

Revisiting the Road Not Taken: Integrating Palliative Care Into Oncology Nursing

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Robert Frost's poem "The Road Not Taken" presents a metaphor for decision making in life (Lathem, 1969). When one comes to a crossroad, the path he or she chooses has major implications for both the traveler and the path itself. I was reminded of Frost's work several times in the last few years as I walked an oncology career path focused increasingly on pain and symptom management and quality of life. The more familiar one I had followed to that point—one focused on caring for patients undergoing bone marrow transplant and other investigative anticancer treatments—seemed more distant. Eventually, I realized that in focusing on palliative care, I had made a philosophical shift in my approach to patients. Early on I thought, I'd "keep the first for another day." But now I realize I could never return to my previous path.

This adventure has been both exciting and humbling in ways I never anticipated. Shifting to a palliative care focus required intense study to understand the evidence supporting my knowledge base of pain and symptom management (Bookbinder, 2001; Ferrell & Coyle, 2001; Wrede-Seaman, 1999). Finding an evidence base for many of the palliative practices applied to or withheld from patients with advanced cancers was a challenge. When consultations were requested and recommendations accepted—when some new nugget of knowledge really benefited a patient and improved his or her quality of life—I was professionally satisfied (Manfredi et al., 2000). The path seemed familiar and easy-going. Sometimes a palliative care focus was

met with resistance. Some colleagues only endorsed a curative focus. Healthcare systems were rigid and could only accommodate the care needs of patients with short-term, episodic, fixable problems. Financial barriers included reimbursement systems that provided only for the options of cure or certain

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death (Lynn & O'Mara, 2001). Patients without a care provider; unwilling to forego beneficial palliative chemotherapy, radiation, or surgery; or with a prognosis that was not absolutely certain to be six months or less, were caught in the middle. This part of the path felt treacherous; we had no trail markers, no compass, and darkness was about to fall.

With help and support, the palliative care team navigated these spots, but not without scrapes and bruises. We suffered from the wounds of unresolved grief, regret, and frustration—wishing we could have made a patient's or family's experience of progressing illness, dying, and death closer to their stated preferences of a "good death" (Institute of Medicine, 1997).

I felt heartened by fellow travelers describing an easygoing section ahead. For instance, some cancer centers were making progress in the integration of palliative care (Dauben-

speck, 1999). Forums that dealt with facing our own mortality had community support (Colby, 2001). Some insurance companies were reimbursing concurrent palliative anticancer treatments and home hospice care (Montana & Duffy, 1999). Medical and nursing curriculums were incorporating palliative care concepts and testing students on this content (Ferrell, Grant, & Virani, 1999). These stretches were healing for us.

Despite this progress, integrating palliative care principles into routine state-of-the-art cancer care is a path that is still "grassy and wanted wear." This presentation summarizes the challenges and opportunities for seamlessly integrating palliative care into the continuum of cancer care. Strategies for successful integration are proposed. What will it take, personally and professionally, to accomplish a culture shift of this magnitude? What is the evidence that such an approach will improve the quality of life for people with cancer and their families? The answers are elusive but forthcoming. And they will only become evident through the hard work of nurses and others at the bedside, in the clinic, at home, and in administrative, educational, and research roles (Oncology Nursing Society, 2000, 2001).

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