

BEST PRACTICE

Recommendations for the integration of palliative care

into a
Comprehensive Cancer Center (CCC)



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List of Abbreviations

AG	Working group
BP	Best Practice
CCC	Comprehensive Cancer Center
CAREPAL	Screening Tool for Family Caregiver Burden in Palliative Care
CPD	Continuing professional development
DGP	German Society for Palliative Medicine
GP	General Practitioner
NCCN	National Comprehensive Cancer Network
QB	Cross-sectoral area
SAPV	Specialised outpatient palliative care
SGB	Social Security Code
SOP	Standard Operating Procedure
SPC	Specialist Palliative Care

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1 Foreword

To improve the treatment of patients with cancer and raise it to a very high standard, German Cancer Aid has been supporting leading oncology centers, known as Comprehensive Cancer Centers (CCC), as part of a priority program since 2006 [1]. In these CCCs, cancer patients receive interdisciplinary care based on the latest scientific findings and are supported by a multi-professional team providing both supportive and therapeutic care, with the involvement of outpatient services in the respective region [2]. Cancer research is also a focus of Interdisciplinary Oncology Centers of Excellence [3, 4].

Adequate access to palliative care is a key objective of our healthcare system and is therefore also an integral part of providing excellent care for people with cancer: from diagnosis and tumor treatment through to supporting seriously and terminally ill patients until their death. This necessity is underlined by legislative initiatives (the Hospice and Palliative Care Act of 1 December 2015, Federal Law Gazette I p. 2114 and Section 37b of Book V of the Social Code [SGB V] on specialised outpatient palliative care, among others) and the national strategy of the “Charter on the Care of the Seriously Ill and Dying in Germany” [5, 6, 7].

Without German Cancer Aid, palliative care in Germany would not be as well developed as it is today. German Cancer Aid paved the way for this process from the very beginning and supported the first palliative care unit in Cologne as early as 1983 [8]. Palliative care is now an indispensable part of healthcare. There are now more than 330 palliative care units in Germany, around 270 inpatient hospices for adults, approximately 1,500 outpatient hospice services, and 21 inpatient hospices for children, adolescents and young adults [9]. As of December 2025, German Cancer Aid had allocated a total of €89.9 million to the development of palliative care infrastructure, endowed professorships, research projects on palliative care issues, and training and further education [10].

In order to pool expertise in palliative care, the Palliative Care Working Group (AG) was established in 2011 within the network of funded CCCs. In a multistage, structured process between 2014 and 2025, the WG worked on developing minimum requirements for the integration of palliative care into clinical practice, teaching and research at a leading oncology center. This updated guide is intended to help further raise awareness of the integration of palliative care into healthcare services, particularly within oncological care.

On behalf of the Palliative Medicine Working Group,
Professor Christoph Ostgathe, MD
Professor Mitra Tewes, MD

② Introduction

2.1 Background

The guiding principle behind the CCC, which is funded by German Cancer Aid, is to ensure that patients with cancer have easy access to high-quality healthcare and receive treatment and support of the highest standard [1–4]. This overarching goal is consistent with the aim of palliative care to offer the best possible treatment and support to patients and their families, and thus represents a significant component of oncological care.

To meet this standard, German Cancer Aid has always been committed to strengthening general and specialist palliative care within the CCCs. As is well known, German Cancer Aid regards palliative care as an integral part of excellent care for people with cancer [11]: from diagnosis and tumor therapy through to the support of seriously and terminally ill patients until their death.

Over the past four decades, palliative care in Germany has undergone dynamic development and diversification of its care structures. The varying degrees of development within the field are also reflected in the CCCs across Germany; this became clear as early as 2011, when the Palliative Medicine Working Group was established within the network. This heterogeneity primarily concerned structures (including the implementation and integration of palliative care services within the CCCs funded by German Cancer Aid) and processes (e.g. documentation, standards, incorporation of guidelines). Furthermore, it became apparent during this period that the implementation of teaching and research in palliative care varied considerably across the individual CCCs. To verify this empirically, a systematic survey was conducted in 2014 across all participating CCCs [12]. Further surveys also enabled the status quo regarding specialised palliative care in the areas of clinical practice, teaching and research within the CCC network to be recorded [13–20]. The survey led, through an empirical process, to an initial version of best practice recommendations [21], which were incorporated as guidelines into the assessment procedures and the accreditation process for CCCs. This has sustainably reinforced the development of palliative care at the sites and beyond, in the spirit of a strengthened patient-centred approach [22]. The changes in the care of cancer patients and in palliative care in recent years, e.g. through the S3 guidelines (Palliative Medicine for Patients with Incurable Cancer [23]; Supportive therapy for oncology patients) and regular updates to certification requirements (including Oncology Centers; German Society for Palliative Medicine, DGP / ClarCert®) demonstrate the need for continuous adaptation of best practice recommendations.

2.2 Palliative Care at a Comprehensive Cancer Center (CCC) – Definition

Palliative care at a CCC is dedicated to people with life-threatening cancer and aims to maintain or improve patients' quality of life by preventing, identifying and alleviating the physical, psychological, social and spiritual suffering that can accompany cancer. Palliative care is provided regardless of the stage of the disease, the location of treatment or ongoing/planned therapeutic measures. It is incorporated proactively, but its focus lies in the period when a cure is no longer considered possible. The focus is equally on the relatives of those affected.

General palliative care is the responsibility of all clinical staff at a CCC. Specialised palliative care at the CCC is available to patients with high symptom burden and/or complex care needs. It comprises multi-professional care provided by a qualified team comprising medical, nursing, social work, physiotherapy, psychology, pastoral care and other relevant health care groups.

Excellent general and specialist palliative care at a CCC is based on a comprehensive consideration of current evidence, to the further development of which the palliative care structures contribute directly through their own research projects and those carried out in collaboration with others. Staff in specialist palliative care participate in the continuing professional development of all professional groups on palliative care-related issues, with the aim of strengthening general and specialist palliative care within the CCC and across the region. Staff in specialist palliative care participate in the curricular and extra-curricular training of medical students and other healthcare professionals.

2.3 Objectives of the Palliative Medicine Working Group within the CCC Network

The Palliative Medicine Working Group supports the efforts of German Cancer Aid and the CCC Network to ensure that patients with cancer receive care in line with the latest scientific findings, including the best possible palliative care. With a focus on palliative care, it helps to raise public awareness of the CCCs, German Cancer Aid and the network activities between the CCCs and beyond their boundaries. The Palliative Medicine Working Group within the CCC network has set itself the following tasks:

- ◆ Development and regular updating of evidence-based treatment pathways (Standard Operating Procedures, SOPs) for palliative care, issued by Springer Medizin Verlag [24]
- ◆ Analysis and structured integration of palliative care into the clinical practice, teaching and research of German CCCs [12-19]
- ◆ Development of systematic strategies for identifying palliative care needs (screening) in oncology patients and the creation of a practice-oriented toolbox containing screening instruments for identifying and assessing these needs [25]

- ◆ Development of structured processes for supporting relatives in oncological care [20, 26–28]
- ◆ Establishment and expansion of palliative care interfaces outside the CCCs, e.g. in other hospitals, GP and oncology practices, outpatient services
- ◆ Cross-working group collaboration, e.g. with the Outreach Working Group and the Psycho-oncology/ Cancer Self-help Working Group
- ◆ Development of joint research projects
- ◆ Provision of training and information materials
- ◆ Organising symposia with public forums and local meetings to facilitate the exchange of information for specialist audiences and the general public, with a view to strengthening the dedicated local networks on the ground with the CCC network of German Cancer Aid

2.4 Objectives of the Guide

The main aim of this guide is to provide information on the empirically based potential for shaping and developing palliative care within a CCC. It is intended to help ensure that seriously ill and dying cancer patients receive continuous, high-quality care within the CCCs.

The guide invites readers to review and incorporate the framework conditions for palliative care in light of the need for strategic decisions. It is aimed at all decision-makers within a CCC, as well as at all those involved in oncological patient care at all levels in a professional context, at the governing expert committee of a CCC and the steering committee of the CCC network, and at all individuals working in clinical care, research and teaching in palliative care and in the field of oncology. Through these top-down and bottom-up approaches, the integration of palliative care across various sectors can be sustainably ensured. At the same time, the guide is intended to provide guidance for centers that have not yet been designated as a Comprehensive Cancer Center by German Cancer Aid, enabling them to further develop the integration of palliative care in a targeted manner at their own sites.

2.5 Scope

The recommendations set out here cover the areas of clinical care, teaching and research. They apply to currently funded CCCs and serve as a guide for centers wishing to be included in the German Cancer Aid funding program. This guidance document includes a grading of recommendations ranging from “must” (strong recommendation) to “should” (secondary recommendation). This clarifies the priority and urgency that subject matter experts attach to the recommendation.

③ Methodology

The development of best practice recommendations for integrating palliative care into the CCCs funded by German Cancer Aid was based on previous surveys [12, 13], which included both qualitative and quantitative approaches. A mixed-methods design [12] enabled a comprehensive analysis of perspectives, experiences and structural conditions. The interviews, conducted either in person or by telephone, were carried out with senior staff from specialist palliative care (including doctors, lecturers, and those responsible for end-of-life care policies), administrative directors, and doctors from other disciplines of cancer care, including CCC directors. A structured guide comprising open-ended and closed questions provided a comparative framework, enabling the interview data to be analysed descriptively. The results of the analysis, which suggested structures that were in some cases highly heterogeneous, led to the decision to develop best practice recommendations and to reach consensus on them through a structured Delphi process. Further analyses [14–20, 22] demonstrated the need to pursue and further develop best practice recommendations.

The best practice recommendations listed here are based on literature reviews incorporating empirical findings and the expanded in 2020 S3 guideline “Palliative care for patients with incurable cancer” [23], which was first developed through a structured consensus process in 2016 [21] and subsequently expanded and revised in 2024 [30]. The monitoring team for the quantitative survey, comprising medical, social and health science experts, agreed on the wording of the recommendations in advance in collaboration with sub-working groups (SWGs) and external experts independent of the working groups. Based on the identified implementation status of the best practice recommendations for palliative care in the CCCs, the UAG Residents [26], UAG Screening [25] and UAG End-of-Life Phase [29] were established to develop evidence-based recommendations.

Survey participants were systematically selected based on the field of their expertise (area of practice). To form this expert group (quota sample), representatives of the Palliative Medicine Working Group within the CCC network were asked by email to nominate one person from their site

- ◆ in a senior medical role within the palliative care department
- ◆ in a medical role with relevant professional experience in the palliative care unit or the multiprofessional palliative care service, with more than three years’ practical experience in the field of palliative medicine
- ◆ with research activity in palliative care in a managerial or coordinating role from the professional groups of psychology, sociology, social work, social, human, health or natural sciences
- ◆ in a senior nursing role within the palliative care unit or as a nurse within the multiprofessional palliative care team and
- ◆ with teaching responsibilities in the interdisciplinary area (QB 13) in a coordinating role

This enabled a pool of 101 individuals to be established in 2024, ensuring that the survey panel reflected expertise in palliative care, teaching and research. They were given the opportunity to rate each recommendation on a 4-point scale (disagree/so-

mewhat disagree/somewhat agree/agree) according to whether it was (i) clearly formulated, (ii) relevant to the integration and networking of palliative care at the CCC, and (iii) feasible for a CCC. A free-text field allowed participants to provide comments on each recommendation. Before the 57 recommendations were included in the Delphi survey process, the questionnaire was piloted by three individuals who do not work for a funded CCC.

If the combined total of the response categories “somewhat agree” and “agree” in all three assessment categories (clarity / relevance / feasibility) reached 75% agreement, the recommendation was deemed to have achieved consensus. Otherwise, the recommendation was put to a vote in the next Delphi round, taking into account the free-text comments, which were presented transparently alongside the results in the subsequent survey process.

Between March and August 2025, three pseudonymised, written survey rounds were initiated, in which a total of 53 stakeholders participated up to the final survey round. The quantitative results were analysed descriptively using IBM Statistics SPSS 21. The free-text responses were summarised by theme and coded using Excel. The response rate exceeded 70% in all three rounds (Round 1: 74%, Round 2: 71%, Round 3: 81%).

As early as the first round of consultations, 40 of the 57 recommendations had been agreed upon. The second round of consultations yielded a total of 48 recommendations, while the third and final round resulted in a total of 54 recommendations. Between rounds 2 and 3, a moderated expert discussion session took place, involving 20 of the 26 funded CCC sites. The discussion session served to review the open comments from Delphi rounds 1 and 2, so that the recommendations were slightly reworded or deleted due to redundancy; this applied in particular to the recommendations regarding the timing of the integration of palliative care, the recommendations for the involvement of relatives, and those concerning screening. However, in addition the general recommendation on symptom and psychosocial burden assessment of 2018 was replaced by more specific screening items. Consequently, a final set of 53 recommendations was submitted to the steering committee of the CCC network of the German Cancer Aid for final review, in November 2024.

Following feedback from the Steering Committee, individual recommendations were slightly refined in terms of content and edited following in-depth joint discussion. In addition, two recommendations were incorporated into previous recommendations. The following areas were affected by these changes:

- ◆ Timing of the integration of palliative care
- ◆ The minimum size (number of beds) of a palliative care unit
- ◆ Number of hours for the palliative care outpatient clinic
- ◆ Multiprofessional palliative care team and its qualifications
- ◆ Screening of relatives for palliative care needs
- ◆ Involvement of relatives
- ◆ Tumor boards or referral to tumor boards
- ◆ Integration into the basic screening process in oncology

A total of 51 recommendations across 20 areas are issued.

④ Best Practice Recommendations



1. Timing of Palliative Care Integration

1.1 Patients within a CCC shall be offered palliative care immediately after receiving a diagnosis of an incurable cancer, regardless of whether they are receiving tumor-specific therapy.



2. Palliative Care Unit

2.1 A palliative care unit is an essential requirement at a CCC to ensure a high quality of care for tumor patients.

2.2 A palliative care unit shall be an organizationally and structurally distinct, independent unit.

2.3 A palliative care unit shall have 8 to 12 beds.

2.4 Palliative care specialists shall be available for CCC patients 24 hours a day, 7 days a week.



3. Inpatient Palliative Care Consultation Team

3.1 A multiprofessional inpatient palliative care consultation team is a necessary component of a CCC and shall be available. Its purpose is to provide advice and support to tumor patients being cared for in other departments and their relatives.

3.2 A multiprofessional inpatient palliative care consultation team at a CCC shall consist of at least three staff members and should incorporate professionals from medicine, nursing, and at least one other profession providing treatment to patients. The team shall be available during typical working hours.

3.3 Information on the availability of the inpatient palliative care consultation team shall be accessible in all departments.



4. Outpatient Clinic and Day Services

4.1 In addition to existing palliative care structures, the CCC shall offer outpatient palliative care consultations. This service should be offered at least twice a week by appointment only.

4.2 Patients shall also have access to specialist palliative care as part of the day-care services offered by all specialist departments treating tumor patients.

4.3 Oncologists should inform patients and family caregivers about the possibility to include palliative care specialists during consultation hours when required or helpful.

4.4 Information on palliative care shall be clearly displayed in the waiting area of outpatient departments that treat tumor patients.



5. Regional Networks

5.1 Specialized outpatient palliative care (SAPV) shall be provided either in-house or in collaboration with regional and supra-regional providers of SAPV.

5.2 In the case of an external cooperation with a SAPV service, a written cooperation agreement shall be in place.

5.3 A CCC shall ensure cooperation with a hospice.

5.4 For CCC patients with incurable cancer, hospice support shall be provided by qualified volunteers.



6. Involvement of Specialist Palliative Care (SPC) in Decision-Making Processes within a CCC

6.1 The CCC's steering committees shall include specialists in palliative medicine to promote interdisciplinary cooperation.



7. Advance Directives and Powers of Attorney

7.1 Regardless of the stage of the patient's disease, doctor-patient consultation shall include questions about whether a health care proxy and / or a living will have been drawn up.

7.2 The existence of a health care proxy and / or living will shall be recorded centrally in electronic form and made available to all co-treating professionals in the CCC.



8. Treatment Pathways for Patients at the End of Life

8.1 The CCC shall have a policy for ensuring the quality of the care provided to patients in their dying phase.

8.2 A treatment pathway for dealing with end-of-life situations should include the following elements: steps for assessing the situation of seriously ill patients in a multiprofessional team, documentation of decision-making, an information brochure for relatives, and instructions to be followed after death.



9. Research

9.1 To promote interdisciplinary research projects in a CCC, specialist palliative care shall be incorporated into the CCC's research structures.

9.2 The palliative care department's research output should be subject to regular evaluation.



10. Teaching

10.1 Each CCC shall have a policy for supporting and promoting research and teaching in the field of palliative care; this should include a chair for palliative care.

10.2 Each CCC shall provide a range of lectures and classes in palliative care, which should be subject to annual evaluation.



11. Continuing Professional Development (CPD) and Training

11.1 Each CCC shall have a CPD policy which enables members of all professions involved in patients' treatment to gain a basic qualification in general palliative care.

11.2 Emergency department staff should receive invitations to attend in-house training on the care and counseling of patients with incurable diseases. This has the purpose of raising staff awareness of decisions pertaining to palliative care or intensive care.



12. Tumor Boards

12.1 Within a CCC, the need for specialist palliative care (SPC) should be documented when registering with the tumor board, and these patients should then be represented by specialists on the tumor board.



13. Primary Care

13.1 The CCC shall systematically inform GP and involve them in care planning at the start of specialized inpatient care and prior to discharge into specialized outpatient palliative care (SAPV).

13.2 General practitioners of all patients with incurable cancers, shall be informed upon their discharge about aspects of their case with relevance to palliative care, such as the aims of their treatment and any advance directives that are in place. Appropriate ways of conveying this information might include a discharge letter, transfer sheet, or handover telephone call.



14. Policies for Ensuring the Quality of Support for Family Caregivers

14.1 Each CCC shall have a policy for ensuring the quality of the support for family caregivers of patients with incurable cancers.

14.2 These policies should include the following aspects:

- ◆ Structured assessment of the burdens and needs of family caregivers during the course of the disease,
- ◆ Provision and mediation of support services to family caregivers,
- ◆ Provision of information materials, e.g. on support services for relatives, disease-specific materials, palliative and hospice care, services for the grieving.



15. Family Caregivers: Assessment of Burden and Support Needs

15.1 Relatives of patients with incurable cancer should have their stress levels and support needs assessed throughout the course of the illness. This includes concerns experienced by children and adolescents in this role.

15.2 For relatives of patients with incurable cancer, standardized self-assessment questionnaires for relatives (such as CARE-Pal^{*}) should be used in addition to personal interviews to assess stress levels and support needs.

^{*}Ullrich, A., Bergelt, C., Marx, G., Daubmann, A., Benze, G., Heine, J., Dickel, Lisa-Marie ... Oechsle, K. (2024). The CAREPAL-8: a short screening tool for multidimensional family caregiver burden in palliative care. BMC Palliative Care, 23(1), doi: <https://doi.org/10.1186/s12904-024-01480-w>

15.3 Family caregivers of patients with incurable cancer shall receive support from the patient's treatment team in accordance with their needs. Multiprofessional teams incorporating professionals from the fields of specialist palliative care, psycho-oncology, specialist nursing, social work, case management, spiritual and pastoral care, outpatient hospice services, etc., shall provide specific support as required. Children and young people should be offered easily accessible, age-specific and age-appropriate support.



16. Providing Information to Family Caregivers and Involving them in Care

16.1 Family caregivers of patients with incurable cancer shall receive information on palliative care and on support services for family caregivers, regardless of whether the patient is receiving tumor-specific therapy.

16.2 Where the patient consents to this, family caregivers of patients with incurable cancer shall receive information on treatment decisions and the planning of treatment and care and should be able to participate actively in doctor-patient conversations. Digital means of communication should be used for this purpose where necessary and appropriate.



17. Integration of Palliative Care in Basic Oncological Screening Procedures

17.1 Screening to identify a need for SPC shall be a component of the oncological screening of patients with incurable and progressive disease.

The primary criterion for the integration of SPC shall be the stress situation of the patient. The stress experienced by relatives can also be a criterion. A limited life expectancy due to illness alone is not a sufficient criterion for the integration of SPC.

17.2 Patients with a potentially curable disease may also require specialist palliative care.



18. Screening: Creating and Managing Internal Processes

18.1 Oncologists and specialist palliative care professionals in CCCs shall agree on and implement a central CCC-wide process for identifying patients with a need for SPC.

18.2 This process should encompass:

- a) ...criteria for identifying which patients should receive screening for SPC needs and the points during the course of disease at which screening should take place.
- b) ... the selection of a screening tool, e.g., based on the toolbox* or the Standard Operating Procedure (SOP) for Oncological Basic Screening**, including the definition of specific evaluation criteria (cut-off) for further in-depth assessment by the specialist palliative care team.

* Müller, E., Gahr, S., Schnabel, A., Müller, M.J., Sölder, P., Tewes, M., Roch, C. (2024) [Screening for specialist palliative care need Know-how and screening tools]. Onkologie 30, 850-856. <https://doi.org/10.1007/s00761-024-01574-3>

** OnkoZert GmbH (2026). Certification Systems. Catalogue of Requirements for Oncology Centres. URL: <https://www.onkozert.de/en/certification-systems/>, 22.04.2026

- c) ...determining which professionals will assume responsibility for the conduction and analysis of the screening and the in-depth assessment of patients whose initial screening is positive, and for taking decisions on whether specialist palliative care should become part of the patient's care.
- d) ...alternative screening approaches in case the selected screening tool is not applicable to all patients (for example, the patient is unable to complete a self-report questionnaire).



19. Choice of Screening Tools

19.1 Patient-reported outcome measures (PROMs; patient questionnaires), scores / lists of criteria completed by healthcare professionals, and/or routine data may serve as potential screening tools.

19.2 CCCs shall choose a screening tool that

- ◆ is able to ascertain the patient's needs and the burden affecting them
- ◆ has been validated for the identification of SPC needs, meaning that criteria for the interpretation of results (such as cut-offs) are available
- ◆ meets the general standards for test criteria in medicine (reliability, objectivity, etc.).



20. In-Depth Assessment for Patients Whose Initial Screening is Positive

20.1 For patients who test positive in the screening, an in-depth assessment by specialist palliative care services shall clarify the extent of the burden and the need for palliative care. Regardless of this decision, general palliative care shall continue.

20.2 Palliative care specialists shall conduct the in-depth assessment of patients with incurable cancer.

20.3 The assessment shall take place in dialogue with patients and/or family caregivers.

20.4 The assessing professionals shall seek to acquire additional information with the specific purpose of identifying remits and responsibilities for the patient's care; such information might include details of the causes and progression of symptom burden and distress or of support/treatment already in place.

20.5 Referral decisions on responsibility shall take account of local conditions and circumstances, such as the resources available in specialist and general oncological palliative care.

⑤ Standard Operating Procedures

In addition to the recommendations agreed upon through the consensus process, Standard Operating Procedures (SOPs) reflect current best practice in the palliative care of patients with cancer within the clinical context. For this reason, the Palliative Medicine Working Group within the CCC network has developed SOPs. The initiative is based on a CCC-wide study by the Palliative Medicine Coordination Unit, which identified which SOPs relating to palliative care are currently in place within the CCCs, appear relevant for the future [22], and have been implemented [13]. They serve to promote and support professional expertise in general and specialised palliative care across the CCCs and beyond their boundaries. The following topics were developed by members of the Palliative Medicine Working Group with the support of the Palliative Medicine Coordination Office and an expert advisory board of the Palliative Medicine Working Group of the CCC network, taking into account guidelines-compliant preparation.

Table 1: Topics Covered in the Standard Operating Procedures Developed by the Palliative Medicine Working Group (CCC Network)

Title	Corresponding authors
Acute confusional states and delirium in palliative care	Elisabeth Jentschke, Carmen Roch
Anxiety	Beate Hornemann
Shortness of breath in adult palliative care patients	Johannes Rosenbruch
Admission criteria for the palliative care unit	Jan Gärtner
Treatment and care during the terminal phase	Thomas Montag
Intestinal obstruction in palliative care	Stefan Schönsteiner
Depression in palliative care	Jacqueline Schwartz
Fatigue	Lukas Radbruch
Loss of appetite and cachexia	Thomas Gelbrich

Intentional sedation in palliative care	Carsten Klein
Subcutaneous medication administration and infusions in adult palliative medicine Version II	Jörg Hense
Managing multidrug-resistant pathogens in the palliative care unit	Christoph Ostgathe
Nausea and vomiting in palliative care patients Version II	Johann Ahn
Pain management in patients with cancer in palliative care	Burkhard Dasch
Dying in hospital – dealing with and caring for the deceased and their relatives and loved ones	Burkhard Dasch
Supporting the relatives of patients with incurable cancer throughout the course of the illness	Karin Oechsle
Co-care of relatives of patients with incurable cancer during the terminal phase	Karin Oechsle

These are available as a series on the “Network of Oncology Centers of Excellence” website at “Palliative Network SOPs” (<https://www.ccc-netzwerk.de/netzwerk-sops/palliative-netzwerk-sops.html>, (as at 16 March 2026) and in the specialist journal “Der Onkologe” published by Springer Medizin Verlag GmbH (<https://www.springer-medizin.de/handlungs-empfehlungen-fuer-die-palliativmedizin/16357060>) and freely accessible.

⑥ Publications from the Palliative Care Working Group

Original Articles

Mueller E, Gahr S, Schnell A, Aulmann C, Roch C (2026) Practice patterns of strong opioid recommendations by palliative care consultation services in German hospitals (online survey). *BMC Palliat Care*, 31;25(1):223. <https://doi.org/10.1186/s12904-026-02266-y>

Mueller E, Gahr S, Schnell A, Schildmann E, Boehlke C, Roch C (2025) Challenges in opioid therapy implementation: national survey of palliative care consultation services. *BMC Palliative Care*, 24(1), 262. <https://doi.org/10.1186/s12904-025-01921-0>

Berendt J, Heckel M, Ostgathe C, Stiel S, Stachura P, Becker A, Beckmann M W, Gahr S (2025) Place of Death of Cancer Patients Treated at a German Comprehensive Cancer Centres. In *Einreichung: Palliative Medicine Reports* 6(1). 273-281, doi: <https://doi.org/10.1089/pmr.2024.0097>

Berendt J, Brunner S, Heckel M, Tewes M, Ostgathe C, Gahr S (2024) Symptom burden and relief in palliative care units of German Comprehensive Cancer Center and other hospitals. *J Cancer Res Clin Oncol*;150(3):160. doi: <https://doi.org/10.1007/s00432-023-05557-6>

Gahr S, Brunner S, Heckel M, Ostgathe C (2023) [Are There Entity-Specific Criteria for Initiation of Specialized Palliative Care for Incurable Cancer? A Scoping Review]. *German Journal of Palliative Medicine* 24(5). <https://doi.org/10.1055/a-2054-1201>

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