Palliative Care—The Challenge of Application

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NCCN has been a pioneer with regard to palliative care. In the 1990s, well before the American Board of Internal Medicine even recognized hospice and palliative medicine as a specialty in 2006, NCCN convened an interdisciplinary panel of experts to draft the first NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Palliative Care. First published in 2001, the NCCN Guidelines were and are designed as an evidence-based resource for oncologists and cancer care teams. Michael Levy, MD, PhD, the first chair of the Palliative Care Panel, described them at the time as the first NCCN Guidelines with death “as an expected outcome.”¹

Despite the many advances in cancer treatments since then, many of our patients will unfortunately die of their cancer. The NCCN Guidelines for Palliative Care provide an opportunity for cancer care teams to promote the best possible quality of life (QOL) for their patients. An increasing body of evidence suggests that integrating palliative care into standard cancer care can not only improve symptom management and patient and family QOL, but also, in some cases, improve length of life and reduce cost of treatment. The evidence base has grown large enough that ASCO recently updated and upgraded its 2012 Provisional Clinical Opinion to a Guideline that proposes the integration of palliative care into standard cancer care “for all patients diagnosed with cancer.”²

Despite the growing recognition that the interdisciplinary team approach of palliative care can be extremely beneficial for patients with cancer and their families, barriers to implementation of the NCCN Guidelines for Palliative Care remain, even among NCCN Member Institutions. The 2015 NCCN Palliative Care Survey revealed that although most NCCN Member Institutions possessed both inpatient and outpatient palliative care services, 80% of the respondents reported that demand for these services outstripped capacity.³

NCCN Member Institutions also noted considerable disagreement on the potential benefits of palliative care, who should receive it, and when it should be started. Given that clinical trial data drive many treatment algorithms in cancer care, one of the suggestions for improving the integration of palliative care into standard oncology care has been to incorporate more palliative screening criteria, such as those included in the NCCN Guidelines, into prospective randomized clinical trials. Where and how patients access care and when they are referred to palliative services may also be points of intervention. Studies have shown that even though most patients who receive palliative care consultation as inpatients are admitted through the emergency department (ED), very little palliative care screening occurs in the ED.⁴ A recent prospective randomized clinical trial involving ED-initiated palliative care consultation for patients with advanced cancer suggested that this type of intervention might improve patient and caregiver QOL without shortening survival.⁵

Another approach to the question of how to better align oncologists' views with published guidelines, such as the NCCN Guidelines, may be to clarify primary and specialist palliative care. A study evaluating oncologist referral practices to subspecialty palliative care clinics suggests that increasing availability of palliative care services and positive referral experiences are important, but that these 2 factors are not sufficient by themselves because not all oncologists agree that palliative care is a valuable addition to standard oncology care.⁶ Some authors have promoted a distinction between primary and specialist palliative care as an opportunity to recognize the tremendous amount of basic palliative care that oncologists already provide their patients, in addition to acknowledging the fact that having specialist palliative care teams attend to all palliative care needs is not possible in most cases.⁷ Indeed, ASCO and the American Academy of Hospice and Palliative Medicine recently published a joint “guidance statement” delineating 9 domains essential to the delivery of high-quality palliative care in oncology practice.⁸

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The answer to how to integrate palliative care into standard oncologic care will probably require a multifaceted approach, including clarifying palliative care interventions most important to oncologic care, showing further outcomes benefits from these interventions for patients with cancer, and raising the awareness of both oncologists and palliative care practitioners that ongoing collaboration is essential in the care of patients.

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