



Editorial

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This article has been peer reviewed.

CMAJ 1998;158:1702-4

Oncology and palliative care: bringing together the two solitudes

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Neil MacDonald has described aptly the need to place greater emphasis on the role of cancer centres in the palliative care of patients with incurable cancer.¹⁻⁴ The need for palliative care is increasing because of the current restructuring of health care in Canada, the threats to existing funding and the increasing number of patients with advanced cancer who require support. MacDonald identified 4 factors dividing oncologists and palliative care professionals: concerns about diminishing resources, concerns (of palliative care professionals) about ignoring diagnoses other than cancer, organizational inertia and the differences between cultures of the 2 specialties.⁴ The last of these merits closer scrutiny and is the subject of this paper.

Palliative care and oncology have different roots. Palliative care grew out of the hospice movement, which tends to the physical and emotional needs of patients and their families rather than focusing on the diseases themselves.⁵ In contrast, oncology developed out of the specialist biomedical model, in which the focus is on addressing the disease process and efforts are made to cure patients or to prolong their lives.⁶ This focus is reflected in the paucity of oncological studies citing patients' symptoms.²

Palliative care and oncology also follow different paths. The interdisciplinary team approach is inherent to palliative care.⁷ Palliative care specialists may act in advisory capacities, but, especially since few Canadians have access to such physicians,^{8,9} family physicians maintain the primary responsibility for medical care right up to the end of life in most jurisdictions.¹⁰ In oncology, true interdisciplinary approaches have become more common in recent years because of the increasing complexity of cancer treatment,¹¹ but the concept of the "patient care team"¹² has not yet been universally adopted. Surveys have shown that both oncologists¹³ and family physicians^{13,14} feel that family physicians should have a prominent role in managing the collaborative care of patients with cancer, but a variety of barriers make collaboration difficult¹³⁻¹⁵ and tend to separate the 2 fields.

Communication between oncologists and physicians in the community is often difficult in the day-to-day management of patient care,^{14,16} which may lead family physicians to withdraw from caring for a patient.¹⁵ Health care workers in cancer centres may take too long to refer patients to palliative care programs in the community or may not refer them at all, which denies patients and their families the benefits associated with early palliative care. Delays in referring patients to cancer centres, delays between referral and consultation with an oncologist and delays between consultation and treatment such as radiotherapy¹⁷ pose problems for patients in situations where palliative antineoplastic treatment might be helpful and may frustrate patients and their health care providers. Almost certainly such delays mean that many patients do not receive this treatment, which could alleviate symptoms quite simply, even in patients with advanced disease.^{2,18} In addition, these delays do little to promote collaboration between oncologists and palliative care professionals. Some palliative care professionals may overestimate the inconvenience and toxicity associated with chemotherapy and radiotherapy and underestimate the ability of these treatments to relieve symptoms,³ perhaps not realizing that much of an oncologist's work is palliative (a fact that many oncologists acknowledge less often than perhaps they should). For example, at the



British Columbia Cancer Agency (BCCA) between 1985 and 1991, 45.6% of all courses of radiation therapy were palliative.¹⁹ Similarly, much chemotherapy is palliative; although data are difficult to obtain, it has been estimated that at least 7% of all cancer patients will eventually receive palliative chemotherapy.²⁰

Unfortunately, when a patient's disease reaches an advanced stage, a point at which symptom management becomes more necessary, oncologists may relinquish their role in the care of the patient because radiotherapy and chemotherapy have nothing more to contribute. They may feel that "nothing further can be done," despite the existence of other therapies to control symptoms.⁵ In fact, oncologists are usually more familiar than family physicians with these therapies because they see more patients with advanced stages of cancer than do other physicians. However, they often have difficulty addressing the spiritual needs of patients and their families,²¹ one of the cornerstones of any high-quality palliative care program, and may underestimate and undertreat patients' symptoms, including pain.²²

We have found that in many communities in British Columbia, professionals in various disciplines looking after patients with cancer may never meet one another, and oncologists, family physicians and palliative care specialists often do not appreciate the challenges other physicians face.²³ It would be interesting to know to what extent these problems occur in other provinces.

A sense of territoriality also contributes to the division between oncologists and palliative care professionals: palliative care professionals fear that oncologists want to assimilate palliative care into their field, which would destroy the community base of the specialty and would prevent patients other than those with cancer from benefiting; at the same time, oncologists worry that increased support for symptom management programs will divert resources from existing programs.²⁻⁴

There are a number of advantages to linking the 2 solitudes of oncology and palliative care. Bringing these disciplines together should allow cancer centres to provide better symptom control, although this hypothesis remains to be confirmed by further study.²⁴ Collaboration may also improve the availability of appropriate palliative antineoplastic therapies and may mean more and earlier referrals from cancer centres to palliative care programs. Improving referrals alone might result in more effective control of symptoms, which would reduce the need for "crisis intervention" in inpatient, acute care settings. This should increase patients' satisfaction with the care they receive at cancer centres and could lead to cost savings,²⁵ although hard data to confirm the fiscal benefits have yet to be obtained.

It has been shown that oncologist burnout is often related to patient suffering,²⁶ implementing a true interdisciplinary team approach, improving communication among

health care professionals³ and clarifying the role of each health care professional involved may reduce this problem.²⁷ Regardless, appropriately assessing patients, managing their symptoms and providing palliative care have all been mandatory at cancer centres since 1995.²⁸

Many provinces support cancer centres through provincial cancer agencies, which often run consultative clinics in small communities. This existing link between palliative care and oncology might help to "get the palliative care message" out to more primary care and other physicians, to other health care professionals, and to patients and their families, particularly those in relatively remote regions. Such links may mean that palliative care professionals gain access to resources in cancer centres and at the National Cancer Institute of Canada (NCIC), which already support basic and clinical research in oncology. This would allow similar research in symptom control, for which there is a widely recognized need.²⁹

In Canada, palliative care and oncology are already coming together, in large part because of the recommendations presented by the Expert Panel on Palliative Care to the Cancer 2000 Task Force³⁰ and because of the increasing recognition by oncologists that comprehensive cancer care includes supportive care.³¹ Many cancer centres now support symptom control clinics. Both the University of Alberta³² and McGill University have divisions of palliative medicine within their departments of oncology, which allows integration of the 2 disciplines. The Tom Baker Cancer Centre, in Calgary, has established a comprehensive pain management program similar to the one that exists in Edmonton.³² The centre is working with partners from outside the institution to develop a community-wide palliative care service. Similar cooperative efforts are under way in British Columbia at each of the BCCA's 4 cancer centres,²³ in Winnipeg,³³ Ottawa and Halifax, and probably in other communities as well. The NCIC has sponsored 2 symposia, one that addressed clinical and quality-of-life research with respect to the symptoms of advanced cancer³⁴ and one that made several recommendations to encourage the dissemination of information about pain control innovations.³⁵ Oncologists and palliative care clinicians participated in an NCIC workshop held in November 1997, during which they identified opportunities in symptom management for basic science research since such research has been conducted only to a very limited extent, if at all, for symptoms such as cachexia and delirium. In 1995 Eduardo Bruera, a palliative care physician, became chair of the NCIC Clinical Trials Group Symptom Control Committee, which has been given a renewed mandate to conduct clinical trials in symptom management.

Nevertheless, much still needs to be done to link oncology and palliative care. The efforts described above must



continue. Despite dwindling health care resources, provincial cancer agencies and ministries of health must increase funding for palliative care and symptom management programs. Detailed studies should be conducted to determine whether there are cost savings associated with programs that provide effective symptom management. To ensure seamless, high-quality care of patients with terminal diseases, family medicine, oncology and palliative care must be strongly represented when the health care system in each region is being restructured. This should improve communication among health care professionals and help to integrate care. Oncologists should be represented to a greater extent in the Canadian Palliative Care Association and its provincial counterparts. Similarly, palliative care professionals should be represented on the boards of provincial cancer agencies. The NCIC should make funding of basic science and clinical research in symptom management an even greater priority. The Canadian Medical Association should work with provincial medical associations and the Canadian Palliative Care Association to advocate for improved funding for end-of-life care and research. Canadian medical schools should adopt the Canadian palliative care undergraduate curriculum.³⁶ I believe that all of these measures would encourage communication and understanding between oncologists and palliative care professionals, as well as furthering their joint interests.

I hope that this article prompts clinicians to report collaborative efforts in Canada between the fields of oncology and palliative care that have not been mentioned here. I also welcome comments and suggestions on ways to link the 2 solitudes, for the good of patients with advanced cancer and their families.

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