

Evolution and Integration of Palliative Care in Modern Oncology: A Holistic Approach to Patient-Centered Well-Being

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Abstract

This article examines the evolution and significance of palliative care within modern oncological practices, tracing its roots from the hospice movement and highlighting key contributors like Dame Cicely Saunders and Balfour Mount. The distinction between palliative care and hospice care is explored, emphasizing the comprehensive nature of palliative care across disease stages. The article underscores the positive impact of early integration of palliative care into standard oncological treatment on patient outcomes, quality of life, and healthcare utilization. Clinical guidelines, exemplified by the American Society of Clinical Oncology (ASCO), underscore palliative care's essential role in patient-centered care. The concluding focus is on collaborative efforts to ensure equitable access to timely and compassionate palliative care services, thereby promoting holistic well-being for individuals facing serious illnesses.

Keywords: Palliative care; Oncology; Hospice; Patient-centered care; Quality of life; Healthcare utilization

Introduction

While the majority of genitourinary cancers detected in their initial stages exhibit promising prognoses, individuals dealing with advanced localized or metastatic conditions encounter enduring and challenging symptoms, alongside restricted life expectancies. Throughout recent decades, the realm of urology has made significant strides in alleviating the physical distress and functional impediments stemming from genitourinary cancers. This progress has been achieved through specialized expertise, innovative surgical techniques, centralized treatment approaches, collaborative multidisciplinary care, and the development of new and enhanced pharmaceuticals. Nonetheless, there is no universal solution to entirely eradicate postoperative complications or counteract the aggressive nature of tumor biology. Patients grappling with cancer confront a substantial load of unaddressed necessities. Extensive literature pertaining to genitourinary cancer comprehensively outlines the adverse and enduring impacts of cancer on physical, functional, psychological, and socioeconomic well-being. Despite the utilization of the most effective available treatments, cancer recurrence remains a reality in numerous cases, leading to persistent disease-related symptoms, functional decline, and ultimately, mortality. Incorporating the principles of palliative care or facilitating a referral to a multidisciplinary palliative care team, when appropriate, can enable urologists to provide comprehensive support for patients across all stages of cancer who are contending with unresolved symptoms, coping challenges, and communication requirements. The Center to advance palliative care defines palliative care as a specialized form of medical care tailored to individuals grappling with serious illnesses, with a primary focus on alleviating the symptoms and emotional strain associated with such illnesses [1-5]. The ultimate aim is to enhance the quality of life for both patients and their families. Palliative care proactively addresses and alleviates suffering by attending to the physical, informational, emotional, social, and spiritual needs of patients and their caregivers. Numerous randomized controlled trials released in the last ten years illustrate the favorable outcomes stemming from the early integration of palliative care alongside standard oncological treatments, particularly in cases of advanced disease. The advantages of implementing concurrent palliative care at an early stage encompass enhanced quality of life, bolstered physical and spiritual wellness, increased satisfaction for both patients and caregivers, utilization of healthcare services in

alignment with patient goals, and heightened utilization of hospice care during end-of-life stages. In 2019, our research team reported a mere 4% utilization rate of subspecialty palliative care among patients in the USA covered by Medicare insurance and afflicted by muscle-invasive bladder cancer. Interestingly, this low level of palliative care utilization persisted even among patients grappling with advanced bladder conditions specifically, those categorized as having stage 4 tumors, lymph node-positive, or metastatic disease which constituted 30% of the subjects in our study. In the realm of urology, aside from investigations based on population-level data or hospital registries, scant attention has been directed towards examining the precise framework and procedural aspects of palliative care. The need for studies becomes apparent in order to shed light on the underutilization of palliative care and to discern the impact of simultaneous palliative and oncological care on outcomes for patients affected by genitourinary cancers.

Within this perspectives piece, we trace the evolution of palliative care within the field of oncology, appraise the indications and guidelines underpinning palliative care utilization, and offer guidance to urological oncologists on adopting optimal strategies. We delve into the historical context of palliative care and underscore the profound interrelation between urology and the emergence of this relatively nascent subspecialty. It is our aspiration to demonstrate that urologists, distinctively positioned among surgical subspecialists, can take a leadership role in advocating for the seamless integration of palliative care into standard cancer treatment protocols. Ultimately, our overarching objective is to contribute to the ongoing discourse centered around the early incorporation of palliative care into urology and to fervently encourage further research into its implications for

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patients dealing with genitourinary cancers. The origins of modern palliative care can be traced back to the hospice movement that gained momentum during the 1960s. It was during this period that studies conducted in the 1990s revealed the limitations of relying solely on hospice services to address the multifaceted needs of patients. The 1960s witnessed a surge of research attention directed towards oncology and a growing recognition of the inadequate medical attention provided to patients in the terminal stages of cancer. In 1964, a transformative figure by the name of Dame Cicely Saunders emerged, leaving an indelible mark on end-of-life care. Her pioneering contributions included the introduction of the concept of "total pain." Just three years later, in 1967, she established the world's inaugural modern hospice in London, UK, known as St Christopher's Hospice. This institution rapidly evolved into a hub of both clinical expertise and research excellence. Dame Saunders played a pivotal role in training the initial cohort of palliative care physician-scientists, a generation that reshaped end-of-life care from being a peripheral concern within oncology to becoming a central and indispensable element of comprehensive patient care. Across the expanse of the Atlantic Ocean, a burgeoning surgeon-scientist by the name of Balfour Mount was cultivating his urologic oncology practice within the precincts of McGill University in Ottawa, Canada. It was during the early 1970s that Mount's awareness heightened, revealing a prevailing sense of abandonment and emotional distress among cancer patients under his care. Consequently, Mount embarked on a quest for guidance from Cicely Saunders, driven by a desire to deepen his understanding of end-of-life care. In the course of his inquiry, Mount discerned a dissonance within the doctor-patient relationship. His investigations illuminated an unmet yearning for candor and attention in patients during their final stages, often withheld by physicians who believed they were shielding patients from potential harm that comes with knowing the unvarnished truth. Curiously, many hospital staff seemed oblivious to this dilemma, with more than half acknowledging that colleagues sidestepped difficult discussions with patients, while less than 20% personally acknowledged grappling with such complex scenarios. Mount's deductions crystallized into the notion that "our own apprehensions influence the extent of our candid discussions about mortality with patients" and influence how physicians perceive the emotional states of their patients²⁰. Mount introduced services typically associated with hospices into inpatient acute-care and community settings, effectively extending the scope of care. To circumvent the unfavorable connotations associated with the term "hospice," which held a negative connotation, particularly among the Quebecois population, Mount coined the term "palliative care" for this novel service. This nomenclature served to sidestep the unfavorable perceptions linked with "hospice," which had garnered a less-than-favorable reputation as a subpar form of care^[6-10].

Building upon Mount's groundbreaking work in the 1970s, the 1995 Study to Understand Prognosis and Preferences for Outcomes and Risk of Treatment (SUPPORT) yielded illuminating insights into the various inadequacies in the care provided to seriously ill patients within hospital settings. Spanning multiple phases, SUPPORT was a comprehensive trial conducted across five centers in the United States. The primary goal of the study was to unravel the decision-making processes and outcomes concerning end-of-life care for patients in advanced stages of nine different chronic illnesses. Subsequently, the aim was to design an intervention to ameliorate these outcomes. In the initial phase, over 4,301 hospitalized patients were enrolled, each of whom had a mean life expectancy estimate of six months, standing at 52%. Within six months, 47% of this phase's participants had passed away. Within this group, a third had spent ten or more

days in the intensive care unit (ICU), fewer than half of the physicians were acquainted with their patients' preferences regarding a Do Not Resuscitate (DNR) order, and families reported that 50% of patients experienced moderate to severe pain for at least half the time during the last three days of life. The SUPPORT study markedly intensified the focus on the unmet needs of seriously ill patients in the United States. This pivotal report urgently called for the development of dependable, skillful, and empathetic care for individuals grappling with potentially life-threatening illnesses. Additionally, it underscored the commitment of healthcare professionals to enhance the quality of care provided to patients nearing the end of life. In response to the Institute of Medicine's recommendations, policymakers and healthcare systems initiated several significant changes. These included the establishment of hospital-based palliative care consultation services and the creation of a distinct medical specialty in hospice and palliative medicine, catering to the needs of physicians and other healthcare practitioners [11-13].

Palliative care

According to the Center to Advance Palliative Care, palliative care is characterized as "specialized medical care for individuals grappling with a severe illness," with a primary focus on alleviating the symptoms and emotional strain associated with that illness. An integral aspect of palliative care is its recognition that caregivers form an integral part of the care unit, working alongside the patient, and thus, it strives to identify and attend to the needs of caregivers. Distinguishing palliative care skills from the clinical skills anticipated of all healthcare providers lies in the specialized training required to adeptly administer these skills to those in need. It is anticipated that all physicians possess competence in fundamental pain and symptom management, including initial interventions for anxiety and depression. Additionally, they should possess the capability to engage in sensitive conversations with patients regarding their prognosis, care objectives, and code status. On the other hand, subspecialty palliative care services are offered by clinicians certified by relevant boards, typically reserved for patients confronting intricate needs. These services encompass an advanced level of pain and symptom management. Furthermore, subspecialty palliative care facilitates seamless communication among medical and surgical teams, ensures clear and consistent dialogues with patients and caregivers especially during emotionally charged times coordinates the smooth transitions of care within hospital settings and post-hospitalization environments, and facilitates thoughtful contemplation of hospice options when these align with patients' medical requirements and care objectives. It is crucial to distinguish between palliative care and hospice, as these two disciplines are frequently misunderstood by physicians, patients, and families. Key differences exist, including the fact that patients are eligible to receive subspecialty palliative care services regardless of their prognosis, whereas hospice care is typically provided to patients in the terminal stages of life. While there is no globally accepted definition of hospice, in the USA, eligibility for hospice requires agreement from two physicians that a patient's life expectancy is six months or less if their terminal diagnosis progresses as expected. Patients can receive palliative care alongside disease-specific treatments, and the assessment of palliative care needs commences at the time of a life-limiting medical condition's diagnosis. The balance between treatments targeting the disease and palliative services adapts over time, responsive to the patient's condition, prognosis, and preferences. In contrast, a hospice offers more focused services either in-home or at a facility, catering to patients with limited prognoses who prioritize comfort and dignity as their primary care objectives. To elucidate the disparity between hospice and palliative care for patients

and their families, a helpful analogy is that hospice constitutes a singular facet of the broader spectrum of palliative care, tailored to a specific subgroup of patients at life's end. Palliative care, in contrast, represents a comprehensive and expansive approach to healthcare, applicable to patients at any stage of a potentially life-limiting illness [14,15].

Guidelines: Numerous cancer patients are often referred to palliative care specialists late in the progression of their disease, arriving with poorly managed symptoms in the final stages of life³⁰. A case in point is a 2012 report from MD Anderson Cancer Center, where patients with advanced cancer were introduced to palliative care a mere 1.4 months before their demise, following a substantial 20 medical team interactions before the referral to palliative care³¹. Over the last decade, a body of evidence has emerged in support of the early integration of palliative care into conventional oncological management for individuals with metastatic disease. A pivotal study conducted by Temel and colleagues stands out in this context. This landmark investigation randomized patients newly diagnosed with metastatic non-small-cell lung cancer into two groups: standard oncological care versus a combined approach of palliative and oncological care. The primary outcome assessed was the quality of life, gauged through a comparison of baseline measurements and those taken 12 weeks after enrollment. Additional analyses encompassed mood assessment, healthcare usage, the recording of preferences regarding resuscitation, and survival rates. The results at the 12-week mark revealed that patients receiving palliative care exhibited significantly improved quality of life and fewer instances of depressive symptoms. The intervention group experienced fewer hospitalizations during their last month of life, an enhanced documentation of resuscitation preferences, and a notably greater median overall survival compared to the control group. It is important to note that while metrics of healthcare utilization and survival are not the primary objectives of palliative care, they are regarded as beneficial outcomes. Initial investigations into the early integration of palliative care during the early 2000s prompted the American Society of Clinical Oncology (ASCO) to issue a provisional clinical opinion in 2012 advocating for an expanded adoption of subspecialty palliative care. This opinion was subsequently incorporated into a comprehensive clinical practice guideline in 2017, incorporating data from 15 additional studies, of which nine were randomized clinical trials. With mounting evidence, the 2017 ASCO guideline recommended that comprehensive palliative care services be extended to patients with advanced cancer in the early phases of their disease, in conjunction with active treatment, and ideally within 8 weeks of an advanced cancer diagnosis. Other professional societies have also issued analogous guidelines, although there may be slight variations in the recommendations regarding the timing, indications, and screening for palliative care referrals.

Conclusion

In conclusion, the evolution of palliative care from its origins within the hospice movement to its integration into modern oncological care has been marked by significant advancements. The pioneering work of figures like Dame Cicely Saunders and Balfour Mount has shaped the way we approach end-of-life care, emphasizing the importance of addressing not only physical symptoms but also the emotional, psychological, and social needs of patients and their caregivers. The distinction between palliative care and hospice care has become clearer over time, with palliative care encompassing a comprehensive and multidisciplinary approach applicable to patients at any stage of a potentially life-limiting illness. The importance of early integration of palliative care into standard oncological care has been underscored by research, revealing its positive impact on patient outcomes, quality of

life, and overall healthcare utilization. The shift towards recognizing palliative care as an integral part of comprehensive patient-centered care is reflected in clinical guidelines and recommendations from organizations such as the American Society of Clinical Oncology (ASCO). The emphasis on multidisciplinary collaboration, timely interventions, and patient-centered communication has paved the way for improved patient experiences and outcomes, particularly for those navigating the challenges of advanced cancer and other life-limiting conditions. As we continue to advance our understanding of palliative care's role in enhancing the well-being of patients and their families, it is imperative that healthcare systems, practitioners, and policymakers work collaboratively to ensure that access to palliative care services is both timely and equitable. By embracing the principles of palliative care and integrating them into the fabric of modern medical practice, we can strive to provide holistic and compassionate care that honors the dignity and preferences of each individual throughout their journey of living with a serious illness.

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Conflict of Interest

Author declares no conflict of interest.

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