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REVIEW

Palliative and End of Life Care: An Important Component of Supportive Oncology

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Abstract

Palliative care, an integral component of supportive oncology, enhances the quality of life for patients living with cancer. Whilst palliative care has historically been synonymous with the provision of care at the end of life, it is increasingly playing a role earlier in a patient's cancer journey; frequently in conjunction with administration of anticancer treatment. Although early integration has been shown to improve patient outcomes, service development remains in its infancy and consideration of challenges bears relevance. Addressing issues pertaining to resource allocation in addition to adequate training of staff will aid to ensure the provision of care that aligns with the goals and priorities of patients. This review presents the role of early palliative care within the realm of supportive oncology with respect to the evidence of benefit and ethical, clinical and practical considerations. Relevant papers have been chosen for inclusion on the basis of clinical relevance, timeliness and relevance to cancer patients and clinical teams involved in their care.

Key words: palliative care; supportive oncology; enhanced supportive care; early palliative care; end of life care; symptom control

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Introduction

Palliative care provides a multidisciplinary approach to improving the quality of life for those facing life-threatening or life-limiting illness. It involves early identification, assessment and management of symptoms including provision of physical, emotional, spiritual, psychological, and social support (World Health Organisation, 2024).

Palliative care was established to provide high-quality care for dying patients. In recent years, however, clinical studies have provided incontrovertible evidence that palliative care is not just for those at the end of life. "Early palliative care" may be beneficial to patients throughout their illness, from as early as diagnosis, alongside anti-cancer treatment (Ferrell et al, 2017; Temel et al, 2010; Vanbutsele et al, 2018).

Two meta-analyses of early palliative care for patients with advanced cancer (including 2980 participants from 12 randomised controlled trials and 1614 participants from seven studies) demonstrated better quality of life in patients receiving early palliative care (standardised mean differences 0.26–0.27, 95% Confidence

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Interval (CI) 0.11–0.15 to 0.38–0.4) (Haun et al, 2017; Shih et al, 2022). Other benefits include better prognostic understanding and enhanced coping when patients approach the end of life (Greer et al, 2018; Temel et al, 2010).

Early studies were focused on patients with diagnoses associated with a poor prognosis such as lung or upper gastrointestinal cancers (Mathews et al, 2021). The reach of evidence has expanded to include other diagnostic groups, including those with haemato-oncological diagnoses. A recent systematic review of 16 studies demonstrated the benefits of early palliative care for patients with haemato-oncological diagnoses in terms of quality of life (Elliott et al, 2021).

This review presents the role of early palliative care within the realm of supportive oncology. Evidence of benefit and ethical, clinical and practical implications is considered. Studies and papers have been chosen for inclusion on the basis of clinical relevance, timeliness and relevance to cancer patients and clinical teams involved in their care. Discussion of the impact on clinical practice and considerations for future care and service planning is presented under headings which relate to specific aspects and challenges of providing palliative care for patients with cancer. A case study is included for illustration.

Palliative and End of Life Care is an Important Component of Supportive Oncology

Advances in oncology have meant more patients are cured from cancer and many live longer with an improved quality of life. Palliative care teams are now involved in the care of patients with “Treatable But Not Curable cancers”, who may live for many years on anticancer treatment (White et al, 2021). However, some cancer diagnoses are still associated with poor outcomes and for many, survival may be uncertain due to the nature of their illness or treatment, e.g., haematopoietic stem cell transplant or Chimeric Antigen Receptors Cell Therapy (Gemmell et al, 2022).

Supportive care in cancer, known as supportive oncology, is the multi-disciplinary approach to the prevention and management of adverse effects of cancer and associated treatments. This includes managing complications across the continuum of the cancer journey from diagnosis, to post-treatment care (Multinational Association of Supportive Care in Cancer MASCC, 2024).

Providing high-quality palliative and end of life care is integral to supportive oncology and is underpinned by several principles:

- Proactive identification, assessment, and management of symptoms. For patients living with “Treatable But Not Curable” cancers, this supports them to maintain a good quality of life and to continue anticancer treatment. For patients who are no longer on disease-modifying treatment, this approach supports them to live as well as possible during their last days, weeks, months, and years of life.
- Holistic, patient-centred care that is aligned with the individual’s beliefs and priorities.
- Sensitive communication about goals of treatment, ensuring care is coordinated across health and social care services, organisations and sectors.

- Identification and preparation for uncertainty and the dying phase, including advance care planning.
- Support for both patients and their families.

Although a novel concept, the literature demonstrates that integration between oncology and palliative medicine across clinical settings not only benefits patients but also has positive implications from a health economics perspective.

One study examining the impact of ‘co-rounding’ (the provision of joint ward rounds for all inpatients) resulted in a reduced length of stay for patients admitted with problems associated with cancer compared to when patients were seen by palliative care alone (Yang et al, 2021).

Furthermore, Guimarães et al (2024) described a model of integration whereby palliative care services were integrated into inpatient oncology and haemato-oncology services, with participation in inpatient rounds and Multidisciplinary Team (MDT) meetings. This model, when compared with outcomes pre-intervention, showed statistically significantly fewer inpatient bed days, fewer emergency room visits and less aggressive care in the last 30 days of life (Guimarães et al, 2024).

Challenges in the Provision of Palliative and End of Life Care

As a comprehensive approach to cancer care, supportive oncology has often been delivered by specialist palliative care teams, acknowledging the central role of holistic care in the attempt to improve quality of life. However, as the profile of cancer patients and available treatments is changing, there is increased recognition that the specialism of other disciplines is also needed (Berman et al, 2023). While palliative care remains an important component of the multi-disciplinary and multi-professional team that is supportive of oncology, as a speciality, it faces a number of challenges in terms of delivering sustainable, equitable and high-quality care for cancer patients who need it.

Timing

When should palliative care be introduced to patients and their families? Patients are generally accepting and welcoming of early palliative care involvement with appropriate information sharing about the nature and remit of the service (Zimmermann et al, 2016). In one of the original landmark studies, early palliative care was introduced within 8–12 weeks of a diagnosis of advanced cancer, with benefits demonstrated up to months later (Temel et al, 2010). Even in these studies, not all patients had significant needs requiring specialist palliative care involvement and mandating specialist palliative care involvement for all patients is unsustainable even in the best-resourced units. Alternative approaches to screening have been proposed and tested including the use of palliative care referral “Triggers” (Hui et al, 2016) or the use of Patient Reported Outcome Measures (Zimmermann et al, 2021).

Availability of Appropriately Trained Specialist Palliative care Resources to Meet Patients' Needs

The ever-changing cancer demographic, with more people 'living with' incurable diseases, raises questions about whether the traditional palliative care model is able to fully serve the needs of this patient group.

The forecasted increasing numbers of patients who will need palliative care at the end of life (Bone et al, 2018; Etkind et al, 2017), together with the increasing complexity of patients living with incurable diseases means that demand for services continues to rise. This presents challenges in terms of resources and training to meet these needs. It is recognised that not all patients have equitable access to specialist services. However, not all cancer patients and not all patients at the end of life need input from palliative care specialists. It follows therefore that all healthcare professionals working with cancer patients should have an understanding of the core concepts of palliative care (Kaasa et al, 2018). Although specialist care may be necessary for patients with complex symptoms or psychosocial needs, the needs of many may be managed by non-specialist healthcare professionals who have received training, education, and support (National Palliative and End of Life Care Partnership, 2021).

Normalising palliative care as part of oncological care is fundamental in the development of integrated services (Kaasa et al, 2018). As the complexity of patients living with cancer increases, so does the requirement for palliative care teams to upskill their understanding of newer treatments and of providing care that is integrated closely with oncology practice. Alternative approaches to symptom management are required for those who are not at the end of life including the management of chronic rather than short-term pain and the identification and management of treatment-related toxicities.

Remit

As the evidence of the benefits of palliative care increases, so too does the potential for expansion into other areas.

Originally developed as a way of integrating palliative care earlier in the cancer journey, enhanced supportive care (ESC) is an approach to care developed in the UK to address the needs of cancer patients who were not imminently dying but who would benefit from early input to improve their quality of life (Scotté et al, 2023). The benefits of ESC have been documented in terms of improved well-being, which supports patients to continue with their anticancer treatment (Monnery et al, 2018). ESC is also associated with lower rates of unplanned hospital admissions, improved patient flow and reduced inappropriate interventions at the end of life (Monnery et al, 2023). Many ESC teams have expanded the breadth of their services to include patients who would not have been referred to traditional palliative care services. This includes developing services for patients receiving radical and curative anticancer treatment and those experiencing late treatment-related effects.

Although ESC refers to the intersectional working between palliative care and oncology, the inherent uncertainties in the disease trajectories for patients living with cancer have meant that collaboration with other medical specialities has become central to the practice of supportive oncology.

In the context of checkpoint inhibitor therapies and associated immune-related adverse events, the field of cardio-oncology is garnering increasing recognition, with timely detection, surveillance and management of cardio-toxicity being shown to improve both oncological and cardiovascular outcomes for patients (Lyon et al, 2022).

Similarly, the field of geriatric oncology as a facet of supportive oncology was borne out of an appreciation of the increasing number of elderly people living with cancer and the nuances involved in tailoring care for this population (Presley et al, 2020).

High-Quality Palliative and End of Life Care Enables Effective Symptom Management to Promote Improved Quality of Life

The use of standardised questionnaires and tools in the assessment of symptoms provides comprehensive information about health-needs (Murtagh et al, 2019). Patient Reported Outcome Measures can provide insight into a patient's perception of their well-being (Etkind et al, 2015) and are used to facilitate communication between patients and professionals, to promote person-centred care (Bausewein et al, 2016).

For patients approaching the end of life, multi-morbidity, frailty, polypharmacy, and drug interactions contribute to the complexity of prescribing and medicines management, necessitating an understanding of drug pharmacology and therapeutics (Wilcock et al, 2022).

In the final weeks of life, the goal of medication is to manage symptoms whilst avoiding adverse effects that may deleteriously impact the quality of life. Rationalising medications can mitigate the risk of adverse events, limit the medication burden, and optimise well-being for patients (Thompson, 2019).

Safe prescribing of medications for symptom control is based on the patient's clinical situation, living circumstance and social support as well as drug availability and route of administration.

Identifying Patients Who are Approaching End of Life

Identification of patients who have incurable diseases and who are approaching death can inform decisions about care and positively impact patient and family expectations.

Although survival estimates may become more accurate when patients with cancer are in the final weeks and days of life (a phenomenon known as "the horizon effect") (Selby et al, 2011), in general prognostication is challenging and often inaccurate (Gwilliam et al, 2013). There are, however, indicators that can be used to anticipate when patients are nearing end-of-life:

- Cancer patients usually have a period of relative stability during which they may or may not be receiving anti-cancer treatment, followed by a terminal phase, evidenced by a marked decline in performance status (Murray et al, 2005).
- The "surprise question" involves clinicians asking themselves if they would be surprised if death were to occur within a certain timeframe (Romo and Lynn, 2017).
- The Supportive and Palliative Care Indicators Tool (SPICT) includes general and cancer-specific indicators of deterioration which may encourage prompt engagement with specialist services (Piers et al, 2021).

Prognostic uncertainty has likely been magnified by the advent of novel anti-cancer treatments; for which the lack of predictive bio-markers can heighten difficulties in determining the likelihood of an enduring, beneficial response.

The literature has highlighted the complex psychological sequelae that can arise with changes in cancer survivorship, with uncertainties in disease trajectories leading to chronic stress and fears of cancer recurrence in those for whom therapeutic benefit is achieved (Kamminga et al, 2022).

The impact of such uncertainties is illustrated in the case below:

Case Study

Bill is a 50-year-old man with previous melanoma of his left foot. This was surgically excised 5 years ago and then 2 years ago it was discovered that it had metastasised to his left groin lymph nodes. Bill has received immunotherapy for 2 years and has had an excellent response to treatment with no measurable disease on imaging. His immunotherapy has finished and he is for 6 monthly surveillance scans.

Bill is unsettled about plans for surveillance. He worries the melanoma will come back. He also feels low because of the side effects he has had and he sometimes wishes he had not survived at all because of his quality of life.

Bill is a teacher but has been unable to return to work due to fatigue.

He previously enjoyed going to the gym and built up a social network through the gym of weight lifters which he was part of. He has lost all that now so no longer has a social role. He feels his cancer has robbed him of all of the positive things in his life.

These more recondite needs are frequently unmet by current models of care-making a case for integrated, holistically minded care throughout the duration of the disease trajectory, including for patients who have garnered therapeutic responses to treatment.

Ethical Challenges in Palliative and End of Life Care

Palliative care can support patients, their families, and healthcare teams in making decisions that are aligned with patients' preferences and priorities. A key consideration in caring for individuals with life-limiting illnesses relates to making decisions that lessen suffering whilst ensuring that these decisions do not cause harm or distress to patients or their families.

"Dignity conserving care" acknowledges personhood and individual identity and promotes patient-centred decision-making and care through the concepts of kindness, compassion, and respect (Chochinov, 2007).

"Shared decision-making" is an approach that has been developed to exchange information between patients, families, and healthcare workers, empowering patients in their understanding of options, risks, and benefits (Brom et al, 2017).

For patients who have an uncertain outcome, this includes planning for the future, a process known as "advance care planning (ACP)" (Rietjens et al, 2017). This is a dynamic component of palliative care, endorsed in international policies and facilitates discussions between patients, families and healthcare professionals about individual preferences and goals for future care. Effective use of advanced care plans can result in fewer interventions of limited clinical value, reduce emergency hospital admissions, fewer hospital deaths, and enable preferences for place of care and death to be met (Orlovic et al, 2020). The most appropriate or effective timing for ACP discussions is unclear in terms of balancing early discussions with appropriate pathways to support patients to revisit discussions and change their documented preferences and goals of treatment. This is pertinent when patients may be eligible to other lines of treatment.

Ethical challenges at the end of life relate to using clinical judgement to ascertain when treatments that may prolong life in different circumstances, are unlikely to confer symptomatic benefit or risk causing harm. Common ethical issues at the end of life include:

Withdrawal and Withholding of Treatment

As part of ACP discussions, a patient may decide that they do not want certain medical treatments or interventions. For example, the likelihood of successful cardiopulmonary resuscitation in the event of cardiopulmonary arrest is low for patients with advanced cancer (Reisfield et al, 2006) and the process of cardiopulmonary resuscitation for these patients can be painful, and upsetting for their families. Including patients and families in discussions and decision-making around a "Do Not Attempt Cardiopulmonary Resuscitation" order is a challenging but important aspect of care.

Clinically Assisted Nutrition and Hydration

This relates to the administration of nutrition/fluids either parenterally, i.e., intravenously, or enterally, e.g., via gastrostomy or jejunostomy or nasogastric/naso jejunal feeding tube. Although this may vary depending on the jurisdiction, these interventions are deemed 'medical treatments', under British law (General Medical Council 2010, updated 2022). As people deteriorate, it is normal for nutritional, and hydration needs to diminish. Decisions pertaining to clinically assisted nutrition at the end of life need to be made after weighing up the benefits and risks of such interventions. Perceived benefits may include reduction of thirst and delirium. Adverse effects include infections, the need for invasive tube placement, worsening peripheral oedema and worsening respiratory secretions (Kingdon et al, 2021). Timely discussions can help facilitate the decision-making process and mitigate distress.

Conclusion

The studies presented in this review reflect the growing body of evidence to underpin the role of palliative care as a core component of cancer care. Identification and proactive management of physical and psychological symptoms as part of holistic patient-centred care is a key component, alongside managing uncertainty, advance care planning and facilitating sensitive and effective communication.

The provision of high-quality palliative and end of life care is a fundamental aspect of supportive oncology, requiring adequate and appropriately trained clinicians working across healthcare sectors, aligning the provision of care with the goals and priorities of patients. Acknowledging changes in the oncological paradigm, it is pivotal that palliative medicine evolves concurrently to meet patient needs independent of disease trajectory.

Key Points

- Palliative care is a core component of supportive oncology, the multidisciplinary approach to the management of adverse effects of cancer and its treatment.
- Palliative care is beneficial to cancer patients at all stages of the disease trajectory, irrespective of prognosis.
- Teams are now often involved in the care of patients with “Treatable But Not Curable cancers”.
- There are challenges to adequate service provision including timing and availability of input as the profile of cancer patients and available treatments are changing.
- Key roles throughout the patient journey incorporate symptom control, skill in prognostication and advance care planning.
- Ethical considerations to the provision of palliative care in cancer patients include withdrawal of treatment and clinically assisted nutrition and hydration.

Availability of Data and Materials

All the data of this study are included in this article.

Author Contributions

PJ, MCR, DM and JD designed and undertook this review. PJ, MCR, DM and JD drafted the manuscript. All authors were involved in the writing of the manuscript. All authors contributed to the important editorial changes in the manuscript. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

Not applicable.

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Conflict of Interest

The authors declare no conflict of interest.

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