



# Palliative care in the era of novel oncological interventions: needs some “tweaking”

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Cancer treatment has evolved enormously over the last 20 years, with developments in surgery, radiotherapy, chemotherapy, targeted therapy, and immunotherapy. As a result, many cancer patients have improved outcomes (versus previous cohorts of cancer patients), with more patients living with cancer for longer, and more patients living beyond cancer (“cancer survivors”). Specialist palliative care has also evolved during this period, with the emergence of “early” palliative care [1], and the greater engagement in supportive care [2]. However, the current / future role of specialist palliative care services within oncology remains a topic of heated debate.

Recently, the International Association for Hospice and Palliative Care (IAHPC) produced a consensus-based definition of palliative care: “Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers” [3]. The definition was supported by a series of additional characteristics (Box 1), including “is applicable throughout the course of an illness, according to the patient’s needs”, and “is provided in conjunction with disease-modifying therapies whenever needed”.

Box 1 Characteristics of palliative care [3].

- Includes, prevention, early identification, comprehensive assessment, and management of physical issues, including pain and other distressing symptoms, psychological distress, spiritual distress, and social needs. Whenever possible, these interventions must be evidence based

- Provides support to help patients live as fully as possible until death by facilitating effective communication, helping them, and their families determine goals of care
- Is applicable throughout the course of an illness, according to the patient’s needs
- Is provided in conjunction with disease-modifying therapies whenever needed
- May positively influence the course of illness
- Intends neither to hasten nor to postpone death, affirms life, and recognizes dying as a natural process
- Provides support to the family and caregivers during the patient’s illness, and in their own bereavement
- Is delivered recognizing and respecting the cultural values and beliefs of the patient and family
- Is applicable throughout all health care settings (place of residence and institutions) and in all levels (primary to tertiary)
- Can be provided by professionals with basic PC training
- Requires specialist PC with a multiprofessional team for referral of complex cases

In many areas, specialist palliative care services are well embedded within oncology centres, although the format / function of these services varies widely. Thus, many services focus on patients with advanced disease, whilst only some services also provide “early” palliative care, and/or supportive care (as defined by MASCC) [4]. The IAHPC definition encompasses these newer models of care. However, while the principles remain the same, the specifics need to be amended (“tweaked”) depending on the specific patient population. In other words, palliative care healthcare professionals (HCPs) need to adopt a “similar but different” approach (cf. COVID-19 pandemic) [5].

Importantly, palliative care HCPs need to appreciate the impact of novel anticancer treatments in terms of likelihood of response, type of response (e.g. partial remission, complete remission), duration of response, and potential acute and chronic toxicities. This will require specific education and training, and so a major change to many existing post-graduate curricula. Palliative care HCPs will also need to review / research the appropriateness of standard palliative care interventions in the differing patient populations.

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For example, opioids are a valid option in cancer patients with acute pain, and in those with pain at the end-of-life. However, opioids have a less defined role in cancer patients with chronic pain, due to lessened efficacy, and concerns about adverse events (e.g. endocrine effects, immune system effects) [6].

Furthermore, there is the universal problem of limited resources (especially human resources). If specialist palliative care services are to increase their input into patients with early cancer and “cancer survivors”, then they will need to develop appropriate models of care for these patients (e.g. a needs-based, “dip in – dip out” approach). Importantly, specialist palliative care services must not spread themselves so thin that they provide inadequate care for their core group of patients (i.e. patients with advanced cancer). Indeed, despite the advances in anticancer treatment, many cancer patients still do not have “good” outcomes, and cancer remains a major cause of death worldwide.

Finally, it should be noted that many specialist palliative care services have been re-branded as supportive care

services (or supportive and palliative care services), due to the negative perceptions of the term “palliative care” amongst patients and oncology healthcare professionals [7, 8]. This practice has been criticised for the rationale for alteration [9], but more importantly because many of these palliative care services do not provide “comprehensive” supportive care services [2]. Thus, palliative care is an important component of supportive care [4], but supportive care encompasses more than palliative care, and necessitates the input from other specialist teams / services (Fig. 1) [10].

## Declarations

**Conflict of interest** AD is the President of MASCC. None of the other authors have any conflict of interest.

## References

1. Bauman JR, Temel JS (2014) The integration of early palliative care with oncology care: the time has come for a new tradition. *J Natl Compr Cancer Netw* 12:1763–1771
2. Berman R, Davies A (2019) Supportive care is broader than palliative care. *Br Med J* 365:11629
3. Radbruch L, De Lima L, Knäuper F et al (2020) Redefining Palliative Care - a new consensus-based definition. *J Pain Symptom Manag* 60:754–764
4. Multinational Association for Supportive Care in Cancer website. <https://www.mascc.org/about-mascc>. Accessed 12/12/2021
5. Davies A, Hayes J (2020) Palliative care in the context of a pandemic: similar but different. *Clin Med (Lond)* 20:274–277
6. McNicol E (2008) Opioid side effects and their treatment in patients with chronic cancer and noncancer pain. *J Pain Palliat Care Pharmacother* 22:270–281
7. Chosich B, Burgess M, Earnest A et al (2020) Cancer patients' perceptions of palliative care. *Support Care Cancer* 28:1207–1214
8. Dalal S, Palla S, Hui D, Nguyen L et al (2011) Association between a name change from palliative to supportive care and the timing of patient referrals at a comprehensive cancer center. *Oncologist* 16:105–111
9. Boyd K, Moine S, Murray SA, Bowman D, Brun N (2019) Should palliative care be rebranded? *Br Med J* 364:1881
10. Berman R, Davies A, Cooksley T et al (2020) Supportive Care: an indispensable component of modern oncology. *Clin Oncol (R Coll Radiol)* 32:781–788

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**Fig. 1** The “extended” supportive care team [10].