Provision of Palliative Care and Pain Management Services for Oncology Patients

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Abstract

Early initiation of palliative care to address pain and other symptoms offers the potential to improve quality of life for patients with cancer. The approaches to implementing and delivering palliative care and pain management services vary depending on patient needs, available resources, provider training, and clinical setting. This article describes the experiences in developing programs in which the need for early palliative care or pain management services for patients with cancer was recognized. In each case, collaborative efforts, careful planning, administrative support, and ample time were needed to implement such services. To tailor services based on the available resources, different approaches were taken, including structuring of services within oncology units; creation of an integrated partnership between oncology and palliative care departments; establishment of a multidisciplinary comprehensive service; and incorporation of nurse-based pain services to address acute, chronic, and cancer pain. These examples offer insights into how to optimize delivery of services in a variety of settings with varying resources. (JNCCN 2013;11(Suppl 1): S17–S27)

Palliative care is an important component of cancer management that reduces the adverse impact of pain and other symptoms, whether attributable to cancer-related treatment or the malignancy itself, on the patient’s quality of life throughout the disease course. Because the number of unmet needs has been associated with decreased quality of life,1 palliative care should not be reserved for the end of life, but ideally should be integrated into a comprehensive cancer care paradigm alongside other treatment modalities.2

Multiple professional oncology organizations recommend early palliative care as an integral component in the management of patients with cancer. The recently published provisional clinical opinion of the ASCO3 recommends that combined standard oncology and palliative care should be considered early in the disease process for patients with metastatic cancer and/or a high symptom burden. Meanwhile, the European Society for Medical Oncology (ESMO) formalized the relationship between medical oncology and palliative care in a series of policy statements published in 2003.4 These policies recognize that alleviation of pain and other symptoms should be given a high priority, that medical oncologists must be experts in evaluating and managing these symptoms, and that cancer centers should provide supportive and palliative care as part of their basic services.

Although agreement exists on the need for early palliative care services for patients with cancer, less guidance is available on optimal ways to develop successful programs. The availability of palliative care and pain management services varies by country and geographic location, and across medical centers. Programs incorporating palliative care services must base their design on the needs of the patients, the training and availability of health care providers, and the resources available.
This article discusses the challenges faced by the authors in addressing the need for palliative care or pain management services in their respective health care settings, and describes the approaches they took and the progress and outcomes they achieved in establishing these services. The combined experiences of these centers offer insights into how services can be delivered in a variety of settings with a range of resources.

**Challenge #1: Incorporate Supportive and Palliative Care Interventions Into Services Provided by Oncology Teams**

The delivery of cancer care typically involves a range of oncology specialists, including medical oncologists, radiation oncologists, surgeons, pathologists, psychologists, and nurses. Although the need for palliative care services has been recognized as an important part of patient care, the availability of palliative care specialists in certain settings or institutions may be limited. Incorporating supportive and palliative care into the services provided in these settings represents a formidable challenge. This section describes the experiences with incorporating palliative care and pain management interventions into 2 oncology settings: a medical oncology department with an identified need to address untreated symptoms, and a new radiation oncology department. In both cases, a systematic approach was used to overcome obstacles to effective symptom management.

**Approach**

Two oncology departments located in Rome, both recognized as an ESMO Designated Center of Integrated Oncology and Palliative Care, initiated supportive and palliative care interventions to treat chemotherapy- and cancer-related symptoms. They adopted the position of the Italian Association of Medical Oncology (AIOM), which identifies the ESMO integrated model as the most appropriate one for addressing the needs of patients with cancer. According to this model, simultaneous supportive and palliative care should be provided throughout the disease course to optimize the patient’s quality of life, allow flexible management, and enable appropriate objectives to be set based on the specific clinical situation. A medical oncologist, specifically dedicated to supportive and palliative care, plays a central role in this model. In addition to providing diseasespecific medical treatment, the medical oncologist must guarantee that the patient achieves the best possible quality of life through delivering continuous care throughout the disease course. To accomplish these goals, the medical oncologist should use validated instruments at every visit regardless of disease stage or disease-specific treatment, and recognize the psychological, rehabilitative, spiritual, and social needs of the patient and their family or caregiver.

The new radiation oncology department was established at a private university hospital in Madrid. It faced the initial challenge of integrating its services into existing multidisciplinary cancer teams, while implementing new technological advances in radiation oncology. The clinic endeavored to improve pain control through applying a systematic approach to cancer pain, both in terms of pain identification and management. Although pain is commonly associated with cancer, the frequency and severity of pain within the patient population seen at the clinic were unclear when the program was started.

In both settings, careful assessment was recognized as critical for adequately managing cancer-associated symptoms, as inadequate assessment can lead to ineffective or inappropriate treatment. A survey administered to 250 Italian medical oncologists in 2003 found that 44% of the respondents used a multiple symptom assessment tool, 38% used a tool to assess a single symptom, and 59% used some instrument to assess pain. Moreover, only 36% of the oncologists indicated that they commonly use a patient-tailored protocol for symptom treatment. Outside of specific training, patient-tailored protocols were rarely administered.

When conducting symptom assessments, the patient’s perspective is important to include. In general, good agreement exists between clinician observations and patient reports, with higher rates of agreement for observable symptoms (eg, vomiting, diarrhea) than for subjective symptoms (eg, fatigue, dyspnea). In one study in which symptom ratings were discrepant, the difference was usually one severity grade (scale: grade 0 [absent] to 4 [life-threatening]). These findings underscore the importance of including patient reporting in the symptom assessment.

**Progress**

Simple instruments to measure symptoms and pain were introduced at the medical and radiation
oncology departments. In the former, an instrument called the Distress Thermometer, designed by NCCN and validated in Italy to measure the level of distress and presence of problems, is administered to all patients at admission to the hospital or outpatient clinic (Figure 1).\textsuperscript{3,9} Overall distress is rated on a scale from 0 (no distress) to 10 (extreme distress), with scores of 4 or higher prompting immediate notification of the oncologist and palliative care expert.

In addition, a risk-perception attitude framework was incorporated to evaluate how symptom ratings are influenced by the views and attitudes of the patient. At admission, patients are assessed for their perception of cancer severity and curability. Patients who believe they have a good chance of being cured generally perceive their symptoms as being less serious and better tolerated, and have high satisfaction with the oncology service and hospital. Conversely, patients who consider their disease to be incurable believe their symptoms are more serious, have low satisfaction with the oncology service, and consider the hospital to be inadequate. Therefore, the perception of symptoms and treatments may differ considerably among patients.\textsuperscript{10} The perception of control and curability must be taken into account to identify patients with cancer who are suffering most and require special medical care, because these factors have an effect on depression and anxiety.\textsuperscript{11}

Patients can be reluctant to report pain from cancer or its treatment because of concerns about distracting their physicians from treating the underlying malignancy.\textsuperscript{12} In the radiation oncology department, pain related to the site of active cancer is seen in most cases, but pain can also be caused by radiation and other anticancer treatments.\textsuperscript{13} The assessment focuses on pain using a questionnaire that is practical, easy to use, adaptable to the needs of the clinic, and easily incorporated into its daily routine. The questionnaire collects information on pain location, quality, intensity, origin/pathophysiology, and type. Simple graphics allow patients to easily communicate information about pain location and intensity. The pain assessment should also distinguish between “background” and “breakthrough” pain; algorithms are available to make this distinction.\textsuperscript{14} Background pain is defined as pain present for 12 hours or more per day during the previous week or that would be present if the patient was not using an analgesic, whereas breakthrough pain reflects transient exacerbations of pain that occur either spontaneously or in response to specific triggers in a patient whose background pain is adequately controlled. In general, breakthrough pain is characterized by rapid onset, very severe pain intensity at the peak, relatively short duration (≈30 minutes), and variable frequency.

Outcomes

In a cohort of 208 patients with cancer admitted for oncology inpatient supportive care from May 2002 to May 2004, 38% had 1 to 2 severe symptoms at hospital admission, 31% had 3 to 4 severe symptoms, 22% had 5 to 6 severe symptoms, and 9% had 7 or more severe symptoms.\textsuperscript{6} Based on the systematic assessments and protocol-based treatment strategies, the prevalence of symptoms at admission, particularly pain and nausea, was reduced substantially by the time of hospital discharge.\textsuperscript{6} After integration of a systematic approach to palliative care interventions within the oncology department, the number of readmissions declined and the number of end-of-life hospitalizations decreased. These initial data illustrate that integrating supportive and palliative care into oncology services can improve patient care and may also offer an economic benefit. Although in Italy several medical oncology divisions have been merged with internal medicine wards for cost containment, the establishment of new palliative care units is not foreseeable in the near future. The ESMO and AIOM proposed integration model may represent a possible alternative that remains to be studied.\textsuperscript{15}

In the radiation oncology department, the number of patients treated has increased steadily since 2007, reaching more than 1400 patients in 2011. Within this period, a substantial amount of time and effort was required to improve the quality of radiation treatments and to integrate multiple and new radiation modalities. The integration of these new technological techniques increases the precision and accuracy of the treatments, achieving better control of the tumors and fewer side effects for the patients. This approach has changed some of the treatment indications, and allowed selected patients with metastatic disease to be moved from palliative to curative intent. Only 16% of the treatments themselves are now considered palliative (eg, for symptom control and/or prolongation of life). However, pain is common in cancer and in radiation oncology department settings, and it is also a clinical challenge to assess and manage pain, and other symptoms associated with cancer and its treatment. Some barriers
A multidisciplinary team should convene to address 4 essential items based on the services available within the local network. First, the team must reach a consensus for defining the time point at which routine palliative care should start based on the type of malignancy. For example, for each solid tumor type, the team must decide whether it is appropriate to integrate palliative care immediately after diagnosis of metastatic or relapsed disease, or recommend waiting until the initiation of systemic chemotherapy.\(^17\) At this point, patients typically receive disease-specific treatment in an oncology setting (eg, oncology unit, oncology outpatient clinic), with the oncologist having the primary responsibility for treatment.

Second, patients should receive standardized palliative care assessments on a regular basis and, if necessary, palliative care interventions during the course of cancer treatment. To accomplish this, the team needs to identify the instruments that will be used to assess the needs of patients.

Third, the team should identify the palliative care infrastructure (eg, specialized palliative care unit, home care service) that is available within their institution and community, and if it is not available, decide whether it should be established. The palliative care infrastructure differs by region, with some countries supporting palliative home care services and others preferring that services be delivered at palliative care units or hospices.\(^17,18\)

Finally, the team should determine who has primary responsibility for treatment based on the disease course. As long as patients remain on an oncology treatment structure, the palliative care physicians serve a consulting role and do not make disease-specific treatment decisions. At this point, the palliative care physician may discuss whether the goal of treatment is consistent with the wishes of the patient. Once patients switch to a palliative care structure, then the palliative care staff assumes primary responsibility for patient care and the oncologist takes on a consulting role. It is critical to confirm that the patient would not benefit from further disease-specific treatment and that it is an appropriate time to transition them to primarily palliative care.

**Challenge #2: Develop a Shared Care Model Between Separate Oncology and Palliative Care Departments**

The traditional sequential model in which palliative care was offered after other treatment options had been exhausted is being replaced by newer approaches that integrate palliative care services at an early point with other treatment modalities. To overcome the constraints of systems in which palliative care services are performed by the oncology team or on a consultation basis, a shared care model has been suggested that allows oncologists to focus primarily on cancer management while a palliative care team simultaneously addresses the patient’s physical, psychosocial, and other nonclinical needs.\(^16\)

The first palliative care unit in Germany was established in 1983 in Cologne and became an independent department with an academic professorship chair in 2005. The oncology and palliative care units have devised systems to work together to most appropriately manage patients.

**Approach**

Several factors had to be considered when developing guidelines for the early integration of palliative care, because the overall approach must be tailored to the needs of the patient population, the setting, and the available resources. Terminology must be clearly defined, because definitions or interpretations may vary. For example, the term *palliative care* is distinguished from *palliative therapies*, which are disease-specific interventions (eg, systemic therapy, radiotherapy, or surgery) designed to prolong life through slowing the disease course.\(^17\) *Palliative care* is also distinguished from *supportive care* or *supportive therapies*, which are prescribed to treat the side effects of disease-specific treatment or to allow for higher doses or dose intensities of the treatment to be delivered. A common understanding of the services provided by the palliative care team is especially important when departments are coordinating patient care. The following approach provides guidance to those working toward setting up similar systems.

**Progress**

In Cologne, within the Center for Integrated Oncology, an interdisciplinary team with representatives from multiple departments, including palliative care, associated with pain management, including those imposed by the health care system, health care professionals, and patients themselves, can be alleviated with a systematic approach.\(^12\)
Outcomes

In this model, palliative care serves as one of the pillars of comprehensive cancer care along with surgery, radiation, and medical oncology. The unit has a strong hospital support team, provides outpatient services mainly to the cancer clinic, and offers services to home care patients (Figure 2). Clinical research is conducted within the palliative care unit, and training and education about palliative care are provided to patients and their families and caregivers.

The impact of early integration of palliative care was evaluated in a retrospective chart review that covered the 2-year period (May 2006–April 2008) after the program was implemented. A total of 862 patients with either inoperable metastatic or locally advanced disease received consultations by the palliative care consulting team. Comparisons were made between patients seen initially during the first year (“program getting started”) versus the second year (“program getting settled”). The proportion of patients in a reduced performance status (ie, ECOG grades 3–4) on initial consultation decreased from year 1 to year 2 (45% vs. 36%; \( P = .016 \)), and the aver-

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Furthermore, the establishment of the palliative care service has enabled the unit to amortize and extend its expertise to assist not only patients with cancer but also those with a variety of medical conditions who could benefit from the specialized palliative care approach.

Challenge #3: Establish a Comprehensive Service Using Multiple Specialties and Enabling Continuity of Care

A close partnership between professionals providing oncology and palliative care services is important, given that advanced or metastatic cancer is generally terminal despite use of modern treatments. Ideally, a coordinated multidisciplinary team, encompassing both inpatient and outpatient settings, would provide continuous care to patients and families from diagnosis to death, and beyond. The establishment of such an integrated service requires commitment.

Table 1 Timing for Integration of Palliative Care According to Malignancy

<table>
<thead>
<tr>
<th>Malignancy</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Breast cancer</td>
<td>Inoperable metastatic or locally advanced disease</td>
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<tr>
<td></td>
<td>Relapsed disease receiving intravenous systemic therapy</td>
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<tr>
<td>Cervical or ovarian cancer</td>
<td>Metastatic or inoperable locally progressive disease</td>
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<tr>
<td></td>
<td>Relapsed disease after initial curative intervention</td>
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<tr>
<td>Colorectal, gastric, or lung cancer</td>
<td>Metastatic disease without option for R0 resection or neoadjuvant chemotherapy followed by R0 resection</td>
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<tr>
<td></td>
<td>Inoperable relapsed disease</td>
</tr>
<tr>
<td>Melanoma or sarcoma</td>
<td>Stage IV disease</td>
</tr>
<tr>
<td>Neuroblastoma</td>
<td>Relapse of high-risk disease or multiple relapses of intermediate-risk disease</td>
</tr>
<tr>
<td>Brain tumor</td>
<td>All patients with malignant disease</td>
</tr>
<tr>
<td>Oropharyngeal cancer</td>
<td>Inoperable locoregional disease after definitive therapy</td>
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<tr>
<td></td>
<td>Metastatic disease without curative options</td>
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<tr>
<td>Oral cancer</td>
<td>Metastatic disease</td>
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<tr>
<td></td>
<td>Locally progressive disease after failure of curative therapies</td>
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<tr>
<td>Parotid cancer</td>
<td>In progress</td>
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<tr>
<td>Pancreatic cancer</td>
<td>All patients</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td>Metastatic or inoperable locally progressive disease</td>
</tr>
<tr>
<td>AML, ALL, or MDS</td>
<td>Intravenous chemotherapy or bone marrow transplant no longer indicated</td>
</tr>
<tr>
<td>CLL</td>
<td>Advanced disease not amenable to allogenic transplant, or relapse after allogenic transplant</td>
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Abbreviations: AML, acute myeloid leukemia; ALL, acute lymphoid leukemia; CLL, chronic lymphoid leukemia; MDS, myelodysplastic syndrome.

on the part of the various specialists and support from the administration, and ample time for implementation.

**Approach and Progress**

The development of a viable partnership, initially within a hospital setting and later extending into outpatient and home healthcare settings, is illustrated by the experience at a Versailles hospital. A multidisciplinary pain treatment unit was formed in 1995, and subsequently palliative care services and later supportive care were established for outpatients with the creation of the Pallium Network in 2000 and the formation of the Epsilon Outpatients Palliative Care Network in 2003. Despite these programs, it was not until 2004 that the French Health Ministry approved 5 beds dedicated to palliative care in the Pneumology Department, where a thoracic oncology unit is located, and another 5 palliative care beds in the Hematology-Oncology Department. A mobile palliative care team was established in 2010.

The hospital has established several weekly or twice-monthly multidisciplinary and multiprofessional coordination meetings reflecting its commitment to integrated care. Some are dedicated to medical oncology (e.g., breast cancer), one is dedicated to pain management, and the most recent one is dedicated to supportive care. The latter coordination meeting includes pain specialists, palliative care specialists, medical oncologists, and representatives from other cancer modalities. Nurses are involved with screening and identifying the patient’s physical, social, and psychological needs, and offering supportive and palliative care to provide comfort and improve quality of life. Additional support for the partnership is provided by an academic psychiatry department, which offers psychological services as needed, including a psychiatrist on duty around the clock. The center employs social workers, dieticians, physiotherapists, and beauty specialists who also contribute to the delivery of care. Because many patients are treated outside of the hospital, the patient’s general practitioner is provided with special telephone numbers for a senior oncologist and a senior hematologist to allow for direct discussions about a patient.

Teaching and research are also part of the integrated partnership. Members of the Hematology-Oncology Department serve on the faculty at the Paris Ile-de-France Ouest Medical University, and in collaboration with members from 2 other hospitals they participate in a program leading to the first French multi-university degree in supportive care. From a research perspective, the department participates in clinical trials together with the mobile palliative care team and the Center of Pain Study and Treatment. Publication is encouraged, and the partnership received the ESMO best poster award in 2006 for a presentation about delivering bad news to patients. This work stemmed from including nurses in the first oncology consultation, thereby providing an opportunity for more interaction with patients and the use of an assessment checklist to identify their needs. This partnership enables continuous care to be delivered from the cancer diagnosis through the patient’s death (Figure 3). Specific anticancer care is provided after diagnosis with the goal of cure or prolonged response, depending on disease stage and tumor type. As the cancer progresses, supportive and palliative care encompass an increasingly larger part of patient management, whereas the role of specific anticancer care decreases. Even after the patient’s death, the partnership can offer support services to family members.

**Outcomes**

In 2011, the hospital was recognized as an ESMO Designated Center of Integrated Oncology and Palliative Care. The ESMO accreditation criteria include closely allied oncology and palliative care services; a philosophy of continuity of care and nonabandonment; expert care in addressing physical, psychological, existential, social, and family needs; coordination of inpatient and home care needs; and participation in clinical research and educational initiatives to improve quality of life and integration of oncology and palliative care.
treatments, increased documented use of pain rating scales, and more efficient use of nonpharmacologic options.27 These structural changes, however, do not always translate into clinically meaningful outcomes for patients in pain.27 Furthermore, randomized clinical studies enroll patients who may not be typical of those seen in real-world clinical practice, and may use artificial or context-dependent study settings. These studies may be of limited use in demonstrating improvement in real-world outcomes.

A challenge for practicing clinicians is to translate the knowledge gained from organizational initiatives and research settings into programs that have a direct benefit to patients.

**Approach**

Various initiatives have led to an increasing number of pain management certifications for German institutions and the concept of pain-free hospitals as a goal.28 This terminology, however, can create unrealistic patient expectations and lead to disappointment with the provided medical services. To address this issue, a pain project called “Don’t Be Afraid of Pain” was implemented at a university hospital in Berlin to remind patients that they may still have pain but not to be afraid of it. Each patient received a leaflet and education on pain management. The positive response to the “Don’t Be Afraid of Pain” project and the literature reports led to the suggestion of a nurse-based pain service.

Justification for this approach was provided through data in an initially German and now European pain registry entitled Improvement in Postoperative PAIN OUTcome or PAINOUT, which was established to evaluate pain management in real-world clinical practice.29,30 The registry currently has a large collection of data sets from patients in a wide range of hospital settings, and uses benchmarking to compare the treatments of similar types of patients. These data enable practitioners to determine which

**Challenge #4: Expand the Role of Nursing Professionals to Optimize Delivery of Pain Management Services**

Many professional organizations have issued initiatives and guidelines that elevate pain assessment and management to the status of a patient right and health care provider obligation.26 However, despite the availability of numerous expert recommendations, up to 50% of cancer patients do not receive adequate analgesia and approximately 30% do not receive appropriate drugs for their pain.26 Pain initiatives have produced structural and procedural improvements, such as reduced use of obsolete

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**Figure 3** The concept of continuous care.

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2012, the health ministry qualified the hospital as a Center of Pain Study and Treatment.24,25

The keys to the partnership between oncology and palliative care are collaboration, commitment, and communication. A successful partnership also requires an understanding among practitioners that cure is not always the goal of treatment, and that telling patients when anticancer treatment is no longer effective is part of the continuous care paradigm. In this center, the successful creation of a recognized partnership between oncology and palliative care took more than 10 years of hard work and persistence, and many discussions with various administrators and representatives of the health ministry.
treatment scenario might provide the optimal pain management strategy for a particular patient. This approach can also be used to identify parameters for “essential documentation.” Notably, patient satisfaction with pain management did not necessarily correlate with the pain management technique (eg, regional vs. systemic analgesia), pain intensity, or pain assessment technique. Interestingly, an item that correlated well with patient satisfaction was the patient’s feeling that someone was taking care of the pain. Therefore, from a simplified perspective, it is important to give patients the feeling that they are being cared for, regardless of the actual technique used to control their pain. Also, instead of focusing on intensity of pain and other symptoms only, the impact of the symptom should be assessed (eg, sleep interference due to pain, impaired mobilization, coughing strength).

The patient spectrum of acute pain services is usually limited to high-risk patients, and therefore leaves most patients in a hospital setting without sophisticated assistance for pain and symptom control. Unfortunately, surveys indicate that a vast number of patients still experience insufficient management of acute pain. Although physicians have limited time to spend on hospital wards, nurses are in the ideal position to offer pain and symptom control; they are highly dedicated providers with frequent patient contact and a continuous presence on the ward.

The medical literature provides examples of effective physician-nurse collaborations in providing pain services. A review of the impact and effectiveness of nurses involved in pain services identified several of their key roles: nurses provide professional support and act as a resource for other nurses; they provide education to patients about pain management across multiple settings, including postoperative care and long-term care; and they serve as patient advocates by regularly assessing and monitoring pain levels, and providing advice to physicians and pharmacists about prescribing decisions. The expansion of the nurse’s role has resulted in improved management of acute and chronic pain at the bedside, with patients reporting less pain intensity and greater understanding of pain management.

In the United Kingdom, specialist pain nurses were given prescribing rights for inpatient care in 2006. In a recent survey of 137 nurse prescribers, 35% worked in acute/chronic and/or integrated pain services and 90% treated more than one type of pain. On average, the nurses spent 53% of their time on hands-on pain management, 25% on staff training, 23% on patient education, 20% on prescribing, and 12% on research or audit activities. Many of these activities (pain management, prescribing, and patient education) overlapped and occurred simultaneously, and therefore the total percentage of time extends beyond 100%. This case illustrates the important role that nurses can play in the diverse aspects of pain management.

Progress

A top-down implementation approach was taken to the establishment of the nurse-based pain service. After discussing the benefits of analgesia, approval was obtained from the hospital administration, and a nurse-physician project team was established. From the outset, the implementation team consisting of accountable “partners” (ward physician, ward nurse, pain management adviser from the hospital acute pain service, and an organizer from central administration) recognized that it would take a minimum of several years to establish a viable service throughout the hospital in a ward-by-ward fashion. Physician and nurse stakeholders were identified in every department and encouraged to have their preferences and special needs included in the local pain management algorithm. This strategy helped to gain physician acceptance, but also added to the length of the implementation process. Audits conducted after 1 year identified strategies that were not useful or were missing and could be eliminated or added.

Within certain limits, nurses manage acute pain autonomously in this framework; however, in chronic pain and palliative care settings, a physician must first see patients and then delegate the next steps in pain care to the nurses. Communication training is provided to the nurses to help facilitate conversations with patients and their relatives/caregivers to identify deficits and issues that may require follow-up with the ward physician. This training enables the nurses to serve as advocates for the patients and their families. Each ward has a written standard operating procedure that defines responsibilities, patient assessment rules, exit rules (ie, when nurses must consult with a physician), standard and on-demand treatment regimens, and an emergency treatment plan.
Outcomes
Benchmarking and internal certification are used to evaluate the pain service. Because of the numerous variables involved, it has been difficult to quantifi-
cably measure how much the nurse-based pain service has improved patient outcomes. However, a dramatic increase has occurred in the number of patients who, when asked 3 specific questions, state that they are not afraid, can sleep well, and are not immobilized. Other positive outcomes include patient satisfaction and initiation of fast-track procedures. This experience suggests that hospital-based pain services can extend beyond their traditional role in acute pain to include services for chronic and cancer pain, and that nurse-led care should be an integral element of these pain services.

Conclusions
Early palliative care is now recognized as an integral component in the management of patients with cancer. The considerations in delivering supportive and palliative care include patients’ needs, the training and availability of health care providers, and the local setting and administrative structure. The experiences described in this article illustrate the implementation of local solutions to establish successful programs. Some programs were established with the specific goal of pain management, whereas others focused on overall supportive and/or palliative care services.

It is anticipated that these programs will continue to evolve with increased recognition of their benefits to patients and families. Recognizing the need for palliative care and pain management services is the first step in the process of implementing programs and improving practice.

The establishment of services requires a long-
term commitment, careful planning, administrative support, and, most importantly, collaboration. The road to implementing these services is not straight or smooth, and obstacles will need to be overcome. However, once established, palliative care and pain management services offer great potential for reducing the suffering of patients with cancer and improving the quality of their life throughout the disease course.

Acknowldgments
The authors gratefully acknowledge Augusto Cara-
ceni, MD; Hernán Cortés-Funes, MD, PhD; Andrew Davies, MB BS, MSc, MD, FRCP; Guido Fanelli, MD; Paul Glare, MD; Sunil Panchal, MD; Philippe Poulin, MD; Alain Serrie, MD, PhD; Jamie Von Roenn, MD; and Giovambattista Zeppetella, FRCPG, FRCP, for their contributions to the discussion at the roundtable meeting, which was supported by Archimedes Development Ltd. Technical and editorial assistance was provided by Barry M. Weichman and by Sharon Sunag and Julie Gerke of Quintiles Medical Communications, Parsippany, NJ, and was supported by Archimedes Development Ltd, Nottingham, UK.

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