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Original Article

Palliative Care Activity in a Medical Oncology Unit: The Implications for Oncology Training

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Abstract. There has been a nationwide reorganization of cancer services since publication of the Calman–Hine report, which encourages the integration of high-quality palliative care into all areas of cancer provision. Details of the daily clinical care activity for medical oncology inpatients are not collected routinely. A prospective survey of activity was carried out in a large teaching hospital, in order to ascertain the extent to which palliative care is exercised in a medical oncology unit, alongside other aspects of care provision. Almost a quarter (23%) of the admissions were for palliative care, either alone or in combination with another aspect of care. Palliative care activity accounted for 34% (169 bed-days) of daily activity, compared with 32% (163 bed-days) for the administration of chemotherapy. A high proportion of patients receive palliative care on medical oncology wards, consideration therefore needs to be given to the place of formal training in palliative medicine for oncology trainees.

Keywords: Clinical activity; Oncology training; Palliative care

Introduction

The Calman–Hine report has prompted organizational changes in cancer services in the UK [1]. The report places emphasis on the development of networks of expertise, from primary care through to secondary and tertiary health care settings. Additionally, it states that palliative care should be integrated with all cancer treatment services, recognizing that 'palliative care should not be associated exclusively with terminal care'. This message is also inherent in the World Health Organization's definition of palliative care as:

> the active, total care of patients whose disease no longer responds to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anticancer treatment [2].

The delivery of specialist palliative care within hospitals will, in many instances, be supervised by specialist palliative medicine physicians, and by clinical nurse specialists in palliative care. Cancer specialists are increasingly embracing the principles of palliative care. At a time when issues of training in both clinical and medical oncology are being debated, the inclusion of specialist palliative medicine experience in their respective curricula seems worthy of serious consideration. This survey was designed to analyse activity in a medical oncology unit, and to allow comparison with some of the recent recommendations for cancer care provision.

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Method

A prospective survey of patient care/clinical activity and bed usage for all patients on the Medical Oncology Unit of St James's University Hospital, Leeds, was carried out in December 1996. Data were collected during 4 working weeks (Monday to Friday). It was not possible directly to record data at weekends, although the assessment of patients on Monday mornings gave some indication of the clinical activity for those patients who had been admitted over the weekend.

Reason for admission and clinical activity were recorded as indicated below, the focus of care/clinical activity being assessed daily by a specialist registrar (SpR) in palliative medicine (MTK) and an SpR or senior registrar in medical oncology. The nature of combined clinical activity was assessed, rather than interventions being recorded in isolation. The reason

for admission and daily clinical activity were recorded carefully, so that patients did not fall into more than one category, and hence be counted more than once. The management of some of the symptoms associated with chemotherapy regimens was designated as palliative care, in the spirit of the WHO definition, although the management of serious toxicity was not. Referrals to the hospital's multidisciplinary palliative care team (PCT) were also recorded during the period and senior nursing staff opinions sought.

Reason for Admission

The reasons for admission were: administration of chemotherapy; treatment of toxicity; palliation of symptoms; palliative symptom control in conjunction with another reason; and other reasons, such as admission for investigations, central venous line insertion.

Clinical Activity Categories

The categories of clinical activity were: administration of chemotherapy alone; treatment of toxicity; palliative care alone; palliative care in conjunction with other clinical activities; chemotherapy administration in conjunction with activities other than palliative care; and other activities (central venous cannulation, awaiting the investigations/results necessary for defining a management plan).

Results

During the study period, 126 admissions were recorded (111 patients). Their combined admission episodes accounted for 503 patient bed-days. Data for clinical activity during the weekends were not recorded. Chemotherapy is not routinely given at these times; it is therefore likely that palliative care activity formed an even higher proportion of the workload during the weekends.

Tables 1 and 2 show the main reason for admission and bed-day activity. The administration of chemotherapy was the commonest admission reason, either in isolation, or combined with another aspect of care. Twenty nine admissions (23%) were for palliative care, either alone or in combination with another aspect of care (Table 1). Palliative care activity, either alone, or in combination with other activities, accounted for the largest proportion (34%) of bed-day usage on the unit (Table 2). This is greater than either chemotherapy administration or the management of toxicity (32% and 14% respectively).

Table 1. Reason for admission

Reason	No.	%	SE
Chemotherapy alone	53	42	4.3
Chemotherapy and another aspect (not palliative care)	4	3	1.5
Palliative care alone	9	7	2.2
Palliative care and another aspect (not chemotherapy)	18	14	3.1
Chemotherapy and palliative care	2	2	1.1
Toxicity	20	16	3.2
Other reason	20	16	3.2
Total admissions	126	100	

Table 2. Bed-day activity

Activity	No.	%	SE
Chemotherapy alone	148	29	2.0
Chemotherapy with other activities (not palliative care)	15	3	0.8
Palliative care alone	100	20	1.8
Palliative care with other activities (not chemotherapy)	45	9	1.3
Palliative care with chemotherapy	24	5	2.2
Toxicity	68	14	1.5
Other clinical activity	103	20	1.8
Total bed days	503	100	

Discussion

This survey sought to analyse the clinical care activity for medical oncology inpatients, regardless of their phase of care, and independent of the involvement of the hospital PCT. It was known that the admission data from the hospital-wide 'patient administration system' were inaccurate. Additionally, there was no routine system for collecting data on clinical activity *after* the day of admission, and yet cancer patients have needs that change frequently, sometimes on a daily basis. It is easy to miss, or fail to recognize, the complexity of clinical care activity in such patients. As an example, patients whose disease progesses through treatment and who are admitted for chemotherapy, may still be recorded as an admission for chemotherapy, despite the fact that their subsequent inpatient episode is primarily spent addressing palliative care needs, both physical and psychological.

The data collected in this study attempt to illustrate the wide spectrum of care provided by a medical oncology service in a cancer centre and give a more comprehensive assessment of the role of palliative care in such a unit than has been documented previously. In negotiation with healthcare managers and purchasers of cancer services, increased recognition of the considerable palliative care workload in such units is needed. This survey also highlights the inadequacies of data collected by non-clinical staff for

patient administration systems and serves to identify pertinent training issues.

During the 4-week period, only 15 patients (14%) were referred to, and assessed by, a member of the hospital PCT. This small proportion may reflect the impact of the regular ward presence of a palliative medicine SpR because referrals from the oncology department usually constitute 20%–25% of the annual referrals to the PCT (personal communication, D. Alison). In this survey, no attempt was made to ascertain the number of patients known to local community specialist palliative care teams. It cannot be inferred, however, that oncologists should necessarily oversee the provision of all palliative care in their units. Distinction must be made between the palliative care approach, as provided by non-specialists, which is central to good clinical practice, and specialist palliative care, as delivered by specially trained doctors and nurses, which will be required by some but not all patients. Clinical oncology practice is probably not dissimilar. Admission to radiotherapy centres for symptom control or terminal care is not unusual, particularly if there are no specialist palliative care units (SPCUs) in the area.

Effective collaboration between the specialties of palliative medicine and medical and clinical oncology is essential. Palliative medicine physicians frequently require the expert opinion of clinical oncologists with respect to the role of palliative radiotherapy for their patients' symptoms, and trainees in all three specialties require insight and knowledge of each others' disciplines. Many palliative medicine training schemes include a secondment to oncology; the Yorkshire region's scheme includes a 6-month attachment.

At a time when attempts are being made to revise and combine medical and clinical oncology training, there is an opportunity to include formal palliative medicine training within rotations, in recognition of the significance of good symptom control, and psychological and spiritual support in the care of all cancer patients [3,4]. A recent survey revealed that 62% of clinical oncology and 72% of medical oncology trainees considered training in palliative medicine to be important [5]. With respect to the ideal duration of a palliative medicine attachment, 40% of each group of trainees felt that 3 months was appropriate, although 20% felt 6 months or more would be warranted.

The establishment of formal palliative medicine training for oncology SpRs would require careful co-ordination. Palliative medicine is one of the most rapidly expanding medical specialties in the country and the higher specialist training of its own doctors must be protected. It makes sense, however, to introduce secondments for oncology trainees to SPCUs, so that they may acquire skills and knowledge that will be of use in their oncology practice. In addition, more detailed analysis of activity in cancer centres and units is justified if the role of specialist palliative care in cancer medicine is to be recognized by health authorities, enabling the provision of the 'seamlesss care' envisaged by the Calman–Hine report to become common practice for all patients with a diagnosis of cancer.

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