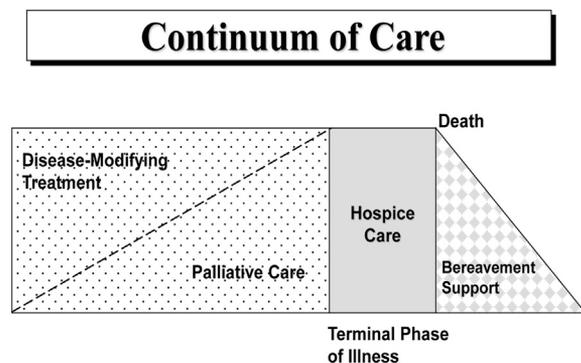


FIGURE 1. Integration of palliative care across the cancer trajectory. (Reprinted with permission from *Clinical Practice Guidelines for Quality Palliative Care*. Ed 2; 2009. National Consensus Project. Pittsburgh, PA).¹³

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