

Palliative oncology: identity, Progress, and the Path ahead

Alexander Bryan*

Department of Pediatrics, University of Washington School of Medicine, Seattle, WA, USA

Abstract

Palliative care is a rapidly increasing specialization of medicine that involves skilled and active assessment, evaluation, and treatment of patients' and families' medical, psychological, social, and spiritual needs. It adds to the patient's usual medical treatment by providing an extra layer of support. Palliative care is becoming more important in the oncology community as disease is discovered earlier and therapies improve. The role of palliative care services for such patients is actively changing as a result of these developments in oncology. We will discuss evolving paradigms in palliative care and try to identify significant education, research, and policy issues for the field of palliative oncology in this paper. Despite the urgent need to improve multi-faceted and multi-specialty symptom treatment as well as patient-physician communication Oncologists have differing viewpoints on the extent of palliative care, and they continue to get contradictory messages. This occurrence highlights a fast changing healthcare landscape, needing ongoing palliative care education and professional self-evaluation in order to give the best possible care to patients with critical diseases

Keywords: Palliative care, oncology, research policy, evidence-based medicine

Introduction

Palliative care was first described by the World Health Organization (WHO) in 1990 as "the active overall care of patients whose sickness does not respond to curative therapies" [1]. While the definition went on to say that "many components of palliative care are also appropriate earlier in the course of the illness," palliative care was originally thought of as a specialty that cared for cancer patients who were nearing the end of their lives. In response to patient requirements during the last two decades, Living with a serious illness for several years, the transformation of many cancers into chronic diseases as a result of treatment advances, and the recognition that patients cannot be divided into those who are alive and those who are dying, the definition and role of health care has changed dramatically. Palliative care has altered and grown throughout time. Palliative care is specialist medical treatment for those who are suffering from life-threatening diseases. This style of treatment focuses on relieving patients of the symptoms, discomfort, and stress associated with a serious disease, regardless of the diagnosis. The objective is to enhance the patient's and family's quality of life. Palliative care is offered by a team of doctors, nurses, and other professionals who collaborate with a patient and other clinicians to provide additional assistance. Along with recent advancements, there remain several roadblocks to bringing cancer patient palliative care ahead, as well as an ever-growing list of complicated patient demands. Many of the disease conditions that fall under the medical oncologist's scope have been turned into chronic illnesses. Upwards of 12 million cancer patients were alive in the United States in 2007 [3], up from 3 million in 1971 [4]. Cancer survivors will be dealing with competing ailments as the number of Americans with various co-

morbidities is expected to rise to 81 million by 2020 [5]. As a result, cancer patients who see a palliative medicine expert on average have more than 10 symptoms [6], and their quality of life is deteriorating [7]. The vast majority of people

Palliative care integration: refining research, building infrastructure, drafting public policy

Better delivery of palliative care services to cancer patients entails expanding the availability of both in-patient and out-patient specialist palliative care services, refining referral criteria for such services, utilizing patient-reported symptom data, and, perhaps most importantly, drafting public policy to support palliative care reimbursement and integration [15]. As of 2009, virtually all National Cancer Institute (NCI)-designated facilities had a palliative care programmer, but only 60% had an out-patient clinic. Only 22% of non-NCI-designated facilities had out-patient services

References

1. David H, Masanori M, Henrique PA, Sun HK, Zhijun L, et al. (2012) The Lack of Standard Definitions in the Supportive and Palliative Oncology Literature. *J Pain Symptom Manag* 43: 582-592.
2. David H, Eduardo B (2015) Models of integration of oncology and palliative care. *Ann Palliat Med* 4: 89-98.
3. Abby R, Joanne W (2017) Approaching the third decade of paediatric palliative oncology investigation: historical progress and future directions. *Lancet Child Adolesc Health* 1: 56-67.
4. Lesley W, Kate W, Libba Q (2002) EMPOWERMENT THROUGH INFORMATION: SUPPORTING RURAL FAMILIES OF ONCOLOGY PATIENTS IN PALLIATIVE CARE.
5. Breffni H, Nadia S, Ashley P, Natasha, Gary R, et al. (2016) Early Palliative Care and Its Role in Oncology: A Qualitative Study *Oncologist* 21: 1387-1395.

*Corresponding author: Bryan A, Department of Pediatrics, University of Washington School of Medicine, Seattle, WA, USA; E-mail: bryan@seattlechildrens.org

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