Case for Dual Training in Medical Oncology and Palliative Care

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Despite improvements in cancer survival, the majority of patients diagnosed with advanced cancer still experience significant symptom burden, high psychosocial distress, and threats to quality of life.[1] Palliative care strives to address these areas through expertly delivered, high-touch, interdisciplinary care. Although multiple medical societies endorse early integration of specialty palliative care for patients with cancer,[2-4] delivery of high-quality palliative care cannot take place without oncologists embracing their role as frontline palliative care deliverers for the majority of patients in their care. This requires that oncologists receive appropriate and adequate training and skills in palliative care.

The benefits of strong training in palliative care for oncologists cannot be overstated. Evidence and experience indicate that a significant proportion of patients in a medical oncology office have advanced, incurable cancer. Systemic therapy is given with palliative intent to improve tumor-related symptoms and, if able, prolong life. This comes with significant toxicities. Delivery of person-centered care thus mandates that an oncologist be competent in cancer treatment and palliative care. In consideration of the breakdown of care provided in a routine day, it would make sense for medical oncology fellows to spend significant training time in learning how to deliver palliative care. Unfortunately, this is not so. In fact, evidence demonstrates that many oncologists leave formal training underprepared to manage patient suffering.[5] Thus, we propose increasing the exposure of medical oncology fellows to palliative care while simultaneously increasing the number of physicians eligible for dual certification in medical oncology and palliative care. As of now, there are no mechanisms in place for oncology fellows to pursue additional expertise in palliative care in any integrated way.[6]

During fellowship, oncology fellows have fairly limited training in areas such as goals-of-care discussions, prognostication, and complex symptom management at the end of life. A national survey of hematology/oncology fellows highlighted the discrepancy in intensity and quality of training in palliative care compared with general oncology principles.[5] In this survey, fellows reported more teaching on how to treat a patient with sarcoma (rare cancer, incidence of 12,000 new cases/year) than on how to manage a patient at the end of life (estimated 650,000 deaths as a result of cancer/year). In addition, most trainees were not able to perform opioid conversions correctly and were not comfortable with counseling patients or families on how to say good-bye to a loved one.[5]

Opportunities to teach these competencies are missed. The same survey found that fellows performed a similar number of end-of-life discussions as bone marrow biopsies, but attending observation and structured feedback occurred significantly less for communication skills.[5] A follow-up survey 10 years later had similar findings.[7] This training deficit influences post-training practices, and patients in the end suffer. Results from two physician surveys, conducted 20 years apart, provided evidence that pain management in oncology clinical practice is poor.[8,9]

In the United States, there are approximately 13,000 practicing medical oncologists, with another 500 graduates joining the workforce annually.[10] More than 80% practice in a community setting. These practices rarely have in-house or concurrent palliative care. Although the goal of both oncology and palliative medicine are to improve the quality of life of patients, the focus of their training is different. Oncology fellowships have classically focused on cancer biology, diagnostics, anticancer treatment selection, and management of treatment adverse effects. Because the landscape of cancer care changes so quickly, is memorizing third-line treatment of refractory sarcoma an appropriate use of a fellow's time? Perhaps, education on the principles of palliative care—communicating prognosis, eliciting goals and values, understanding what patients and caregivers endure—will better prepare trainees to meet the needs of patients. This shift in training goes beyond easily digestible, fact-based knowledge acquisition (that is subject to change) and edges into skills-based areas (eg, goals-of-care setting) sometimes at the periphery of the comfort zone.

Traditionally, the teaching of these components of patient care depends on physician role modeling and deliberate practice. Learners must spend time with good clinician-educators to absorb these skills. How to communicate the benefits and risks of a phase I trial, thus balancing uncertainty with hope and goals with realities, to a young mother should not be on-the-job training. As it now stands, the majority of palliative care

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rotations are taught by faculty outside oncology. This may send an unintended, but important message to fellows about the relative value of palliative care within standard oncology practice. Supportive care must be seen as the responsibility of all oncologists, not just palliative care specialists.

We envision that oncologists with an interest in symptom management and palliative care may choose to specialize (and be board certified) in palliative care and oncology. Unfortunately, no such integrated pathway currently exists.[6] As we presented at the 2019 ASCO Supportive Care in Oncology Symposium, there are no programs that lead to dual certification in oncology and palliative medicine. Moving forward, the ideal model would provide training in both specialties in a combined 3-year program as opposed to completing two separate fellowships. It would need to ensure mastery of all the essential skills and educational needs in both oncologic and palliative medicine, with a strong focus on faculty development to provide the needed skills in teaching, curriculum development, and research. For individuals with a strong interest in research, there could be an adapted curriculum to have up to 12 months of scholarly time. For the rest who may reject this notion and instead prefer the traditional 3 years in combined oncology/hematology fellowships, improved training in palliative care can only benefit our patients. Although this would require a paradigm shift in oncology training and a strong commitment from program directors, it is the right thing to do.

After joint training in medical oncology and palliative medicine, clinician-educators will be needed to help to develop curricula for learners to gain the essential skills, regardless of ultimate career path. At this time, we must be realistic about the limited effect of what is now a standard palliative care rotation in a medical oncology fellowship. An isolated, 2-week rotation with the palliative care team and/or hospice is unlikely to provide the skills necessary for a lifelong career in caring for patients. To move this concept forward, we recommend that educators:

- Develop and disseminate a minimum set of core competencies aligned with the fellowship general and curricular milestones and focused on symptom assessment, prognostication, and communication.
- Encourage and expand the use of existing educational materials, such as the ASCO University modules, the Education in Palliative and End-of-Life Care for Oncology online curriculum, and the Center to Advance Palliative Care online course tools.
- Integrate additional formal palliative oncology clinical experiences (eg, home hospice rotation) with currently existing rotations (eg, palliative medicine, continuity clinic elective, inpatient solid tumor service) to minimize the need for additional clinical time.
- Encourage and fund advanced degrees to promote research to advance palliative care delivery and best methods to deliver educational content (eg, master of science in palliative care).
- Routinely incorporate palliative care topics (eg, communication, goals-of-care setting, conflict resolution) when discussing patients during fellows' case conferences, educational sessions, and related publications that promote awareness of supportive oncology needs.
- Identify palliative care and palliative oncology champions at one's local institution to help to fill these knowledge gaps within the training program and foster collaboration.

The health of patients living with cancer would benefit from embracing more aspects of humanistic, patient-centered care. This means being proficient in the principles of palliative care. Palliative care skills can be taught and learned.[7,11] Repackaging what we teach our fellows is a useful and important venture. More time in teaching palliative care principles recognizes this education as one of the most important and therapeutic tools in cancer medicine.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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