

Optimal Cancer Care: Concurrent Oncology and Palliative Care

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Optimal cancer care requires the integration of palliative care into practice. This concept has been endorsed by widely respected organizations, including the WHO, the Institute of Medicine (IOM), the European Society of Medical Oncology (ESMO), and ASCO. With the aging of the population, the associated increase in the incidence of cancer, and the growing number of patients living with complications of cancer and its treatment, palliative care is more important than ever. Despite strong recommendations and growing clinical data supporting the benefits of concurrent palliative care and cancer care, resistance continues. Why is this? What are the barriers and, more importantly, what are the solutions?

A group of international experts met in Rome, Italy, to review the current status of concurrent palliative and oncology care in different countries and to address these questions. This supplement is a product of these discussions. The group focused on the following key issues in the integration of palliative care into cancer care: development of a standard definition of palliative care and its component parts; models for care delivery; standardization of tools for patient assessment; educational programs designed to meet the needs of health care professionals; and the importance of developing best practices in symptom management using breakthrough pain management as an example (see article by Von Roenn et al in this supplement).

Palliative care is an essential component of excellent cancer care. All patients and families deserve patient-specific information about their illness, its treatment, and natural history. All patients should expect cutting-edge cancer treatment in the context of their personal goals, with attention to their physical, psychological, social, spiritual, and practical concerns. This type of care is best provided by an interdisciplinary team focused on the relief of suffering in all of its dimensions. Although this view is widely accepted, the group identified continued confusion about the definition of palliative care (see article by Glare in this supplement). In different parts of the world, the term *palliative care* refers to care at the end of life only, and in others, to patient- and family-centered care across the trajectory of illness, regardless of prognosis. The differences in definition are primarily ones of timing (when in the course of illness the care is provided) as opposed to differences in the components of excellent palliative care. The term *supportive care*, rather than *palliative care*, has been suggested as an alternative name because it might be less distressful to patients, families, and health care professionals. However, I suspect the distress is based on the widespread misconception (at least in the United States) that referral to palliative care means that the patient is dying. If *supportive care* replaced the term *palliative care*, the former would take on the same meaning unless we work to educate the public about the benefits of this care, no matter what we label it.

Results of a recently completed project of the Center to Advance Palliative Care (CAPC) support this contention and suggested language that might reduce this distress.¹ In collaboration with the American Cancer Society, the CAPC commissioned a study to explore the awareness and understanding of palliative care by consumers and policymakers and to test language, terminology, definitions, and messaging that might be better used in discussions of palliative care with the public. While evaluating American consumers, the researchers discovered that the term *palliative care* had little or no meaning to most patients, there was a general lack of awareness that palliative care services exist, and physicians tended to equate palliative care with end-of-life



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care. Once consumers were informed, however, they were extremely positive about palliative care and thought it was important that it be available for patients with serious illness.

Agreement exists on the need to integrate palliative care services into the care of patients with cancer; however, there is no one-size-fits-all model for how to meet this need. Available health care resources and personnel, education and training of staff, and health care settings and infrastructures to support palliative care services are all important considerations when developing a service model. The primary goal of all of the models is to improve quality of life and relieve suffering using standardized assessment and reassessment and a collaborative approach to care. Marchetti and colleagues offer insight into the challenges of developing palliative care services in a radiation or medical oncology setting, with a shared care model between an oncology and palliative care department, a comprehensive multidisciplinary service, and a nurse-physician collaboration. Further research is needed to delineate the relative effectiveness and costs of different models.

The early integration of palliative care into cancer care is in its infancy. We need to understand the impact of different palliative interventions on overall outcomes and quality of life. What are the essential elements of an early palliative intervention for patients with cancer? Improvement in physical symptoms is one of the essential end points of palliative interventions, but even for common symptoms, the knowledge base of physicians is surprisingly limited. Consider pain management as an example: multiple international guidelines for the treatment of cancer pain have been published and effective medications to treat cancer pain are available. Despite this, up to 50% of patients continue to experience uncontrolled pain (see articles by Caraceni and Zeppetella in this supplement). Why is this? How often is this because of an inadequate analgesic dose or lack of effective treatment for breakthrough pain versus poor assessment of the pain syndrome? Further research, training, and education are clearly needed.

Progress is being made. Interest in palliative care from both the professional and lay community is greater than ever before. There is increasing emphasis on education and training in palliative care practices and principles for oncology trainees and a growing workforce committed to its integration into cancer care. Despite the dearth of available research funds, investigations into the science of symptom management and clinical investigations to identify the best treatment for symptoms are being presented at professional meetings and published. I am optimistic that, with the enthusiasm and commitment of many like those who gathered at the meeting in Rome, concurrent cancer and palliative care will become the norm.

Reference

1. Center to Advance Palliative Care (CAPC). 2011 Public Opinion Research on Palliative Care: a report based on research by public opinion strategies. CAPC Web site. Available at: <http://www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf>. Accessed September 18, 2012.