

The medical oncologist's role in palliative care: AIOM's position

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Progress made in the treatment and better management of cancer patients has significantly improved overall survival, with 75% of the patients alive 5 years after the first diagnosis and 50% over a follow-up of 10 years. Therefore, cancer often becomes a chronic illness with a deep impact on the quality of life of the patients and their families. In fact, taking care of patients with cancer means not only to offer them the best therapeutic options but also to understand and anticipate their physical, functional, psychological, social and spiritual needs throughout the course of the disease. The quality of life of a cancer patient, thought of as the fundamental end point to achieve at every step of the disease, recognizes in supportive palliative care and rehabilitation the most important aspects.

AIOM recently established a task force "Palliative care in oncology", with three main targets:

- 1) to assure medical oncologist' humane and professional growth in the context of palliative care;
- 2) to focus on the quality of life of all cancer patients admitted to oncology units and oncology departments;
- 3) to suggest operative solutions in order to assure to all cancer patients the best palliative support.

AIOM believes that the mission of medical oncology should follow the "nonabandonment" culture, guaranteeing quality of life and continuity of care to all cancer patients at every step of the disease, always considering the patient instead of the disease as the most important target.

According to ASCO¹⁻³, ESMO³⁻⁵ and AIOM's previous document⁶, AIOM has defined its position about palliative care in oncology with regard to the Italian Health Organization and scientific knowledge.

Clarifications

As the definition and the distinction between supportive, palliative and end-of-life care are still lacking, AIOM wants to specify the meaning of these terms, identifying the real and the distinct needs of cancer patients as well as the oncologist's required skills.

Supportive care includes the prevention and treatment of the adverse effects of anticancer therapies in addition to the complications of cancer. Symptom control and therefore quality-of-life are the end points of supportive care, when the main outcome is patient survival.

Key words: medical oncologist's training, palliative care in oncology, simultaneous care.

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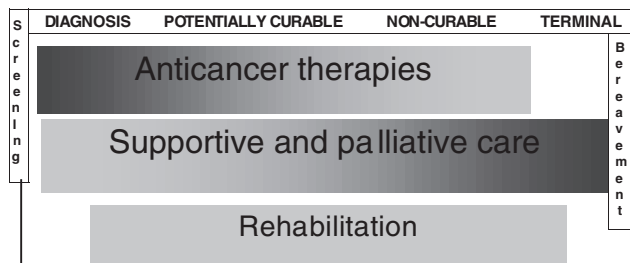


Figure 1 - AIOM's simultaneous care model.

Palliative care concerns the prevention, identification, assessment and treatment of physical, functional, psychological, social and spiritual needs of cancer patients in the setting of advanced-terminal disease, when the aim can no longer be patient survival but is represented by the quality of life of the patient and his/her family. Hence, end-of-life care is included in palliative care⁷. Therefore, supportive, palliative and end-of-life care represent a “continuum” towards the course of the disease for all cancer patients (Figure 1).

Training of the medical oncologist

The training of a medical oncologist should include the assessment and treatment of symptoms, throughout the evolution of the disease, and supportive care during the antineoplastic treatment. AIOM supports the inclusion of specific palliative care training in Medical School as well as in Oncology Postgraduate School. According to AIOM, acknowledgement by the National Health Service of “palliative care” as a subject matter is considered necessary in order to regulate leadership in palliative care organization.

In accord with ESO⁸, AIOM recognizes two levels in palliative care: a basic one for all medical oncologists and an advanced one for physicians working in palliative care areas for advanced-terminal disease. The training of a medical oncologist should include the organizational ability of coordination and integration with other physicians to define a unique supportive plan, which is shared and defined according to patient needs.

Before such specific professional training becomes effective, AIOM will support and promote a training stage and practical courses held at Italian centers certified by ESMO (as centers for integration of oncology and palliative therapies), towards a specific task force of palliative care in oncology, in order to support the acquisition of skills by medical oncologists. Furthermore, AIOM will define relationships with Italian and international scientific associations to support attendance by medical oncologists in the palliative care stage, also in foreign centers. AIOM will guarantee an adequate and updated presence of palliative care and rehabilitation in national congresses, conferences and interregional meetings.

The role of the medical oncologist

The medical oncologist has to guarantee the best quality of life to the patient and constant and continuous care at every moment of the illness, in addition to the anticancer medical treatment⁹. The medical oncologist should consider prevention and treatment of symptoms of the disease, as well as evaluating response to anticancer therapy. Assessment of symptoms with validated instruments is necessary during every visit regardless of disease stage or anticancer treatment. Symptoms and therapy should be easily found in the medical chart. The medical oncologist has to be able to prevent and treat symptoms regardless of their nature or current treatments. The medical oncologist should be able to establish an effective communication and a care's relationship with the patient, giving correct and clear information during all steps of the disease. Moreover, the medical oncologist should be able to discuss the prognosis with the patient, anticipating such information in the early stages of the disease and assuring the patient's understanding to actually share in treatment decisions¹⁰⁻¹⁵.

The medical oncologist should be able to recognize psychological, rehabilitative, spiritual and social needs of patients and their families. Furthermore, the medical oncologist has to guarantee that intervention by such specialists is timely in all phases of the disease in order to resolve every symptoms.

The medical oncologist has to assure optimum supportive care and the best palliative care for the patients enrolled in clinical trials on new drugs and new anticancer treatments, with the assessment of patient symptoms and quality of life. The medical oncologist has to be able to coordinate the treatment in all phases of the disease, finding the solutions which best fit all a patient's needs. The medical oncologist has to be able to manage the end of life, from a humane and professional point of view, including the guidelines for palliative sedation.

The role of a medical oncology unit

Medical oncology units need to include symptom assessment and treatment in daily clinical practice. Continuous care and the “non-abandonment” approach need to be included in the culture and in the activities of all oncology units. A medical oncology unit needs to define palliation processes and guidelines of the main symptoms, i.e., pain, dyspnea, bowel occlusion, palliative sedation. Assessment and treatment of symptoms have to be specified in medical charts as part of a patient's file. According to the World Health Organization, pain assessment needs to be considered as a vital sign and consequently reported daily on a patient's medical chart.

AIOM supports the development of clinical trials on palliative treatment and considers them as important as anticancer drug studies.

Medical oncology units should include specialists able to support psychological, spiritual and social needs of patients and families. Each oncology unit should include at least one physician with specific palliative care training or an expert consultant.

The nurses of medical oncology units should consider symptom assessment and care of priority in daily practice. Medical oncology units need to plan training and updated courses on symptom assessment and care for nurses.

Medical oncology units have to be able to look after every disease stage and, in case they cannot, they have to define shared continuity of care programs to assure rehabilitation and palliative care to all patients affected by cancer.

According to AIOM, cancer patient care should include optimal palliative and continuous care up to advanced-terminal disease stage by medical oncology units or through predefined agreements. If palliative care is supplied by a different unit, i.e., a palliative care unit, hospice, home care unit, integrated home care service, or non-profit organization, oncology units should establish close relationships with them, sharing guidelines and assuring continuous care and medical advice or admission to hospital, if necessary.

Organization

AIOM identifies ESMO's integration model as the best one for the needs of cancer patients, in particular in anticipating them^{13,15}. Simultaneous care optimizes quality of life throughout the course of an illness and guarantees flexible patient/disease management and appropriate objectives in each clinical situation¹³.

The experience of Italian centers certified by ESMO has shown that to realize simultaneous care is feasible in different Italian regions and hospital agencies. In order to realize this model, each oncology unit should have admission beds available for critical decision-making in the management of cancer patient. Moreover, it would be useful if each oncology unit would specify a physician for clinical management, training and research on palliative care.

Furthermore, AIOM outlines the importance of *ad hoc* instruments (pain intensity, distress, multiparametric tests of quality of life) for early control of pain and other symptoms during anticancer treatment and of prognosis indicators (PaP score) in an advanced stage.

Timing and organization of oncology units need to be reevaluated to guarantee adequate time for each patient.

AIOM believes that an oncology department could be the most consistent model to realize simultaneous care and to assure continuity of care in advanced disease. Otherwise, oncology units have to create the necessary relationships at an interdepartmental level with other hospitals and/or with territorial structures (regional oncology network).

Palliative care management in advanced-terminal disease could be realized through close collaboration between the oncology unit and the palliative care unit of an oncology department (if it does not provide its own resources). According to ESMO, a simultaneous care of all persons affected by cancer assures complete care through a "flexible primary care coordination", defined on the basis of disease stage and organization of each hospital.

Nevertheless, the duty of the medical oncologist is to guarantee continuity and end-of-life care of all persons affected by cancer in qualified structures whenever needed.

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