

Palliative care for cancer patients: integration into oncology practice

"Early palliative care integrated into clinical oncology seems to be the way forward if we intend to reduce the suffering of cancer patients and their families."

KEYWORDS: cancer patients ■ integrated care ■ palliative care

The latest statistics indicate that nearly 12.7 million new cancer cases and 7.6 million cancer-related deaths occurred in 2008 worldwide [10]. Cancer diagnosis and its treatment have several devastating impacts on patients' lives and their families. For instance, there is evidence that a considerable number of cancer patients in the last year of their life suffer from pain (84%), depression (38%), confusion (33%), breathlessness (47%), sleep difficulties (51%), nausea (51%), constipation (47%) and loss of appetite (71%) [1]. To palliate these and other problems, palliative care was proposed in order to lessen the severity and suffering of cancer patients and their primary caregivers. The WHO defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual' [2]. Therefore, the essence of palliative care for cancer patients might be summarized in three main areas: improvement of quality of life of patients and their families; prevention and relief of suffering by means of treatment of pain; and identification and provision of perfect care for patients' physical, psychosocial and spiritual health.

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It is argued that simple measures would result in effective palliative care, and relieving symptoms and suffering. These measures include pain relief, sensitive communication and well-coordinated care [3]. In addition, two other measures have been proposed for effective palliative care for cancer patients: enhancing hope and interventions for demoralization syndrome.

As suggested, hope plays a very important role in the experience of advanced cancer patients and their family members. Hope is linked to coping, which might buffer the stress and thus improve physical and mental wellbeing [4]. Demoralization is a separate entity to depression, described as a disorder of meaning and hope. Management includes psychotherapy and narrative therapies. Narrative therapies build up a coherent account of the patient's accomplishments, and a sense of fulfillment, highlighting roles and relationships as well as the purpose of the patient's life [5].

However, the main question is how can these goals be achieved in practice? The American Society of Clinical Oncology indicated that integration of palliative care, as a routine part of comprehensive cancer care, might be a solution to accomplishing these objectives [6]. Although apparently simple, at the same time it seems that integrating palliative care into routine clinical practice is not an easy task.

A study on availability and integration of palliative care at US cancer centers reported that out of 101 cancer centers surveyed overall, 89 centers (88%) provided palliative care, but only 40% had an outpatient palliative care clinic, and few centers (23%) had dedicated palliative care beds [7]. The study also demonstrated that palliative care patients were referred to care too late in the disease trajectory, a marker of limited access and integration. The authors commented that although a great majority of cancer centers reported the presence of a palliative care program, many of these programs were limited to providing inpatient consultation services and only few centers had a palliative care unit.

A recent publication on development of successful models of cancer palliative care services highlighted the issue of integration to reflect on the topic [8]. The authors reviewed the structure, process and outcomes of a program, namely



Ali Montazeri

Quality of Life Research Group, Iranian
 Center for Breast Cancer, ACECR,
 Tehran, Iran, P.O. Box 13185-1488,
 Tehran, Iran
 Tel.: +98 216 648 0804
 Fax: +98 216 648 0805
 montazeri@acecr.ac.ir

Concurrent Oncology Palliative Care (COPC). The International Oncology and Palliative Care Expert Panels introduced COPC (also known as simultaneous), and the main driving force of the program is to ensure that patient values, preferences and treatment goals guide care not only at the end of life but also throughout the illness trajectory, from diagnosis through to death. The paper indicates that despite many successes, the program has faced a number of challenges. The three challenges that have been of greatest concern and are common among both developing and mature COPC programs include: establishing structures and processes to identify all appropriate patients; maintaining consistent expert palliative care across multiple transitions of care from diagnosis to end of life; and establishing relevant quality indicators to measure outcomes of providing integrated COPC [8]. However, palliative care challenges in developing countries go further. There are at least two more problems: opiophobia and lack of well-educated palliative care specialists. For instance, although 83% of the world's population live in developing countries, they only consume 9% of the world's morphine [9]. This means that cancer patients in developing countries suffer even more as a result of the above-indicated problems. In other words, cancer patients in developing countries, in addition to suffering from a lack of access to quality cancer care or financial difficulties arising from the disease, its treatment and subsequent job loss, for example, also suffer from inappropriate pain relief.

Early palliative care integrated into clinical oncology seems to be the way forward if we intend to reduce the suffering of cancer patients and their families. Evidence from a study of 151 cancer patients suggests that patients who were assigned to early palliative care had a better quality of life than patients assigned to standard care. In addition, fewer patients in the palliative care group had depressive symptoms compared with patients in the standard care group (16 vs 38%; $p = 0.01$). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33 vs 54%; $p = 0.05$), median survival was longer among patients receiving early palliative care (11.6 vs 8.9 months; $p = 0.02$) [10]. As recommended elsewhere [6], oncologists, palliative care specialists, executives and political leaders need to work closely together to ensure access to high-quality palliative care for all patients with cancer not only in developed countries but also in developing countries, and not only at the end of life but also as early as possible.

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