Journal of Palliative Care & Medicine
ISSN: 2165-7386
Faruq, J Palliat Care Med 2023, 13:4
Short Communication Open Access

Patients and their Caretakers Outcomes for Cancer Therapy Optimization

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Introduction

In patients with advanced disease, palliative care should be incorporated into oncology practise, according to a growing body of research that has developed over the previous ten years. What is the best model of delivery, when is the best time to refer, who needs a referral the most, and how much palliative care should oncologists themselves be delivering are the questions that need to be answered instead of whether palliative care should be provided. Given the lack of palliative care resources globally, these inquiries are especially pertinent. We will first go through recent research exploring the effects of specialised palliative care on various health outcomes in this state-of-the-science review for practising cancer clinicians. After that, we will offer conceptual frameworks to promote coordinated, timely, and focused palliative treatment. The multidisciplinary team members of team-based palliative care are able to fully meet the complex care requirements of patients and their carers. The finest kind of timely palliative care aims to avert crises towards the end of life. Similar to targeted cancer medicines, focused palliative care entails selecting patients who are most likely to benefit from specialised palliative care measures. Last but not least, we will list the advantages and disadvantages of cutting-edge care delivery models such automated referral, embedded clinics, nurse-led palliative care, primary palliative care offered by oncology teams, and outpatient clinics. Further study is required to understand how various health systems may effectively personalise palliative care to deliver the appropriate amount of assistance to the appropriate patient in the appropriate place at the appropriate time.

Despite tremendous advancements in cancer therapies over the past few decades, morbidity and death among cancer patients remain high [1]. According to cross-sectional research, the average cancer patient has 8 to 12 symptoms, many of which go undiagnosed and untreated [2,3]. These patients frequently have unmet requirements for supportive care in addition to the physical symptom load, such as psychological distress and a desire for health knowledge and care planning. The fact that cancer incidence is rising globally due to an ageing population and that many patients with advanced cancer are living longer with an incurable illness due to increasingly potent cancer treatments further highlights the need for supportive care [4,5]. Oncologists have always been a major player in the provision of supportive care. Many doctors view supportive care as a crucial facet of cancer treatment and find joy in giving it [6,7]. Oncologists, who work in the front lines of cancer care, are frequently involved in treating side effects from therapy, talking about prognosis, enabling end-of-life talks, and referring patients to other disciplines. However, there are big differences in how oncologists suggest patients for supportive care and palliative care. It becomes more and more difficult for the oncology team to fully address supportive care demands as a result of the cancer treatment landscape becoming more complicated and busy clinics [8-11]. While this is happening, regular symptom distress screening is revealing even more cancer patients who require supportive care. As a result of a rapidly expanding body of knowledge and research, supportive care is also becoming more specialised in and of itself [12-15]. Data outlining ideal primary palliative care delivery strategies by cancer teams alone are few. Oncology clinic nurses who have received training in a care management intervention that facilitates symptom assessment, participates in ACP, offers emotional support to patients and carers, and facilitates communication with other oncology team members were used in a pilot research. Patients, relatives, and oncologists found this paradigm to be workable and acceptable; a cluster RCT of this intervention is under underway. It should be noted that several RCTs showing increased quality of life when a palliative care team was also engaged used care provided by oncology teams alone as the control arm.

Acknowledgement

Not applicable.

Conflict of Interest

Author declares no conflict of interest.

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Received: 01-Apr-2023, Manuscript No. jpcm-23-96617; **Editor assigned:** 03-Apr-2023, PreQC No. jpcm-23-96617(PQ); **Reviewed:** 17-Apr-2023, QC No. jpcm-23-96617; **Revised:** 21-Apr-2023, Manuscript No. jpcm-23-96617(R); **Published:** 28-Apr-2023, DOI: 10.4172/2165-7386.1000519

Citation: Faruq O (2023) Patients and their Caretakers Outcomes for Cancer Therapy Optimization. J Palliat Care Med 13: 519.

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