Palliative medicine and medical oncology

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Summary

Traditionally, medical oncology and palliative care have been considered two distinct and separate disciplines, both as regards treatment objectives and delivery times. Palliative care in terminal stages, aimed exclusively at evaluating and improving quality of life, followed antitumor therapies, which concentrated solely on quantitative results (cure, prolongation of life, tumor mass shrinkage). Over the years, more modern concepts have developed on the subject. Medical oncology, dealing with the skills and strategic co-ordination of oncologic interventions from primary prevention to terminal phases, should also include assessment and treatment of patients' subjective needs. Anticancer therapies should be evaluated in terms of both the quantitative and qualitative impact on patients' lives. Hence, the traditional view of palliative care has to be modified; it constitutes a philosophical and methodological approach to be adopted from the early phases of illness. It is not the evident cultural necessity of integrating medical oncology with palliative medicine that may be a matter of argument, but rather the organizational models needed to put this combined care into practice should continuous care be guaranteed by a single figure, the medical oncologist, or rather by an interdisciplinary providers' team, including full-time doctors well-equipped for palliative care? In this paper the needs of cancer patients and the part that a complete oncologist should play to deal with such difficult and far-reaching problems are firstly described. Then, as mild provocation, data and critical considerations on the ever increasing needs of palliative care, the present shortcomings in quality of life and pain assessment and management by medical oncologists, and the uncertain efficacy of interventional programmes to change clinical practice are described. Finally, a model of therapeutic continuity is presented, which in our view is realistic and feasible: an Oncologic Programme as the unifying process; the Comprehensive Cancer Centre, or the Oncologic Department, the delivering structure.

Key words: comprehensive cancer centre, medical oncology, oncology department, palliative medicine

The needs of cancer patients and outcomes of cancer treatments

The goals of medical oncology can no longer be exclusively limited to the reduction of tumor burden and prolongation of life, but must also include qualitative aspects.

In 1996 the American Society of Clinical Oncology (ASCO) published a 'special article' in which the major outcomes of cancer treatments were identified [1]. The outcomes were subdivided into 'patient outcomes' and 'cancer outcomes'. Patient outcomes have both a quantitative aspect, survival, and a qualitative one: quality of life. Multidimensional quality of life (QoL) assessment involves several specific parameters (physical, psychological and social) and their comprehensive evaluation. Cancer outcomes (e.g., response rate, response duration, time to progression and biomarkers trend) should receive lower priority than patient outcomes, their value depending on their ability to influence patient outcomes and decision-making. Patient outcomes must be assessed systematically and regularly.

The fundamental study of Portenoy et al [2] clearly stated that symptomatic prevalence is noteworthy in every stage of disease, not only in the terminal phase. In their report, part of a validation study of the Memorial Symptom Assessment Scale (MSAS), 49.4% of the population studied were outpatients. 92% had a Karnofsky performance status > 61 and only 62.6% had metastatic disease. In this 'non-terminal setting' of patients, the mean number of symptoms per patient was 11.5 ± 6.0 (range 0–25). Although the values were statistically lower in the prevalence of symptoms in the 'favourable' subgroups (e.g., outpatients vs. inpatients and patients with KPS > 80 vs ≤ 70), the absolute number of symptoms was important even in these categories (9.7 ± 6.0 for outpatients and 9.2 ± 4.9 for KPS > 80, respectively). In Table 1 we have reproduced a description of symptoms experienced by that population, in terms of prevalence and intensity, obtained from a correlated paper [3]. Another important finding from that study was the association of a higher number of symptoms with poorer quality of life, which might also be responsible for its prognostic predictivity, shown by defined instruments for quality of life assessment [4]. Similar results emerged from a more recent research on
Table 1 Twelve exemplificative symptoms taken from the study on the Memorial Symptom Assessment Scale (33 symptoms were assessed with a prevalence > 10%) in 218 cancer patients. The selection has been made in order to demonstrate that overall prevalence, intensity, frequency and distress of a given symptom are not correlated with each other and that the best evaluation of the clinical impact of that symptom can be deduced only from the combination of the said characteristics.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Overall prevalence</th>
<th>Degree of symptom if present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Intensity Mod - Very Sev (%)</td>
</tr>
<tr>
<td>Lack of energy</td>
<td>73.4</td>
<td>77.0</td>
</tr>
<tr>
<td>Worrying</td>
<td>72.4</td>
<td>72.3</td>
</tr>
<tr>
<td>Feeling sad</td>
<td>67.4</td>
<td>68.7</td>
</tr>
<tr>
<td>Pain</td>
<td>63.1</td>
<td>74.6</td>
</tr>
<tr>
<td>Lack of appetite</td>
<td>44.5</td>
<td>82.7</td>
</tr>
<tr>
<td>Feeling bloated</td>
<td>38.7</td>
<td>81.0</td>
</tr>
<tr>
<td>Numbness/tingling in hands/feet</td>
<td>36.4</td>
<td>60.3</td>
</tr>
<tr>
<td>Constipation</td>
<td>33.6</td>
<td>79.5</td>
</tr>
<tr>
<td>Swelling of arms or legs</td>
<td>27.5</td>
<td>66.7</td>
</tr>
<tr>
<td>Problems with sexual interest or activity</td>
<td>23.3</td>
<td>78.0</td>
</tr>
<tr>
<td>Vomiting</td>
<td>21.1</td>
<td>65.2</td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td>10.6</td>
<td>82.6</td>
</tr>
</tbody>
</table>

* Percentage moderate to very severe, *b* Percentage frequently to constantly, *c* Percentage quite a bit to very much

NE - not evaluated


a population of the Veteran Administration Medical System [5]

Obviously, the more the disease progresses, the more both frequency and intensity of psycho-physical symptoms and factors contributing to distress and suffering are going to increase. Recent reviews have identified the comprehensive burden and the single prevalence of a variety of factors in populations of terminally ill cancer patients. In a consecutive series of 1,000 patients with advanced cancer, the prevalence of the ten most frequent symptoms ranged from 50% to 84% in all patients, with a median number of symptoms per patient of 11 (range 1-27) [6]

The role of the oncologist

The clear division of cancer care into two phases, anti-neoplastic treatment and then symptomatic or palliative therapy is no longer appropriate [7-9]. A recent ASCO publication [10] underlined that "it is the oncologists' responsibility to care for their patients in a continuum that extends from the moment of diagnosis throughout the course of illness", including anticancer treatment, symptom control and psychosocial support during the whole course of the disease, and end-of-life care.

Catane and Cherny [7, 8] suggested a series of initiatives to facilitate the integration of palliative care into medical oncology. An ad hoc European Society for Medical Oncology (ESMO) Task Force was constituted in 1999 and its work is ongoing.

The four-point programme of the ESMO Palliative Care Task Force is aimed at:

1) elevating the priority of palliation This process requires a notable change in medical oncologists' mentality. The steps to be taken to achieve this aim can be defined as follows:

- developing guidelines and standards of symptom management,
- enhancing the priority of palliative scientific papers and communications in oncological journals and conferences;
- developing a policy that will stress the responsibility of the medical oncologist;
- educational initiatives (see point 4),

2) developing clinical programmes for the integration of palliative care in oncology, so that the centres offering such programmes can be accredited as 'Comprehensive Cancer Centres' or 'Centres of Excellence in Integrated Oncology and Palliative Care',

3) developing research: both clinical and organizational, in psycho-physical symptoms and QoL assessment in oncologic trials;

4) developing training in palliative care in oncologic educational programmes and academic institutions and including palliative medicine in the curriculum for ESMO certification and accreditation [7, 8].

So far we have described the ESMO programme for integrating palliative care into oncology and hinted at ASCO guidelines for cancer care in the last phase of life.

Unfortunately, these suggested guidelines and programs are often disregarded by medical oncologists, so that timely contribution by other professionals has been made inevitable. However, some data reported below seem to suggest how difficult it might be for the medical oncologist to be the sole palliative care provider.
The epidemiologic issue

The need for palliative care will surely increase in the early part of the twenty-first century. Data and estimates from the World Health Organization show that, while in 1990 deaths from cardiovascular, infectious-parasitic and neoplastic disease were about 50 million worldwide, this figure will reach about 62 million in 2015 (four-fifths in developing and one-fifth in developed countries) [11-13]. In 1990, for every death due to cancer, there were three due to infectious-parasitic disease, projections for 2015 predict this ratio as becoming 1 to 1. In developed countries, the negative effect of increased population ageing will overshadow the decreasing incidence of certain types of cancer due to prevention, while high mortality rates for AIDS and tobacco-related diseases will spread from industrialized countries to the rest of the world.

Recently there has been much ado about the decrease in cancer incidence and mortality in the USA since the early 1990s. In particular, the magnitude of cancer death rate for all sites decrease was 0.5% per year during 1990-1995 [14, 15]. The Health and Human Services Secretary stated that this decrease is 'a turning point in the 25-year war on cancer, and it should be a cause for celebration by every American' [16]. However, cancer death rates are age-adjusted and expressed per 100,000 population of a given age range. The increased proportion of elderly people, that is the changing age structure of the population, results, obviously, in an increase in the total number of certified cancer deaths [17-19].

Even in the U.S., therefore, the relative proportion of deaths due to cancer could actually increase, the overall cancer incidence is likely to rise and median survival prior to death could be prolonged for many types of cancer. Such trends mean an increased burden of human suffering for the patients and of support work for the providers involved. Let us only note that recent studies identify the 'lack of staff time to attend to the patient's pain' as 'one of the major causes of undertreatment of pain' [20]. One problem that should be tackled is: will the oncologic world and, in particular, medical oncologists, be able to deal with a dramatic increase in 'tumor burden', in terms of organization and assistance commitment?

A second epidemiologic topic is the following: if palliative care is appropriately devoted to cancer patients in the advanced phase of disease, is it suitable for many other kinds of disease, namely: renal failure, stroke, congestive heart failure, dementia and Alzheimer, chronic-obstructive pulmonary disease, HIV/AIDS, motor neurone disease? The percentage of non-cancer patients cared for ranged from 40% in single institution reports [21, 22] to 20% in 6451 Medicare assisted hospice patients in the USA in 1990 [23] and to 3.3%-3.7% of the total number of new admissions in hospices, palliative care inpatient units and hospice home care services in the UK and Ireland in 1995 [24]. In the palliative world there is a trend for providing care to non-cancer diseases [25], since it has been reported that about 15%-20% of non-cancer patients approach death with a symptom burden (eight or more symptoms, three or more distressing symptoms, three or more symptoms lasting more than six months in the last years of life) requiring palliative care [26, 27]. Moreover, there is evidence that many needs for palliative care in cancer and non-cancer patients remain unfulfilled [28]. A question comes to mind: is the medical oncologist the best qualified figure to assist terminal non-oncological patients or is a specialist totally devoted to palliative care a more adequate figure?

Current shortcomings in oncologic care for patients with advanced cancer

Cherny and Catane's proposals for integration between palliative care and medical oncology appeared both in the review this work owes so much to [7], and in the ESMO Newsletter, where they were put forward in a more synthetic and schematic form [8].

We maintain that their proposals would be more easily put into practice if they fell on 'fertile soil', that is medical oncologists eager to be involved in such an integrating process, conscious of their limits, and willing to implement their own abilities to symptom treatment. But are oncologists really interested in QoL-related problems?

Unfortunately, an extensive review by Batel-Copel et al. [29] on cancer treatment clinical trials showed that, from 1980 to 1995, the percentage of studies on chemotherapy that included QoL assessment rose from 0% to 3%. Moreover, only four of the studies involving QoL assessment, of the 827 reviewed, had an adequate assessment of the different domains of a comprehensive QoL evaluation. The authors commented, however, that a lot of review and commentary articles published in the same years reported an increasing interest of oncologists in this field. It may seem that, over the course of years, a divergence has been developing between high methodological interest on the part of some 'quality of life assessment specialists' and a scarce or absent backsliding to trials and, consequently, to oncological clinical practice.

More recently, Bruera et al [30] reported that the percentage of Symptom Control and Palliative Care (SCPC) papers presented at ASCO Meetings from 1983 to 1999 had continuously diminished, due to the proportionally lower number of submissions and to a higher rejection rate (62% for SCPC papers vs. 43% for non-SCPC papers). The percentage of 1983 to 1999 SCPC presentations-publications fell from 10.7% to 5.6% and from 8.2% to 5.4%, respectively. Moreover, about 40% of these concerned supportive care in a narrow sense, i.e., treatment complications/infections/blood products.

In addition, in two studies regarding the attitudes of French oncologists in prescribing morphine, 93% of whom expressed satisfaction regarding their own skill in cancer pain management, no less than 50% declared to...
be reluctant to prescribing morphine [31]. When comparing oncologists’ perceptions of their patients’ pain with those of the patients themselves, it evidently resulted that pain prevalence was judged to be around 21%–30% by oncologists and 57% by patients themselves. Moreover, while oncologists said they were satisfied with their pain management in 93% of cases, and prescribed morphine for severe pain in 78.3%, patient satisfaction was much lower (49%), as was the percentage of patients with severe pain declaring to be treated with morphine (40.8%) [32].

Another example is to be seen in a more recent paper from a German Outpatient Hematology/Oncology Department in which intensity of pain and opioid dosages were not recorded, or recorded in less than 25% of visits, in 62.9% and 48.2% of cases, respectively. From 70% to 80% of charts had no mention of bowel movements, laxative therapies and characteristics of rescue pain drugs. Only one doctor (out of 12) used a visual analogue scale to measure pain [33]. The model followed by certain oncologists in facing chronic pain has even been defined by some experts as professional negligence [34].

Even more paramount are the barriers to symptom control due to family doctors, geriatricians and other physicians’ difficulties in assessing and treating cancer pain and prescribing opioids [31, 35–38]. ASCO, in two special articles published some years after each other [10, 39] described a series of barriers to correct cancer pain and end-of-life management: health care system barriers, patient and family barriers and health professional barriers. To overcome this last type of obstacle, ASCO suggested the education of physicians and other health care providers to be improved through development of training programs, formal curricula and other initiatives. The same is recommended by the ESMO Task Force [8].

Efficacy of interventional programmes to change behaviour

Supposing oncologists became aware of their inadequacies, could educational programmes change their habits in clinical practice? It has been reported that improvement in theoretic knowledge is not enough to improve clinical practice [40]. From data emerging from palliative literature [41–43], it can be noted that the relevant professional barriers to end-of-life management cannot be removed, neither can behaviour be modified by any single method.

Moreover, as regards cancer pain management, Kathleen Foley, in her editorial: ‘Pain relief into practice: rhetoric without reform’ [44], stated that translation of know-how about cancer pain management from theoretic bases to clinical care is one of the major weaknesses in US health care.

An example of the inefficacy of a structural intervention to change behaviour, whose objectives were to improve end-of-life decision making and reduce the frequency of artificially prolonged processes of dying, is the SUPPORT study [45, 46]. In the programme named Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), a part of which was randomized and controlled, the intervention models had no impact on:

- doctor–patient communication or the doctor’s understanding of the patient’s preferences;
- change in the moment of signing the Do Not Resuscitate (DNR) order;
- pain reduction;
- reduction in the number of days spent in an undesired setting before death (e.g. in Intensive Care Units),
- reduction of inappropriate use of hospital resources.

Institutional and educational efforts to promote changes in the management of end-of-life care obtained similar ineffectiveness in a recent observational cohort study [47].

Considering what has been said above, we think it legitimate to maintain that only one specialist team, engaged in both the research and direct management of complex clinical situations, can carry out effective permanent education in palliative care.

Palliative care as a speciality

In a recently published review in Annals [48], Grilli et al. showed that, as far as active cancer care is concerned, specialized centres and physicians obtained better results than non-specialized ones. Similarly, the question might be asked whether the provision of palliative care by specialists obtains better results than that provided by non-specialists.

An attempt to clearly distinguish the level of palliative care services from that of palliative attitude and approach has been made by the National Council for Hospice and Palliative Care Services [49, 50]. Such definitions are reported in the Appendix.

The tasks of a physician totally devoted to palliative care are similar to those of other specialists, namely:

1) to conduct both clinical and health organizational research;
2) to train other physicians in order to enable them to cope with the largest possible number of situations;
3) to act as consultants to the physicians directly providing care in home/hospital settings;
4) to manage the most complex situations personally.

But is there enough evidence to prove that palliative care delivered by Specialist Palliative Care Services (SPCS) is more effective than care delivered by non-specialist teams?

Some systematic reviews have been carried out aiming at answering this question. In their study, Rink et al [51] underlined how the studies they reviewed showed a number of methodological problems. Such pitfalls concerned accrual of the study population, homogeneity of
the studied group, patient attrition, design of strategies and intervention, outcome selection and evaluation, and presentation of results. The authors concluded that effective research into palliative cancer care is still in the early stages and needs to improve its quality. Such a review could, however, be criticized in its turn, for at least two reasons:

- firstly, in spite of an apparent accurate literature search methodology, it seems to us that a few relevant randomized clinical trials have not been included in the review, without giving explicit reasons for their exclusion;
- secondly, going through the originals examined by the authors, it may be said that some of the reviewers’ interpretations tended, more or less, to ‘soften’ the advantages of the experimental palliative arm; occasionally they reported as ‘equivalent’, findings considered tendentially ‘favourable’ in the original.

More recently, in their systematic literature review, Hearn and Higginson [52] identified 18 relevant studies, five of which were randomized controlled trials. The authors stated that they found strong evidence, from the well-conducted observational studies and the few randomized clinical trials, that the impact on outcomes of multiprofessional Specialist Palliative Care Teams (SPCT) was favourable, also when compared with conventional care in terms of symptom control, satisfaction of patient and family or carers, and fulfillment at patients’ wishes with regard to where they wanted to die.

The favourable impact on health organization (i.e., increased number of days spent at home, reduction of hospitalization in ‘for-acute beds’, and reduction in overall cost) was also shown in this review, as in original papers [53–56].

Reviews aimed at evaluating the cost-effectiveness of the palliative care approach showed that most of cost savings from hospice programmes versus conventional care were due to reduced hospitalization, longer home stays and little resort to aggressive and high technology manoeuvres; moreover, SPCSs were significantly more satisfactory than customary care [57, 58].

On the whole, it seems to be sufficiently demonstrated that a multiprofessional specialist palliative approach is superior to a conventional one, in terms of both quantitative and qualitative results.

**Proposals for improving medical oncology–palliative care integration**

Some final remarks may be necessary to conclude this study on a subject matter so complex from an organizational point of view, and so weighty as to political issues.

Some authors [59] have shown that the development of different care models for the terminally ill is extremely diversified in each country, depending on the health and academic systems and health care financing. Patient and family needs, however, universally consist in appropriate assessment and management, follow-up and access to multiple services for optimal care (Table 2).

Every model needs great flexibility and integration between different care levels. Primary care cannot meet all patient needs and, alone, it is insufficient to care for advanced cancer patients globally. Patients with particularly severe needs require SPCSs that have their core interest in palliative care [50]. Family doctors have been involved in the care of patients in inpatient hospices in community hospitals or residential palliative care units, but a number of problems have arisen [60–62].

Throughout the years, the focus of palliative care has broadened from needs which are strictly presented by dying cancer patients to psycho-physical and spiritual needs of patients at any stage of the disease’s natural course [63, 64]. No doubt the palliative approach must be integrated from the earlier stages of the disease, but it is perhaps wrong to maintain that the intensity of palliative intervention should be the same at the start as at the end of the trajectory of the disease.

In the early and advanced stages of the disease the direct role of the medical oncologist in the management of the toxic effects of antineoplastic drugs, i.e., supportive care in a narrow sense, is unquestionable. However, the palliative and supportive approach of the medical oncologist responsible for the care of the patient could benefit from the advisory intervention of a SPCT which could take place in the terminal phase of the disease. The role of the individual medical oncologist could shift from the focused attention of the palliative needs of his/her patient (and the direct provision of palliative/supportive treatment in the early stages of the disease), to the coordination of cancer care in the last period of life [7].
The oncologist can remain the primary provider of palliative care until the patient's death, provided he is specifically trained for the purpose and the time he devotes to terminal patients covers the majority of his working day; otherwise, in our view, the label 'medical oncologist' is not sufficient to guarantee the expertise and skills necessary for palliative care provision. Therefore, we suggest that a therapeutic continuity care programme during all phases of the illness could and should be carried out, not necessarily by a single person, seeing to all aspects of care.

The model we have put forward for our country [65, 66] is an active Palliative Care Unit (PCU) within the Oncologic Department (OD). Such a unit should be directed by a medical oncologist, or another figure, from the departmental team. We believe that transferring a patient to a Palliative Care System wholly separate from his/her oncologic centre might make him/her feel abandoned by the oncologic team. The Comprehensive Cancer Center (CCC) in the United States is similar in concept to the OD as developed in Italy and Europe. The institution of this kind of service has recently been suggested by the American Cancer Society Task Force on Purchasing Oncology Services [67] (Table 3). One of the recommendations in establishing a CCC is that 'plans should provide access to end-of-life and palliative care'. In fact, specialized clinical and research services for the assessment and management of psycho-physical symptoms and spiritual needs have been implemented in the largest cancer centres in North America and developed countries in integrated oncological-palliative programmes [7, 68] (Table 4). Obviously, such specialist services should guarantee therapeutic and assistance continuity both inside and outside the CCC or the OD through Home and Hospice services [59] acting as consultants and/or direct care providers.

Acknowledgements

The authors would like to thank Professor Felice Cenesi for his help in translating the paper and Ms Alessandra Pizzigatti for her careful typing.

Appendix – definitions by the National Council for Hospice and Palliative Care Services

Palliative care

Palliative care is the active total care of patients whose disease no longer responds to curative treatment, focusing on the quality of life and integrating the physical, psychological, spiritual and social aspects of care. It requires a collaborative (multiprofessional) approach and follows the patient it is provided at home, in nursing homes, in residential care, in hospital and specialist units. Domiciliary care may involve day care and respite inpatient care.

Palliative care services

This is a broad term which covers provision in both community and inpatient settings. Services may be NHS or voluntary, multiprofessional or unprofessional, and may be provided by individuals or teams. Some services will meet the definition of specialist palliative care services, others may not, they are all staffed by professionals who have extensive experience and/or additional training in aspects of palliative care, some up to specialist level.

Palliative care approach

The palliative care approach aims to promote both physical and psychosocial well-being. It is a vital and integral part of all clinical practice, whatever the illness or its stage, informed by a knowledge and practice of palliative care principles. The key principles underpinning palliative care which should be practised by all health professionals in primary care, hospital and other settings comprise:

- focus on quality of life which includes good symptom control,
- whole-person approach taking into account a person's past life experience and current situation,
- care which encompasses both the dying person and those who matter to that person,
- respect for patient autonomy and choice (e.g., over place of death, treatment options),
- emphasis on open and sensitive communication which extends to patients, informal carers and professional colleagues.

Specialist palliative care services

Specialist palliative care services are those services with palliative care as their core specialty. Specialist palliative care services are needed by a significant minority of people whose deaths are anticipated, and may be provided directly through the specialist services or indirectly through advice to a patient's present professional advisers/carers.

### Table 3

Programmes and services recommended to be included in multidisciplinary comprehensive cancer care

<table>
<thead>
<tr>
<th>Programme and service offered (%)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Screening</td>
<td>100%</td>
</tr>
<tr>
<td>- Prevention and early detection</td>
<td>95%</td>
</tr>
<tr>
<td>- Diagnostic evaluation and staging</td>
<td>84%</td>
</tr>
<tr>
<td>- Primary therapy</td>
<td>84%</td>
</tr>
<tr>
<td>- Adjuvant therapy</td>
<td>95%</td>
</tr>
<tr>
<td>- Follow-up monitoring</td>
<td>84%</td>
</tr>
<tr>
<td>- Supportive care</td>
<td>84%</td>
</tr>
<tr>
<td>- Education and communication</td>
<td>77%</td>
</tr>
<tr>
<td>- Psychosocial care</td>
<td>77%</td>
</tr>
<tr>
<td>- Pain and other symptom control</td>
<td>77%</td>
</tr>
<tr>
<td>- Rehabilitation and reconstruction</td>
<td>77%</td>
</tr>
<tr>
<td>- End-of-life care</td>
<td>77%</td>
</tr>
</tbody>
</table>

Modified from Coluzzi PH et al., J Clin Oncol, 1995 [68]

### Table 4

Survey of the provision of supportive care services at National Cancer Institute-designated cancer centres

<table>
<thead>
<tr>
<th>Personal support services offered (%)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Dietary</td>
<td>95%</td>
</tr>
<tr>
<td>- Osmoty care</td>
<td>84%</td>
</tr>
<tr>
<td>- Rehabilitation/post mastectomy care</td>
<td>84%</td>
</tr>
<tr>
<td>- Specialized pain management team</td>
<td>77%</td>
</tr>
<tr>
<td>- Sexual counselling</td>
<td>74%</td>
</tr>
</tbody>
</table>

Symptom management programmes offered (%)

<table>
<thead>
<tr>
<th>Symptom management programmes offered (%)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pain</td>
<td>77%</td>
</tr>
<tr>
<td>- Nausea/vomiting</td>
<td>72-74%</td>
</tr>
<tr>
<td>- Constipation</td>
<td>53%</td>
</tr>
<tr>
<td>- Diarrhoea</td>
<td>53%</td>
</tr>
<tr>
<td>- Depression</td>
<td>53%</td>
</tr>
</tbody>
</table>

Modified from Cangialose CB et al., Cancer, 2000 [67]
Hospice and hospice care

Hospices and hospice care refer to a philosophy of care rather than a specific building or service and may encompass a programme of care and array of skills deliverable in a wide range of settings. The majority of hospices meet the specialist palliative care definition.

Terminal care

Terminal care is an important part of palliative care and usually refers to the management of patients during their last few days or weeks or even months of life from a point at which it becomes clear that the patient is in a progressive state of decline.

Terminally ill people are those with active and progressive disease for which curative treatment is not possible or not appropriate and for whom death can reasonably be expected within twelve months.

References

lines for cancer pain management. Results of a randomized controlled clinical trial J Clin Oncol 1999, 17 361–70
45 Teno JM. Lessons learned and not learned from the SUPPORT project. Palliat Med 1999, 13 91–3
50 National Council for Hospice and Specialist Palliative Care Services. Specialist palliative care: a statement of definitions (occasional paper 8). London: National Council for Hospice and Specialist Palliative Care Services 1995
63 Ahmedzai SM, Walsh D. Palliative medicine and modern cancer care. Sem Oncol 2000, 27 (1) 1–6
64 Ahmedzai S. Making a success out of life's failures. Prog Palliat Care 1996, 4 1–3
66 Maltoni M, Derrn S, Fabbrini L, Sansoni E. The specialist palliative care team in Forli, Italy. Support Care Cancer 2000, 8 2876–86

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