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Commentary

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Rapid access palliative care and radiation oncology: an underused referral pathway

Summary

Radiation oncology treats one of the most symptomatic populations in cancer care yet generates few specialty palliative care referrals. The remedies described so far, embedding palliative specialists in radiotherapy clinics or creating new consult services, require resources many centers lack. We argue that most departments already have the two components needed: a radiation therapist who triages every palliative referral and a supportive oncology service that can see patients within days. We describe a framework that joins them with a brief symptom screen and one electronic order, present institutional data showing why the connection is needed, and outline a staged plan for prospective validation.

Keywords: palliative radiotherapy; palliative care referral; rapid access; radiation therapist triage; supportive oncology; implementation

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Key Points

- About half of radiotherapy courses are given with palliative intent, yet radiation oncologists originate few specialty palliative care referrals.
- Rapid access palliative radiotherapy and rapid access palliative medicine have matured as separate systems with few points of contact.
- At our center, palliative medicine visits rose about fourfold between 2017 and 2025 while radiation oncology referrals remained at 20 to 37 per year, a pattern that points to referral generation, not service availability, as the likely bottleneck.
- We propose a five-step therapist triage bridge that requires no new clinic, specify which components are fixed and which can be adapted locally, and outline a two-stage prospective evaluation.

The referral gap

About half of patients with cancer receive radiotherapy, and roughly half of all radiotherapy courses are given with palliative intent.[1,2] Radiation oncologists therefore meet large numbers of patients with pain, dyspnea, bleeding, neurologic compromise, and limited prognosis, often at a point when symptoms rather than tumor control define the encounter. The 2024 American Society of Clinical Oncology guideline update recommends referral of patients with advanced cancer to interdisciplinary palliative care early in the illness and alongside active treatment.[3]

Referral practice has not followed. In a single-center cohort of 162 patients receiving palliative radiotherapy for metastatic cancer, 46% received any specialty palliative care, and radiation oncologists originated 1.4% of referrals, no more than the patients who referred themselves.[4] Inpatient teams and medical oncologists accounted for nearly all the rest. In an Irish national radiation oncology network, 55% of patients who died within 30 days of palliative radiotherapy had been referred to specialist palliative care, and only 26% had a documented performance status.[5] Reviews of palliative radiotherapy attribute the gap to limited palliative training in radiation oncology, limited familiarity with radiotherapy among palliative clinicians, the absence of shared pathways, and a persistent view of referral as an end-of-life step rather than a route to symptom control.[6,7]

Why radiation oncology is structurally disadvantaged

The deficit is not simply a matter of attitude. Three structural features of palliative radiotherapy work against conventional referral.

Compressed contact

Palliative courses are short by design, often one to five fractions and increasingly a single fraction delivered on the day of simulation.[8] This is good care, but it reduces the clinical relationship to one or two encounters and leaves little room for an unmet need to surface and be acted on.

Referral asymmetry

Many patients arrive already followed by palliative medicine through their medical oncologist. A department's referral rate therefore captures new palliative involvement, not total involvement, and a low rate may partly reflect appropriate avoidance of duplicate referral.

Denominator dilution

Rates calculated against all consultations include patients treated definitively for early-stage disease, for whom specialty referral is rarely indicated. Only rates anchored to palliative-intent consultations or an explicit advanced-disease population can be compared across centers, and published studies are inconsistent on this point.

Two rapid access systems that rarely meet

"Rapid access" names two different services, and the shared label has obscured an opportunity.

Rapid access palliative radiotherapy clinics, described internationally for about two decades, compress consultation, simulation, and treatment into a single visit. They broaden multidisciplinary roles, increase guideline-concordant single-fraction treatment, and reduce patient travel.[8] Newer versions use automated planning to deliver same-day volumetric modulated arc therapy

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without loss of throughput,[9] and an advanced practice provider–led bone metastasis clinic shortened the interval from referral to consultation.[10] These programs are built to accelerate radiotherapy; palliative care referral is, at most, a secondary outcome.

Rapid access palliative medicine services are urgent symptom clinics within supportive oncology. They accept same-day or same-week referrals for pain crises, nausea, dehydration, and acute functional decline, and follow patients closely over the next 24 to 48 hours. Their referrals come predominantly from medical oncology.

Where the two have been joined, referral rises. In the Irish rapid access palliative clinic, which embedded specialist palliative care, 75% of patients were referred, well above the network's overall rate.[5] A multidisciplinary palliative radiation oncology consult service was associated with more timely specialty palliative care consultation, shorter hospital stays, and greater use of abbreviated fractionation, with no loss of symptom benefit.[11] Both findings suggest that the deficit lies in how referral happens rather than in whether clinicians value it. Both models, however, required building something new, a dedicated clinic with embedded specialist staff in one case and a physician-led consult service in the other, and many centers cannot staff either.

The radiation therapist as the link

The strongest evidence for faster access in palliative radiotherapy concerns radiation therapists. A scoping review of triage by clinical specialist radiation therapists identified 20 studies and one government report from four countries.[12] Therapist-led triage reduced waiting times by about half on average (range, 30%–82%), screened out inappropriate referrals, enabled pre-booking and coordinated appointments, reduced handoffs, and lowered reliance on on-call services.

The triaging therapist is often the first clinician to review a referral and the first to speak with the patient. That position makes the therapist the person most likely to learn, days before the physician visit, that pain is uncontrolled or that a caregiver is not coping. Yet the triage literature measures almost nothing beyond time to radiotherapy. To our knowledge, no study has asked whether the same triage contact can identify unmet palliative needs and route patients directly to rapid access palliative medicine.

Where this proposal fits

Table 1 places the proposal alongside existing models. It differs from them in three respects. First, it adds a function to an existing role rather than creating a new clinic or service; the triage therapist and the rapid access palliative medicine clinic already exist in many cancer centers. Second, it is targeted rather than universal. A systematic offer of palliative team consultation to all patients with symptomatic bone metastases is now being tested in a randomized trial,[13] whereas our framework refers only patients who screen positive and are not already followed, which conserves palliative medicine capacity. Third, it treats pre-existing palliative involvement as information rather than noise: screen results for patients already followed are sent to their existing team, and that involvement becomes visible in the referral metric instead of deflating it.

Table 1 Existing models linking radiotherapy and palliative care compared with the proposed therapist triage bridge

Model	Who identifies palliative need	New resources required	Main outcomes reported	Gap addressed by the proposed bridge
Rapid access palliative radiotherapy clinic[8,9]	Radiation oncologist during one-stop visit	Dedicated clinic session; multidisciplinary staffing; same-day planning	Time to treatment; single-fraction use; patient travel	Palliative care referral not a core outcome
Rapid access clinic with embedded specialist palliative care[5]	Embedded palliative specialist	Dedicated clinic plus specialist palliative staff	Referral to specialist palliative care (75%)	Requires staffing many centers lack
Palliative radiation oncology consult service[11]	Physician-led multidisciplinary team	New consult service	Timely palliative consultation; length of stay; fractionation	Requires a new physician service
Advanced practice provider–led bone metastasis clinic[10]	Advanced practice provider	Dedicated clinic	Time from referral to consultation	Focused on radiotherapy access
Therapist-led triage[12]	Not assessed	None beyond triage role	Waiting time; inappropriate referrals; handoffs	Palliative needs not screened
Universal offer of palliative consultation (TIPZO-RT, ongoing trial)[13]	All eligible patients offered consultation	Palliative team capacity for every patient	Satisfaction with care (primary endpoint)	Universal rather than targeted; bone metastases only
Proposed therapist triage bridge	Triage therapist using ESAS-r and PPS	Brief screen and one electronic order; no new clinic	Referral among eligible patients; time to visit; feasibility (proposed)	Untested; requires prospective evaluation

ESAS-r, revised edmonton symptom assessment system; PPS, palliative performance scale.

A local service observation and its measurement limits

Our institution illustrates the paradox this commentary addresses. Palliative medicine service visits rose from 2,465 in 2017 to 10,234 in 2025, a roughly fourfold increase, and in 2025 the service saw 1,551 new patients (Table 2A). A rapid access clinic, with visits first recorded in 2019, has delivered 215 to 270 visits in every year since 2020. Across 2022–2024 the service completed 24,059 visits, 665 of them in the rapid access clinic. Over the same three years, radiation oncology providers referred 37, 20, and 24 patients to palliative medicine against roughly 1,450 consultations a year (2.5%, 1.4%, and 1.7%; Table 2B).

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Table 2 Palliative medicine service volume, 2017–2025 (A), and radiation oncology referrals to palliative medicine, 2022–2024 (B)

A. Palliative medicine service volume

Year	All palliative medicine visits	New patients	Rapid access clinic visits	Rapid access visits, % of all visits
2017	2,465	—	—	—
2018	5,746	—	—	—
2019	6,598	—	48	0.7
2020	7,415	—	245	3.3
2021	7,363	—	270	3.7
2022	6,689	—	235	3.5
2023	8,430	—	215	2.6
2024	8,940	—	215	2.4
2025	10,234	1,551	231	2.3

B. Radiation oncology consultations and palliative medicine referrals

	2022	2023	2024
All radiation oncology consultations	1,494	1,454	1,447
Palliative medicine referrals, n (% of all consultations)	37 (2.5)	20 (1.4)	24 (1.7)

—, not available. Panel A: rapid access clinic visits were first recorded in 2019; new-patient counts were available for 2025 only. Visit counts describe service activity and do not measure unused capacity. Panel B: the denominator includes all radiation oncology consultations, including curative-intent consultations, and does not exclude patients already followed by palliative medicine. Treatment intent and prior palliative medicine involvement were not available as structured data for 2022–2024.

Two observations follow. First, the radiation oncology referral deficit arose alongside, not in the absence of, a growing palliative medicine service with same-week access. Visit counts do not measure unused capacity, so these data cannot show that the service could have absorbed more referrals; they do show that a functioning destination existed throughout, which points to referral generation rather than service availability as the more likely constraint. Second, while total visits continued to rise, rapid access volume plateaued, falling as a share of all visits from 3.7% in 2021 to 2.3% in 2025. Whether this reflects stable demand, scheduling limits, or referral friction cannot be determined from aggregate counts.

The referral data carry the limitations described above. Treatment intent and prior palliative medicine involvement were not available as structured data for this period, so the denominator includes curative-intent consultations and patients already followed by palliative medicine. If about half of consultations were palliative in intent, as published estimates suggest,[1,2] the rate among palliative-intent patients would be roughly double the figures shown; the rate among patients not already followed is unknown. With counts this small, year-to-year variation is expected, and we do not interpret it as a trend. We present these data as the observation that prompted the proposal and as an illustration of why current referral metrics are difficult to interpret, not as an estimate of unmet need or as evidence that the proposed pathway would work.

We reviewed the data with two radiation oncologists and an oncology-certified nurse, who offered four explanations that we treat as hypotheses. The year with the most referrals coincided with a department-wide initiative requiring referral of all patients with head and neck cancer, and referrals fell when it ended. Earlier referral from medical oncology may absorb part of the apparent deficit. Short fractionation limits opportunities for contact. And referral to the rapid access clinic ran through a telephone pathway that staff found burdensome because it required repeated nurse-to-nurse calls. Friction of this kind is a recognized barrier: a fellow-led quality improvement project that replaced a fragmented process with a single order set and a named scheduler raised palliative care use from 11.5% to 48.4% within six months.[14]

The therapist triage bridge: an adaptable framework

Figure 1 shows the framework. It relies on staff and services that already exist in many departments and adds two elements: a brief symptom screen at triage and a single electronic referral order.

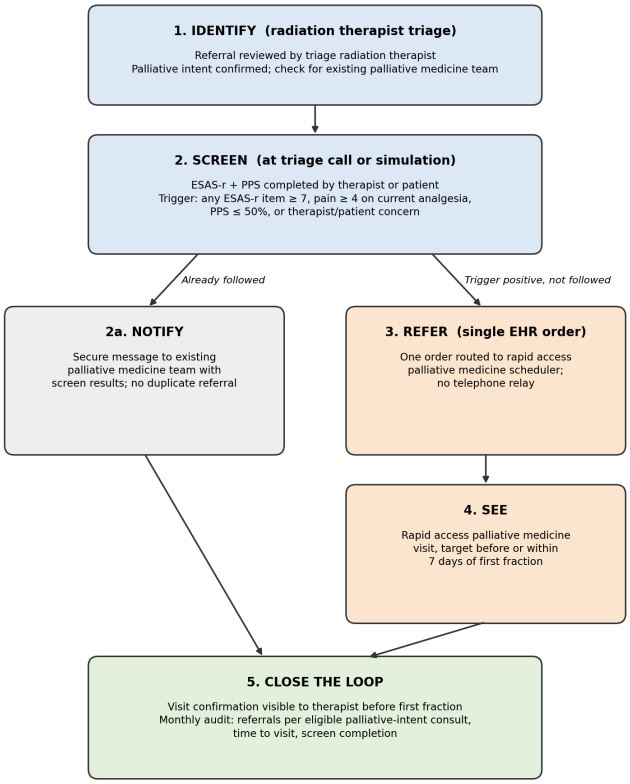


Figure 1 The therapist triage bridge: a proposed framework linking radiation therapist triage to a rapid access palliative medicine service.

ESAS-r, revised edmonton symptom assessment system; PPS, palliative performance scale; EHR, electronic health record

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1. **Identify.** The triage radiation therapist, who already reviews each incoming referral, confirms palliative intent and checks the record for an existing palliative medicine relationship.
2. **Screen.** At the triage call or at simulation, the patient completes the revised Edmonton Symptom Assessment System (ESAS-r)[15] and the therapist records the Palliative Performance Scale (PPS).[16] We suggest defining a positive screen as any ESAS-r item of 7 or more, pain of 4 or more despite current analgesia, PPS of 50% or less, or concern raised by the therapist or patient. Patients who screen negative are rescreened at the first fraction.
3. **Notify or refer.** Patients already followed by palliative medicine are not referred again; their screen results go to the existing palliative team by secure message. Patients with a positive screen who are not already followed receive a single electronic order routed directly to the rapid access palliative medicine scheduler, replacing the telephone relay our stakeholders identified as the main source of friction.
4. **See.** The target is a rapid access palliative medicine visit before, or within 7 days of, the first fraction. When a single fraction is delivered on the day of simulation, the visit may follow treatment, but the order should be placed before the patient leaves the department.
5. **Close the loop.** Confirmation of the scheduled visit is visible to the treating therapist before the first fraction. A monthly audit reports referrals per eligible palliative-intent consultation, time to visit, and screen completion.

Adapting the Framework

Table 3 separates the components we regard as essential from those that can be changed without altering the model. Three prerequisites apply: a triage role with first contact, a palliative medicine service able to see patients within about a week, and an electronic record that can route an order to a named scheduler. Centers without a formal therapist triage role can assign the screen to the nurse or navigator who makes first patient contact. What matters is that screening occurs at that contact and that a positive screen leads directly to an order rather than waiting for a physician to initiate one. Where institutional policy requires the treating radiation oncologist to sign the order, a standing protocol should allow co-signature without reintroducing delay. Centers without a rapid access clinic can route orders to the earliest routine palliative appointment, but should report time to visit separately, because the value of the bridge depends on the patient being seen during, not after, the radiotherapy course.

Table 3 Core and locally adaptable components of the therapist triage bridge

Component	Core (retain)	Adaptable (local choice)
Eligibility	All palliative-intent radiotherapy consultations	Add defined advanced-disease groups
Who screens	The clinician making first patient contact during triage	Radiation therapist, nurse, or navigator
Screening measures	A validated patient-reported symptom measure plus a functional measure	ESAS-r and PPS, or equivalent measures already in local use
Positive screen	Prespecified thresholds plus clinician or patient concern	Threshold values matched to palliative service capacity
Existing palliative care	Checked before referral; existing team notified instead of re-referral	Notification channel (secure message, record flag)
Referral route	Single electronic order to a named scheduler; standing co-signature protocol where required	Destination: rapid access clinic, routine clinic, or telehealth
Timing target	Visit during the radiotherapy course	Target interval adjusted to fractionation
Measurement	Eligible denominator; prior palliative involvement; screens, positive screens, orders, completed visits, time to visit	Audit frequency; additional clinical outcomes

ESAS-r, revised edmonton symptom assessment system; PPS, palliative performance scale.

Prospective validation: a staged path

Stage 1: Single-institution feasibility and implementation study

We plan a pre–post design with interrupted time-series analysis of monthly referral rates to account for secular trends. Because our historical data lack treatment intent and prior palliative involvement, the baseline will be a 6-month retrospective chart review of consecutive radiation oncology consultations in which both are abstracted, creating the eligible denominator that the 2022–2024 data could not supply. A 6-month implementation period will follow.

The primary outcome is the proportion of eligible patients (palliative intent, not already followed by palliative medicine) referred to palliative medicine within 14 days of consultation. Implementation outcomes, defined using an established taxonomy,[17] are feasibility (screen completion among eligible patients), fidelity (proportion of positive screens that generate an order), acceptability to therapists and patients, and therapist time per screen. Clinical outcomes are time from consultation to palliative medicine visit, change in ESAS-r scores at 2 and 4 weeks among referred patients, and emergency department visits within 30 days. We will also compare screening and referral completion across age, sex, race and ethnicity, primary tumor site, and distance from the treating center, so that a pathway intended to widen access does not inadvertently narrow it. We will consider the framework feasible if at least 70% of eligible patients complete the screen and at least 80% of positive screens in patients not already followed generate an order.

As an illustration of scale, if the baseline referral rate among eligible patients were 5%, approximately 140 eligible patients per period would provide 80% power (two-sided $\alpha = .05$) to detect an increase to 15%. At current volume, about 725 consultations per 6 months, this requires roughly one in five consultations to be eligible. The final sample size will be set from the rate observed at baseline.

Stage 2: Multisite controlled evaluation

If Stage 1 meets its feasibility thresholds, a stepped-wedge cluster design across the radiotherapy sites in our network would provide a controlled comparison, with each site contributing control time before

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crossing over to the intervention. Read alongside the randomized trial of universal palliative consultation,[13] its results would help establish whether targeted, screen-triggered referral or universal offering better serves patients receiving palliative radiotherapy.

Reporting standards for the field

The literature on palliative care referral from radiation oncology is small, mostly single-institution, and inconsistent in its denominators. Two reporting conventions would make studies comparable: referral rates reported against palliative-intent consultations or an explicit advanced-disease definition, with all-consultation rates as a secondary figure; and the proportion of patients already followed by palliative medicine at consultation. Our own data show what is lost without them.

Conclusion

Radiation oncology sees a highly symptomatic population under conditions that work against conventional referral. Rapid access services exist on both sides of the gap, but they developed separately, and the therapist triage role that could join them has been studied almost entirely for its effect on radiotherapy waiting times. Our institutional experience, a palliative medicine service that grew fourfold while radiation oncology referrals remained low, suggests that the missing element is a connection rather than a clinic. We propose a brief screen, a single electronic order, a defensible denominator, and a staged evaluation that other centers can reproduce. Whether this bridge increases timely palliative care, and whether patients benefit, is an empirical question the proposed evaluation is designed to answer.

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Author contributions

AO collected the data and wrote the initial draft. MO and MPD edited the manuscript. All authors approved the revised version.

Conflicts of interest

The authors declare no conflicts of interest.

References

1. Lutz ST, Jones J, Chow E. Role of radiation therapy in palliative care of the patient with cancer. *J Clin Oncol*. 2014;32(26):2913–2919.
2. Scirocco E, Cellini F, Donati CM, et al. Improving the integration between palliative radiotherapy and supportive care: a narrative review. *Curr Oncol*. 2022;29(10):7932–7942.
3. Sanders JJ, Temin S, Ghoshal A, et al. Palliative care for patients with cancer: ASCO guideline update. *J Clin Oncol*. 2024;42(19):2336–2357.
4. Chen JJ, Rawal B, Krishnan MS, et al. Patterns of specialty palliative care utilization among patients receiving palliative radiation therapy. *J Pain Symptom Manage*. 2021;62(2):242–251.
5. O'Leary C, Cleary S, Linane H, et al. Palliative radiotherapy and the introduction of a Rapid Access Palliative Clinic in a national radiation oncology network. *Ir J Med Sci*. 2024;193(2):577–583.
6. Chasty B, Berman R, Ahamed A, et al. Palliative radiotherapy at the crossroads of supportive oncology: addressing global gaps, guideline deficits, and the expanding need for symptom–directed cancer care. *Cancers (Basel)*. 2026;18(4):564.
7. Meador A, Waldron B, Fiandt K. Barriers in palliative care referrals by oncology providers. *Clin Oncol J*. 2025;6(1):1–7.
8. Dennis K, Harris G, Kamel R, et al. Rapid access palliative radiotherapy programmes. *Clin Oncol (R Coll Radiol)*. 2020;32(11):704–712.
9. O'Reilly E, Golshan M, Chng N, et al. Effect of same–day volumetric modulated arc therapy on resource utilization in rapid access palliative radiotherapy clinics using a radiation oncologist–initiated automated planning script. *Cureus*. 2025;17(10).
10. Wear MA, Hoppe BS, Rutenberg MS, et al. Impact of an advanced practice provider directed palliative bone metastasis radiation therapy clinic on patient care. *Adv Radiat Oncol*. 2025;10(10):101712.
11. Chang S, May P, Goldstein NE, et al. A palliative radiation oncology consult service's impact on care of advanced cancer patients. *J Palliat Med*. 2018;21(4):438–444.
12. Paterson P, Fairchild A. Triage for palliative radiotherapy by clinical specialist radiation therapists: a scoping review. *Tech Innov Patient Support Radiat Oncol*. 2023;27:100213.
13. van Oss A, van der Velden JM, Verkooijen HM, et al. Timely integration of specialist palliative care into oncology care for patients receiving radiotherapy for bone metastases: a study protocol for the TIPZO–RT randomized controlled trial. *PLoS One.* 2026;21(5).
14. Sedhom R, Gupta A, Shah M, et al. Oncology fellow–led quality improvement project to improve rates of palliative care utilization in patients with advanced cancer. *JCO Oncol Pract*. 2020;16(8).
15. Watanabe SM, Nekolaichuk C, Beaumont C, et al. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456–468.
16. Anderson F, Downing GM, Hill J, et al. Palliative performance scale (PPS): a new tool. *J Palliat Care*. 1996;12(1):5–11.
17. Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. *Adm Policy Ment Health.* 2011;38(2):65–76.

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