Journal of Palliative Care & Medicine
ISSN: 2165-7386
Adams, J Palliat Care Med 2023, 13:5
Editorial Open Access

Improving Quality of Life: Integrating Palliative Care in Gynecologic Oncology

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Palliative Care in Gynecologic Oncology

Gynecologic cancer patients suffer from several symptoms. The symptoms and emotional support required change as the disease progresses, through chemotherapeutic and surgical therapies, and towards the end of life. Gynecologic oncologists monitor their patients as they progress through these various stages of treatment and offer counselling at each turning point. Both inside the gynecologic oncologist's clinic and as a referral to a palliative care team, palliative care plays a crucial role. Gynecologic oncologists can refer patients to palliative care teams and provide palliative care in a variety of ways. In general, gynecologic oncologists are willing to collaborate extensively with a palliative care team. In a poll conducted by the Society of Gynecologic Oncology (SGO), 75% of healthcare professionals agreed that palliative care should be included in cancer treatment when advanced disease is diagnosed. The poll also identified hurdles to referrals for palliative care, with 80% of gynecologic oncologists believing that many of these barriers would be eliminated with more access to outpatient palliative care, for instance [1]. Identified patterns of palliative care engagement at the time of a challenging end-of-life clinical diagnosis; a malignant bowel obstruction [2] in a qualitative research of gynecologic oncologists in a major metropolitan region. The majority of those who participated in the interviews worked in higher education and had access to both inpatient and outpatient palliative care. The majority frequently consulted the palliative care team for symptom management and prognosis counselling, and they frequently worked closely with palliative care physicians when identifying a patient with a malignant intestinal obstruction. But once more, there were several obstacles to treatment. These included reservations about fragmenting care by bringing in a new team and questions about patient selection for access to the scarce resource of a palliative care referral. Salyer and colleagues address the majority of the issues raised by gynecologic oncologists in the SGO survey and qualitative interviews mentioned above [1-3] in their narrative review of palliative care in gynecologic oncology. For situations when access to palliative care consultations as inpatients, outpatients, or both is different, they offer recommendations for when to refer to this type of treatment. They also propose "primary palliative care," which they claim should be expected of gynecologic oncologists. Examples of primary palliative care include basic therapy of nausea, constipation, and objectives of care discussions. They also emphasise how this training may be accomplished. Salyer and coworkers emphasise the value of primary palliative care training, preferably through a fellowship in palliative care that may be applied to a gynecologic oncology practise or, at the at least, as part of the gynecologic oncology fellowship. A scoping review of primary palliative care training across residency and fellowship specialties found that emergency medicine, general surgery, internal medicine, and medicine-pediatrics, as well as subspecialists in oncology, nephrology, and paediatric subspecialties, were the specialties most likely to have publications on palliative care training [4]. They discovered significant variance in both the amount of time spent on issues related to palliative care and the material itself. The Accreditation Council for Graduate Medical Education (ACGME) milestones have recently added palliative care skills, but programmes differ in how they handle and assess these goals. Salyer and colleagues focus on palliative care training especially for gynecologic oncology fellows.

The two core facets of primary palliative care basic symptom management and communication are the focus of research on instructional work in the field during training. A crucial component of palliative care is communication, which is challenging to teach through didactic sessions. Time restrictions, concerns about diminishing hope and trust, and patients' unreasonable expectations were among the referral hurdles cited by gynecologic oncologists in the SGO study on palliative care and gynecologic oncology practise. In dialogues about shifting from curative to end-of-life care, patients have emphasised the significance of information clarity, allowing for grief, and maintaining hope [5,6]. While not all of these can be accomplished through effective communication, it can help remove obstacles to delivering end-of-life counselling and referring patients to palliative care. In a qualitative research we did on patients hospitalised for ovarian cancer-related malignant intestinal obstructions, we discovered several communication and expectation gaps between patients and their primary gynecologic oncologist [7]. Planning for support after discharge (patients were much more likely to discuss a desire to go home), frustration with the uncertainty associated with the diagnosis (patients desired more concrete information and physicians struggled with prognostic uncertainty), and discussion of goals such as future chemotherapy (most patients expected more chemotherapy after the diagnosis of a malignant bowel obstruction while most physicians considered it a contraindication. We indicated that a decision aid, similar to that put out by Wieringa and colleagues [8], may help in providing information on the diagnosis, alternatives, risks, and advantages, as well as serve as a guide for patient preference consideration. Increased communication, education, and a multidisciplinary team have been demonstrated to enhance patient satisfaction and symptom control in the context of malignant bowel obstructions, particularly during a challenging and crucial period in a woman's life [9]. Although a fellowship can include classroom instruction and in-person mentoring, training in communication skills must continue after the fellowship and throughout the early stages of a person's employment. Resources for communication training are made available by Salyer and colleagues through SGO, VitalTalk, GyoEdu, best care/worse case scenarios, and

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Received: 26-Apr-2023, Manuscript No. jpcm-23-98342; **Editor assigned:** 28-Apr-2023, PreQC No. jpcm-23-98342(PQ); **Reviewed:** 04-May-2023, QC No. jpcm-23-98342; **Revised:** 10-May-2023, Manuscript No. jpcm-23-98342(R); **Published:** 17-May-2023, DOI: 10.4172/2165-7386.1000525

Citation: Adams S (2023) Improving Quality of Life: Integrating Palliative Care in Gynecologic Oncology. J Palliat Care Med 13: 525.

other forums. In addition to surgical training in fields like gynecologic cancer, palliative care fellowships also offer significant training. However, they might present difficulties, particularly when it comes to maintaining certification by the American Board of Internal Medicine.

The narrative review by Salyer and colleagues serves as a crucial reminder of the value of palliative care teams in the treatment of gynecologic cancer patients as well as the part that gynecologic oncologists play in primary patient care. This is especially true in places where referrals for palliative care are not easily available in either the inpatient or outpatient environment (or both); even when available, referrals for palliative care are a scarce resource, and access is typically constrained. Many patients already have a full schedule and may find it challenging to make time for an additional palliative care appointment, especially when they have a lot of symptoms [10-15]. In the end, patients have a relationship with a gynecologic oncologist, and we are required to participate in prognostic counselling and hospice transitions as their main oncologist. To give patients with gynecologic malignancies the best treatment possible, it is essential to get training in symptom management and, in particular, communication during fellowship and beyond.

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