

## For a Modern Concept of Palliative Care

Sebastiano Mercadante\*

Pain relief and palliative care Unit, La Maddalena Cancer Center, Palermo, and University of Palermo, Italy

Palliative care culture has grown from the sixties. During the 1970' various organizations, usually charities or no-profit organizations, developed hospice care for patients with advanced stage disease. In the last decade there have been investments in the field of community care and health districts under the input of new legislations, and new resources from the Health Care System have been allocated for palliative care. In Italy, for example, active centres involved in palliative care progressively increased with a large distribution in Northern Italy, and more than 200 hospices are now available for cancer and non cancer palliative care population [1].

Unfortunately, in most countries hospice care addresses end-of-life care. In Italy, for example, despite a new law has generated much interest in palliative care and pain control in Italy, also facilitating opioid prescription, institutional indications have suggested that the palliative care network should be formed by home care and hospice care only, excluding the vast majority of patients living some years or months during the course of disease. This limited network may result in more expenses due to inappropriate admissions in hospitals without expertise in palliative care while excluding most patients for a large period of time for prolonged periods of time, when they should need a specific help in pain and symptom management. Patients are referred to palliative care only in the last weeks of life, as reported in many studies in home care setting [1,2]. This aspect was even underlined in very specialized centers in other countries [3].

In fact the most relevant findings of palliative care population are the short survival either at home or in hospice and the high number of patients dying in hospice. In the last three months before hospice admission, most patients are admitted to hospital and spent about 1/3 of this period in hospital, and half of them received chemotherapy in the last month of life. Thus, home care and hospice patients receive specialized palliative care only for 2-3 weeks before death, implying an unacceptable timing for patients with several problems presumed to be present early during the course of disease. This is confirmed by the large number of hospital admissions in different acute settings expected to not providing specialized palliative care resulting in a low level of cost-effectiveness [4].

This approach is misleading and contradicted by many experiences the duration of survival of patients enrolled in hospice programs is an important measure to assess the appropriateness of timing of referral of terminally ill patients to palliative care. In a national follow-back survey representative of Italian population, 51% of patients died at home, meaning that many patients were admitted to acute wards unfit to provide end-of-life care [5]. Finally, about 25% of patients followed at home presented severe symptom intensity for which home care was practically impossible, suggesting that the best option would probably be the admission to hospices or specialized inpatients hospital units. More recently, 10% of patients followed at home were admitted to acute wards unfit to provide end-of-life care hospital [3]. This late referral to palliative care is also in contrast with the classical definition of palliative care provided by WHO: "Palliative care is ..... applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and

includes those investigations needed to better understand and manage distressing clinical complications" [6]. Finally, recent scientific evidence in a population subgroup confirms this WHO statement either for quality of life as well as survival. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival [7]. Futile treatments should be limited [8,9].

Recent evidence strongly suggests to spread palliative care in other settings, other than traditional home care and hospice, to intercept oncologic patients in their disease trajectory early, for example in high volume oncologic departments, rather than restricting the action area only in the last weeks of life [10-16]. While oncologist should be comfortable with the competencies related to symptom management, psychological interventions, communication, and transition of care, for patients with severe distress, early referral to an interdisciplinary supportive/palliative care team should be recommended [17].

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\*Corresponding author: Sebastiano Mercadante, Pain Relief and Palliative Care Unit, La Maddalena Cancer Center, Via San Lorenzo Colli 312, 90146, Palermo, Italy, E-mail: [terapiadeldolore@lamaddalenanet.it](mailto:terapiadeldolore@lamaddalenanet.it), [03sebelle@gmail.com](mailto:03sebelle@gmail.com)

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