

The Role of the Cancer Center in Supporting Palliative Care Services Development

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Editorial

We have witnessed great progress in both Oncology (Onc) and Palliative Care (PC) in the last twenty years. In Onc we have witnessed the establishment of Multi-Disciplinary Teams and meetings, centralization of care, new Radiotherapy (RT) techniques: Intensity Modulated RT, Image Guided RT and stereotactic RT, to the revolution of molecular biology, with the understanding of oncogenic addiction, the emergence of targeted therapy and now immunotherapy with checkpoint inhibitors. In PC, essentially a new specialty was set up in many countries worldwide with major steps made in capacity building leading up to integration in a few countries [1,2]. Furthermore, there has been a recognition of the important role of PC in the palliation of patients with advanced illness, whilst more recently evidence for the earlier integration of PC in the disease trajectory has been produced [3,4].

In many countries however PC services are so under-developed that without outside help, capacity building and expansion of services may be very difficult or may take too long to achieve. This is especially true in developing or low resources countries, and in settings with very limited PC services [5]. Oncology providers may be in a good position to help and they need to consider ways of helping to develop PC services both within their own organizations but also within the community. We shall provide you with the example of Cyprus, where PC teams were community and hospice based, with no link with the Onc centre and hospital services, and the initiatives that have been undertaken in the last few years, with the origin in the Onc centre leading to better PC services overall for all cancer patients in Cyprus.

The set up in Cyprus was of two main PC teams, working predominantly in the community and organized by two Non-Governmental Organizations (NGOs), essentially independent non for profit organizations (like Marie Curie in the UK), and one hospice being run by one of the NGOs *Anticancer Society. There was little communication or collaboration between the PC and Onc teams [6]. There were essentially only two PC physicians for a population of just under one million, and they both worked for one of the NGOs, being based at the hospice, with no presence in either the main hospitals or the main oncology centre in Cyprus. Furthermore, in Cyprus the predominant oncology practice used to be of disease directed therapy very much until the end of life, and then referral to the hospice or in fact patients would often die in hospital (as there was a stigma attached to going to the hospice, as the place "where you go to die") [6].

But things can change. About six years ago in 2010, following a number of PC training courses organized by the Middle East Cancer Consortium (MECC) [6] involving both PC and Onc staff, it was

realized that there was a need for more collaboration between the Onc and PC providers and need for increased PC input within the Onc centre [7]. As a result a number of initiatives were set up. Firstly a weekly specialist PC clinic was set up at the Onc centre run by one of the PC physicians, allowing for the referral of patients with difficult to control symptoms [7]. On the same day of the clinic, the PC physician would attend the daily ward-round in the Onc centre, helping both with symptom control issues and also facilitating the referral of patients to the hospice. Furthermore, joint training through lectures for both Onc and PC staff was organized at the Onc Centre, including a residential communication skills course [7,8]. Following the success of these initiatives, encouraging earlier introduction of PC in patients with advanced/metastatic cancer, in 2012 the Board of the Onc Centre decided to fund the training of two staff grade physicians from the Onc centre to receive post-graduate/specialist training in PC in the US. This was followed by both NGOs, deciding to employ another physician each, and train them within the same program in the US. Whilst one of the physicians from one of the NGOs subsequently dropped out of the training, the result of this initiative was to have three [3] extra physicians with an interest in PC in Cyprus. As a result both NGOs were able to start using the two physicians being trained in PC based at the Onc centre, to help them man a true 24-hour service in the community, which was a major step forward in community PC in Cyprus.

Equally within the Onc centre, a daily supportive/PC unit/drop in centre was set up, to address urgent symptom control problems for cancer patients. Finally, since February 2013, a weekly Multi-Disciplinary Team meeting involving both Onc and PC professionals (oncologist, PC nurses, physicians training in PC, Onc nurses, pharmacists, psychologist and a Christian Orthodox priest), has been set up at the Onc Centre [7,8]. This has resulted in a more comprehensive multidisciplinary care, by involving earlier the appropriate members of the multidisciplinary team to meet the complex needs of patients with advanced cancer, and to improve collaboration and communication between the Onc and PC community and hospice teams [9]. As a result of the various initiatives in Cyprus, there has been a gradual change in terms of attitudes of oncologists and their approach to PC, resulting in increased referrals from oncologists to PC and earlier involvement of PC teams in patients' care in the community, evidenced by increased cancer patients receiving PC under the care of both NGOs in 2012 compared to 2010 [7].

If you were to replicate these initiatives where you work, you would need to form alliances with other health care professionals sharing the same values as you. It may be appropriate to start with common

training initiatives as was done in Cyprus, and help from other PC organizations from other countries in setting up these training initiatives may be needed [10]. It would be worth considering also some obvious obstacles and prejudices that need to be taken into consideration. Even recently in a European survey of lung cancer oncologists, up to 22% held negative attitudes regarding PC [11], and this was similar to the ESMO survey carried out ten years earlier [12]. In terms of patient attitudes, even in countries with established PC, surveys of oncologists show that the biggest barrier for referral related to negative attitudes of patients to PC [13,14], possibly due to “the misconception that PC is only for patients at the end-of-life and the death-defying mentality in our society” [15]. It is therefore important that both physicians and patients attitudes and misconceptions are addressed, whilst cultural norms in the individual countries are being respected [16] in setting up initiatives with increased presence and collaboration between Onc and PC. Let us all work towards this goal, in our respecting countries.

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