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ORIGINAL RESEARCH

Expanding the Toolbox: A Palliative Care Lecture Series for Oncology Advanced Practice Providers

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Abstract

Purpose: Initiation of early palliative care (PC) is vital in order to assure that the physical, psychological, spiritual, and social needs of patients and their families are addressed before, during, and after treatment for a serious illness. According to the World Health Organization, PC is patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. It is holistic care that addresses the physical, psychosocial, and spiritual needs of patients and their families. **Methods:** To improve early PC in the oncology setting, a free educational series was established for advanced practice providers (APPs). Evaluations were obtained and a post-survey was completed. **Results:** Evaluation results were positive; staff liked the case presentations and the topics covered. A post-survey was completed. Results demonstrated that most APPs were familiar with basic concepts of symptom management as well as the holistic needs of patients and their families. One area that did not improve was the concept that PC is compatible with aggressive treatment. **Conclusions:** A PC lecture series for APPs was well received by participants. Participants were able to demonstrate knowledge regarding delivery of PC but failed to understand that PC can be delivered simultaneously with aggressive therapy. **Recommendations:** Education regarding PC through the disease process and appropriate referrals to PC specialty need to be reinforced. Educating APPs in early PC is beneficial, and creative methods of teaching need to be further explored.

Initiation of early palliative care (PC) is vital in order to ensure that the physical, psychological, spiritual, and social needs of patients and their families are addressed before, during, and after treatment for a serious illness. According to the World Health Organization (WHO; 2020), PC is patient- and family-centered care that optimizes quality of life (QOL) by anticipating, preventing, and treating suffering. It is holistic care that specifically addresses the physical, psychosocial, and spiritual needs of patients, as well as their families. Moreover, PC is appropriate at all stages of illness, from diagnosis through the end of life (EOL), and it should be integrated into the treatment plan of every patient with a serious illness (National Consensus Project [NCP], 2019). The National Comprehensive Cancer Network (NCCN), the WHO, and the American Society of Clinical Oncology (ASCO) have expressed support for early PC (NCCN, 2018; Tan & McMillan, 2019; WHO, 2020). Moreover, ASCO recommends that all oncologists be educated in primary PC competencies (Smith et al., 2017). Likewise, Mason and colleagues (2021) concluded that oncology advanced practice providers (APPs) should take a lead in making early PC available to all oncology patients. They also stressed that a key role of all APPs is patient advocacy, stating that connecting patients to early PC is an important way to ensure that all patients with cancer receive the holistic and compassionate care they deserve. To achieve this, APPs need quality and focused education regarding early PC.

REVIEW OF LITERATURE

The literature demonstrates that early PC intervention improves symptoms and QOL, gives greater control over the delivery of care, decreases health-care costs, and may even improve disease outcomes (Gonzalez-Jaramillo et al., 2021; Schlick & Bentrem, 2019; Temel et al., 2010; Zaborowski et al., 2022). Therefore, early PC is a vital part of oncology care because patients with cancer, as well as their families, experience many obstacles that can negatively affect their autonomy, QOL, and disease outcome.

According to the WHO (2022), cancer was the leading cause of death globally in 2020. The economic impact of cancer is significant and continues to escalate. According to Chen and colleagues (2023), the global economic cost of cancer is estimated at $25.2 trillion in international dollars between 2020 and 2050.

While the financial burden of cancer care is high, the cost to caregivers is also substantial. A systematic review of caregiver burden and QOL found several significant themes. In this review, symptom management was identified as a source of burden to caregivers. Additionally, anxiety was identified in 33% of caregivers, while depression was found in 12% to 32% of caregivers (Chong et al., 2022).

There is also a psychological and physical cost to patients undergoing cancer treatment. One study asked stage IV lung cancer patients to complete a physical problem list. They discovered that a high number of physical symptoms and lower body mass index were associated with a decrease in survival. Furthermore, the presence of physical symptoms was often associated with depression (McFarland et al., 2020).

In order to meet these concerns, PC should be initiated early in the cancer trajectory. According to the Center to Advance Palliative Care (2020), PC is focused on providing relief from the symptoms and the stress of illness. The overarching goal is to improve QOL for both the patient and their family. Additionally, PC can reduce the cost of health care by including quality outcomes for health-care organizations. Oncology, specifically, is an area where early PC can help patients and their families achieve improved QOL, while also decreasing treatment cost and health-care utilization (WHO, 2020; Zaborowski et al., 2022; Gonzales-Jaramillo et al., 2021).

A pilot study of 711 patients found that early PC can decrease the length of stay by longer than 1 day and reduce costs by 26% (Zaborowski et al., 2022). Gonzalez-Jaramillo and colleagues (2021) discovered that oncological and non-oncological patients who received home-based PC consistently had fewer hospital visits, a decrease in length of stay, decreased hospitalizations, and lower overall health-care costs.

Additionally, patients with cancer who received early PC experienced significant improvement in patient-reported outcomes and received care consistent with their desired treatment plan

at the EOL (Karin & Eisenhauer, 2016; Schlick & Bentrem, 2019; Temel et al., 2010). Temel and colleagues' landmark study also noted that patients with non–small cell lung cancer who received early PC experienced a significant increase in overall survival when compared with patients receiving standard of care.

Hui and colleagues (2018) completed a state-of-the-science review of the literature regarding PC in the oncology setting. They ascertained that timely PC is associated with improved QOL, as well as EOL care for patients with cancer. Vanbutsele and colleagues (2018) completed a trial in which 186 patients were randomized to standard oncology care or oncology care coupled with PC. The patients in the study sample scored higher on overall QOL, as well as existential well-being.

Yet, due to a shortage of PC specialists, it is impossible for all eligible patients to receive a PC consultation. It is calculated that the shortage of PC specialists today is a serious problem. The ratio of PC doctors to eligible patients is 1:808, and it is projected to become worse due to physician burnout and age (Kamal et al., 2019). It is, therefore, vital for oncology providers to offer primary PC, which includes symptom management, clear communication about prognosis, goal setting, and decision-making.

Brown and colleagues (2021) identified that a generalist PC model achieved similar health-care utilization outcomes when compared with a consultation PC model, comprised of both generalist and specialist care, and specialist-only PC model. In both the generalist and specialist PC models, an interdisciplinary approach is necessary to provide high-quality PC interventions. Hui and colleagues (2018) asserted that an interdisciplinary team is crucial when providing holistic PC. Different members of the team bring distinct areas of expertise to the practice, thus providing the patients and their caregivers a wider range of services. Other advantages of an interdisciplinary team include enhanced patient-clinician communication and shared responsibility, workload, decision-making, and leadership responsibilities. These benefits can help to decrease the burden usually placed on one discipline (Hui et al., 2018).

Advanced practice providers, due to their role in assessing and treating a patient's response to disease and treatment, are well situated to take a lead role in providing PC and EOL care (Mason et al., 2021). Furthermore, according to Dahlin and Coyne (2019), advanced practice registered nurses (APRNs) are in a prime position to lead and transform PC's role in health care. They stress that with the national shortage of palliative care clinicians, APRNs will need to take a leading role in the care of patients and their families with serious illness.

According to Ferrell and colleagues (2020), APRNs can influence a change in practice and improve overall care when they implement strategies to promote early PC. Additionally, Desai and Schneiderman (2019) claim that the need to change PC culture calls for further training and education of other team members, such as social workers, RNs, and APRNs in PC practices. All APPs, including physician assistants, nurse practitioners, and pharmacists, can make early PC possible for their patients with cancer.

Although a generalist PC model in oncology would be beneficial, many oncology providers do not have an adequate knowledge base in PC principles. They also lack the necessary comfort level to effectively manage difficult symptoms. Mason and colleagues (2021) used the Palliative Care Quiz for Nurses (PCQN; Ross et al., 1996) as a pre-survey to assess APPs' baseline PC knowledge at a large Midwest teaching cancer center. They found that while 93% of respondents understood that PC is appropriate for all seriously ill patients, only 38% understood the philosophy that PC and aggressive disease–focused therapies could be offered simultaneously. Most respondents had an understanding of symptom management but lacked sufficient training, especially in the areas of dyspnea, sedation, anxiety, and the use of placebos. Unfortunately, 100% of respondents felt that the extent of disease should be the driver for pain management. Likewise, Ferrell and colleagues (2020) found that APRNs lacked triggers that would help them identify patients who would benefit from PC services.

The literature supports the use of education to improve knowledge of and comfort with the implementation of early PC. The National Cancer Institute funded a training program to prepare oncology APRNs to provide early PC. Following the program, participants established goals to help them function as generalist PC providers. A

6-month follow-up found that participants were successful in implementing their goals into practice (Ferrell et al., 2021). Likewise, Mason and colleagues (2020) developed a PC class for undergraduate and graduate level nurses. It used a multimodality approach based on Kolb's Experiential Learning Theory, which was found to be highly effective in this pilot study. The class addressed each of Kolb's stages of learning through lectures, games, simulation, small-group discussions, computerized learning modules, readings, and reflections. The PCQN (Ross et al., 1996) and Frommelt Attitudes Toward Care of the Dying (FATCOD; Frommelt, 1991) results, as well as the students' reflections, demonstrated both an improvement in PC knowledge and comfort administering early PC. Ferrell and colleagues (2020) noted improvement in APRNs' involvement in family meetings, ability to prepare other clinicians for EOL care, communication with family members, and early referral to PC following education.

The American Nurses Association (2017) have stated that all nurses practicing primary PC should actively pursue further PC education. Similarly, physician assistant program accreditation standards include required education in PC and EOL care (Beresford, 2021). Therefore, PC education should be a standard for all APPs.

Table 1. Palliative Care Education Series Topics

2021–2022
- Principles and Pearls of Pain Management
- Basic Principles of Pain Management with Buprenorphine/Methadone/Ketamine
- Psychiatric Medication Review
- Difficult to Control Symptoms
- #1 Reported Symptom and How to Manage It: Fatigue
- Case Studies in Ethics and Palliative Care
- Potential Unsafe Low Evidence Therapy (PULET)
- Helping Patients Cope with Anxiety/Depression

2022–2023
- Difficult Conversations
- Palliative Care in Action
- Complementary and Alternative Medicine
- Use of Marijuana for Pain Control
- Disparities in Cancer Care
- Young Adults with Cancer (YAC) & Overcoming Obstacles When Treating Young Adults
- Using Ketamine and Other Unconventional Treatments for Depression

Note. One lecture was offered per month; eight lectures during 2021–2022 and seven lectures during 2022–2023.

INTERVENTION

To improve early PC in the oncology setting, an education series was established in a cancer center at a large Midwest teaching hospital. Initial lectures were built around the eight domains of PC established by the National Consensus Project in 2004. These domains serve as the framework for clinical practice guidelines for quality PC (National Consensus Project, 2019). Participant evaluations from year one were used to organize and enhance lectures for years two and three. Based on these evaluations, subsequent lectures focused on complex symptoms, difficult conversation skills, and ethical issues in oncology care (Table 1). Advanced practice providers from all specialties throughout the cancer center were invited to attend these lectures. The lecture series was open to inpatient and outpatient oncology nurses, although the content focused on the provider role in PC. Each 1-hour session was delivered via Zoom. The Zoom format allowed APPs to participate in their offices, clinics, or wherever was most convenient. Continuing education (CE) credits were offered for each session, including pharmacology CEs where appropriate. Speakers with expertise on the given topic were invited to speak. Since PC is a multidisciplinary approach to care, speakers were chosen from all disciplines. The speakers included APPs, social workers, chaplains, psychologists, pharmacists, ethicists, and PC inpatient service providers. Lectures were recorded for APPs who could not attend, although CE credits were only available for in-person attendance. The content was created with the goal of immediate application into clinical practice. Lectures were designed to be interactive. There were case studies with open discussion, a Jeopardy! format to solidify learning, and activities such as a guided visualization and meditation after the "Coping With Anxiety" lecture. The project was coordinated with the Department of Nursing Professional Development & Education and received support from the Cancer Center administration.

ANALYSIS

Evaluations were completed after each session. The evaluations asked whether the objectives were met, content was consistent with learning

objectives, instructional methods enhanced learning, and the speaker was knowledgeable about the subject. There were areas for participants to leave comments about their experience and ideas for future topics. Qualitative analysis, using a thematic analysis, was used to capture themes and patterns in the responses to the open-ended comments. These themes were then reviewed, defined, and named. There were four themes identified: speakers, Zoom platform, content, and value of case studies in learning (Table 2).

Additionally, a post-lecture survey was completed after 2 years of PC lectures. Once again, the PCQN was used for this survey, consisting of 20 true/false questions. A higher percentage correct correlates with greater PC knowledge. The questions addressed physical, psychological, spiritual, and social needs of PC and EOL care patients. This quiz has been used in multiple studies and was found to be both consistent and reliable in demonstrating the presence of nursing knowledge in PC. The PCQN has an internal consistency of 0.78 (Ross et al., 1996).

RESULTS

Sixteen APPs completed at least one of the educational offerings. While not explicitly tracked, many providers attended several, if not all of the sessions. Sixty-four percent of participants were APRNs, 33% were RNs, and 3% were graduate nursing students.

Evaluations were completed after each session. Under the content theme, participants concluded that many of the lecture topics included important information that is often overlooked. They shared that the lecture content was useful and felt they could readily apply it to their practice. Specific comments, separated into the four themes identified, are included in Table 2. Overall, participants appreciated the Zoom format, as it allowed them to attend from home rather than staying late after their clinics. They also found it easy to participate in the sessions and unanimously enjoyed the case studies. One participant noted "It was nice to have real-life situations to connect the dots." Furthermore, participants recognized the speakers as experts in their fields and appreciated the speakers' willingness to share their expertise. The reviews were overwhelmingly positive and used to plan lectures each year. More specifically, participants found that the educational sessions provided them with ideas for the management of complex symptoms, allowing them to role play difficult conversations

Table 2. Palliative Care Education Series Evaluation Comments, 2021–2023

Speakers
- Outstanding speakers
- Great speakers
- The speaker relayed information that was easy to understand
- So interactive
- I liked to hear their examples of difficult conversations
- Great perspective and insight
- Liked how she drew on her legal consulting knowledge
- Always in touch with his audience
- I never get tired of hearing his presentation
- Good job sharing their expertise
- Clear, concise, and well-explained
- I liked to hear their experiences in different conversations

Zoom platform
- I appreciate being able to attend from home
- I loved Zoom, I could see, hear, and participate while doing regular work
- I loved the Zoom format
- Zoom is a challenge for sure, some technical difficulties, but they were handled quickly

Content
- I was able to connect certain medications to clinical experiences
- The educational sessions provided me with ideas for managing complex symptoms
- I feel more comfortable approaching difficult conversations
- A lot of specific interventions we could use right away
- Really got me thinking about ways I can improve disparities in my practice
- Valuable information on communicating with patients and families
- Great information on non-pharmaceutical ways to help fatigue
- Nice overview that went beyond basics
- Covered topics rarely discussed
- This was a topic we do not hear enough about
- Good information about resources available
- Discussed methadone, ketamine, and buprenorphine agents that I am not familiar with

Value of case studies in learning
- It was nice to have real-life situations to connect the dots
- I appreciated the case studies and the discussions
- I feel more comfortable approaching difficult conversations
- I appreciate the interactive nature and good discussion
- I liked how she used case studies to demonstrate real-world examples
- The case studies were so interesting
- Excellent examples and cases

Table 3. Palliative Care Quiz for Nurses (PCQN) Questions

		Pre-Study (*N* = 15)		Post-Study (*N* = 11)	
		True	False	True	False
Q1.	Palliative care is appropriate only in situations where there is evidence of a downhill trajectory or deterioration.	1	**14**	0	**11**
Q2.	Morphine is the standard used to compare the analgesic effect of other opioids.	**11**	4	**10**	1
Q3.	The extent of the disease determines the method of managing pain.	0	**15**	1	**10**
Q4.	Adjuvant therapies are important in managing pain.	**14**	1	**10**	0
Q5.	It is crucial for family members to remain at the bedside until death occurs.	0	**15**	2	**8**
Q6.	During the last days of life, the drowsiness associated with electrolyte imbalance may decrease the need for sedation.	**8**	6	**3**	6
Q7.	Drug addiction is a major problem when morphine is used on a long-term basis for the management of pain.	1	**14**	1	**10**
Q8.	Individuals who are taking opioids should also follow a bowel regimen.	**15**	0	**11**	0
Q9.	The provision of palliative care requires emotional detachment.	0	**15**	0	**10**
Q10.	During the terminal stages of an illness, drugs that can cause respiratory depression are appropriate for the treatment of severe dyspnea.	**12**	2	**8**	2
Q11.	Men generally reconcile their grief more quickly than women.	1	**10**	0	**9**
Q12.	The philosophy of palliative care is compatible with that of aggressive treatment.	**5**	8	**2**	8
Q13.	The use of placebos is appropriate in the treatment of some types of pain.	3	**9**	2	**7**
Q14.	In high doses, codeine causes more nausea and vomiting than morphine.	**13**	0	**5**	0
Q15.	Suffering and physical pain are synonymous.	1	**14**	1	**10**
Q16.	Demerol is not an effective analgesic in the control of chronic pain.	**11**	1	**11**	0
Q17.	The accumulation of losses renders burnout inevitable for those who seek work in palliative care.	5	**9**	3	**6**
Q18.	Manifestations of chronic pain are different from those of acute pain.	**14**	1	**11**	0
Q19.	The loss of a distant or contentious relationship is easier to resolve than the loss of one that is close or intimate.	1	**13**	0	**10**
Q20.	The pain threshold is lowered by anxiety or fatigue.	**5**	9	**8**	3

Note. Bold indicates correct answer.

and consider how they may best advocate for their patients and early PC.

An additional post-lecture survey was completed after 2 years of the PC lecture series. Once again, the PCQN (Ross et al., 1996) was used for this evaluation. Overall, the results were similar to those from the pre-study (Mason et al., 2021; Table 3). Most APPs were familiar with basic concepts of symptom management, as well as the holistic needs of patients and their families. One area in need of improvement was the concept that PC is appropriate during aggressive treatment. Only 34% of respondents agreed with this concept in the pre-study, and 38% agreed in the post-study. Interestingly, most respondents (97% in the pre-study, and 93% in the post-study) still agreed that PC is appropriate for all stages of serious illness.

DISCUSSION AND FUTURE DIRECTIONS

The PC lecture series initially began with an overview of PC principles. The inaugural series lectures were based on the eight domains of PC. Since then, the series has been expanded to include more specific complex symptom management. This included the management of fatigue, ethics, communication, anxiety, and depression. Although participants recognized the material was valuable and had practical application, scores on the PCQN did not show an improvement in knowledge of and comfort level in delivering PC.

To help promote the idea of early PC for all oncology patients, future lecture series will readdress how PC can be appropriate through all the phases and transitions of cancer care, from diagnosis to treatment to EOL care (Harden et al., 2023). Lectures will begin with a slide highlighting the WHO's (2020) definition of PC, which specifies the appropriateness of PC in all stages of cancer. Additionally, a discussion about the patients, disease processes, and refractory symptoms eligible for referral to a PC specialist will be included in the series.

It would be helpful to conduct an audit of all PC referrals and compare this to referrals prior to instituting the lecture series. An analysis of new PC referral wait times for specialty providers should also be conducted. The post-survey should also cover changes to APPs' practices regarding the delivery of primary PC to their patients. This could be completed through a chart review. Finally, patients can be included in the post-series analysis to better assess their perception of care, especially in regard to symptom management and communication. It would also be interesting to assess if they believe that their plan of care is in alignment with their values and goals.

The surveys were delivered via Qualtrics and were anonymous, so there was no direct correlation between pre- and post-survey participants. Therefore, this method may not be the most accurate assessment of the impact of the lecture series. Alternative survey methods will be considered for future lecture series.

Some sessions did not have high attendance based on the session topic and the time offered. Presently, the sessions are promoted with frequent emails, posted flyers in high traffic areas, and word of mouth. The promotion strategy will be reevaluated to ascertain areas in need of improvement. Continuing education credits for independent study will also be offered to increase session attendance. Additionally, the offered times for the sessions will be varied to better assess which has the highest attendance.

As the number of specialty PC providers continues to be disproportionate to the growing need for PC services, the necessity for providers to have foundational PC knowledge is vital. Clinicians who provide cancer-focused care would especially benefit from more specialized skills in primary PC in order to make early PC the standard of care. ●

Disclosure

The authors have no conflicts of interest to disclose.

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