The Compleat Oncologist

We all take pride in our designated profession—oncology, the study of tumors. In its infancy as a specialty, oncology focused on the biology of tumors and the means to alter the relentless progression of these uninhibited cells. Had the specialty restricted its purview to only the use of specific antitumor interventions, we would have designated ourselves as cancer surgeons, radiotherapists, and chemotherapists. But we do not: we are surgical oncologists, radiation oncologists, and medical oncologists.

Although it is perhaps literally the study of tumors, in reality oncology is the study of the care of the cancer patient, care viewed in all its dimensions. From this overarching perspective, supportive care and symptom management are seen as being as much a part of the oncologist’s expertise as surgical techniques or radiation and chemotherapy dosing. What has also emerged is a group of clinical scientists who have made their research goals the systematic study of symptoms—their pathogenesis, measurement, and amelioration.

In some areas of supportive care, the needs of the cancer patient are unique. The science and pharmacology of managing chemotherapy-induced nausea and vomiting is a prime example of a symptom complex primarily addressed in the cancer world. In others areas, the symptom was traditionally studied and treated by other disciplines, and only recently has oncology focused on the ramifications of management within the context of antitumor therapy. In some instances, this must involve the acquisition of new skills and an expansion of clinical expertise. A good example is depression, which is now recognized as a major problem in treating the cancer patient. Unfortunately, research has shown that many oncologists display considerable deficiencies in addressing this need.

The three guidelines presented in this issue of JNCCN focus on areas of interest to the compleat oncologist: management of fatigue, distress, and palliative care. In developing these pathways, the Panels were breaking new ground. The decision-making that guides clinical practice has not been systematically addressed. Figure 1 shows the template for mapping out these decisions in the realm of symptom management. This framework allows the clinicians to approach these problems in a well-defined, logical manner, so that the full range of diagnostic and therapeutic interventions are systematically applied.

These algorithms are just the first step; supportive care must be viewed on many levels. Our accompanying articles deal with many of these: ethical issues in the delivery of terminal analgesics, implementation of clinics for providing symptom management, recognizing the emerging problem of drug addiction, and addressing the complexity of providing psychological support either because of the advanced age of the cancer patient or the stigmatization of seeking help. Finally, we also include an article discussing methodological issues in supportive care research that must be addressed as we move forward.

Reference