ESMO PRECEPTORSHIP PROGRAMME SUPPORTIVE AND PALLIATIVE CARE

SESSION 1 OVERVIEW

INTEGRATION OF NEEDS-BASED PALLIATIVE INTERVENTIONS IN ROUTINE CARE: SUPPORT COPING, ADDRESS SYMPTOMS, COORDINATE CARE, PREPARE EOL

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ESMO Designated Centers Working Group, past Chair

Monday 16. April 2018 / 09:15-09:35
Lugano

What are needs?

. Assess patients in routine cancer care

Palliative Interventions

. Opening the black box of spez. PC RCTs
. Single interventions - Communication

Support coping

. Illness understanding
. Prognosis talk

Address symptoms

. Basic principles

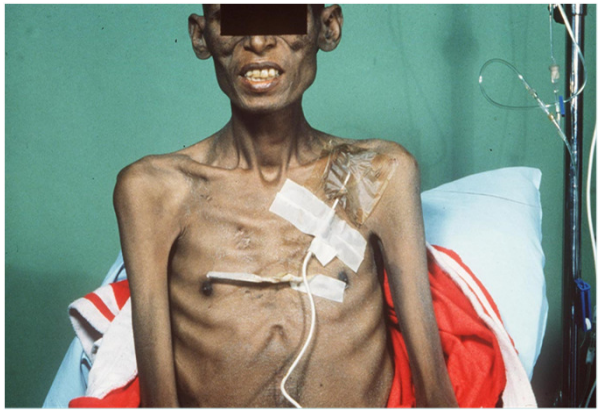
Coordinate (professional) care

. Work as team - foresee

Prepare for End-of-life

. Work as team – foresee complications

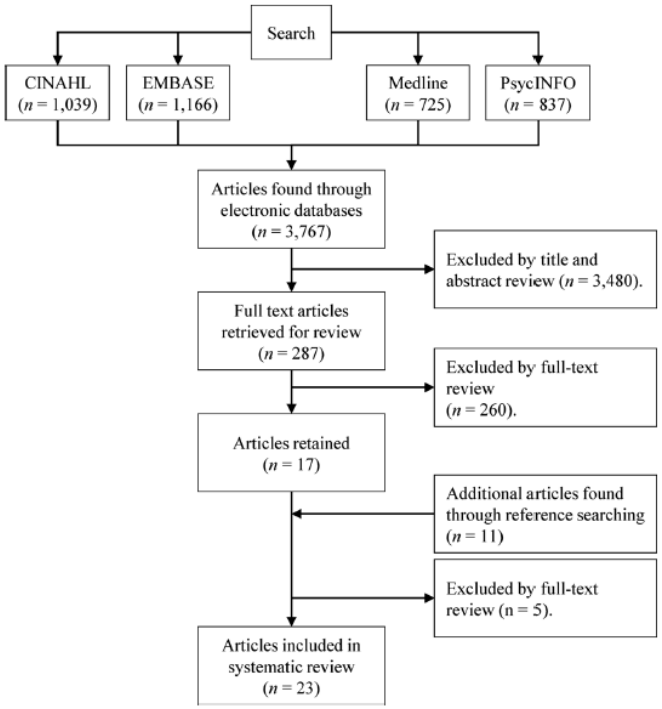
What are your needs?



Unmet care needs in people living with *advanced* cancer: a systematic review

Cancer AND advanced disease AND needs
(exp needs assessment, unmet need$, need$ assess$, perceived need$, support$ care need$, psycho$ need$, physical need$, exp symptom assessment, information need$)

23 included studies: 5 UK, 5 USA, 4 Australia, 3 Canada, 2 Netherlands, 1 each Hong Kong, Japan, Italy, and Denmark. 19 quantitative surveys (most used: *S*upportive *C*are *N*eeds *S*urvey in 6 studies) , 4 qualitative studies (semistructured interviewing: individual or focus group).



Domain	No. of studies	Total *N*	Pooled proportion (%)	95 % CI	I^2 (%)
Psychological/psychosocial	11	1941	29.3	18.4–41.6	97.0
Physical	10	1720	31.6	17.1–48.4	98.1
ADL	10	1722	26.3	17.2–36.5	95.3
Information/health system	9	1509	41.9	29.5–54.8	96.1
Economic	3	636	18.0	12.0–25.0	77.0
Spiritual	7	1203	12.8	10.9–14.7	0.0
Sexuality	3	475	7.4	2.6–14.5	83.7
Patient care and support	2	280	33.3	2.5–77.1	98.1

Note. Pooled proportions and 95 % CIs computed under random-effects models. I^2 indicates level of inconsistency across studies

→ 1/3 - 2/5 Patients have unmet needs

Moghaddam N et al. Support Care Cancer 2016; 24:3609–22

Unmet care needs in people living with advanced cancer: a systematic review

Table 3 Most endorsed items of need (by domain) across studies using the Supportive Care Needs Survey

	Domain of need				
Study	Psychological	Physical	ADL	Health system and informational	Other
Uchida [37]	Fears about the cancer spreading (79 %)	Lack of energy/tiredness (48 %)	Not being able to do the things you used to do (46 %)	Having one member of staff with whom you can talk about your concerns (67 %)	Sexuality: changes in sexual feelings/ relationships (15 %)
Waller [8]	Concerns about the worries of those close to you (28 %)	Lack of energy/tiredness (26 %)	Not being able to do the things you used to do (33 %)		
Fitch [26]	Fears about pain (28 %)	Pain (45 %)	Not being able to do the things you used to do (29 %)	Information about managing illness and side effects (16 %)	Spiritual: uncertainty about the future (13 %)
Beesley [22]	Fears about the cancer spreading (25 %)	Lack of energy/tiredness (18 %)		Information about things you can do to help yourself get well (20 %)	
Aranda [20]	Concerns about the worries of those close to you (41 %)	Pain (28 %)	Not being able to do the things you used to do (25 %)	Information about things you can do to help yourself get well (41 %)	
Au [21]	Worry that the results of treatment are beyond your control (18 %)	Lack of energy/tiredness (11 %)	Not being able to do the things you used to do (14 %)	Having one member of staff with whom you can talk about your concerns (64 %)	

Moghaddam N et al. Support Care Cancer 2016; 24:3609–22

Need versus Symptom versus Syndroms versus PRO

- **Symptom**: subjective experience, only patient can judge it
  - Intensity: visual-analogue (---) , categorial (numbers), visual-categorial (Smiley) ***EdmSymAssSca***
  - Impact: Work, QoL, Relationships, Mood, Physical Acivity ***Brief Fatigue Inventory***
  - Distress ***Distress Thermometer***
- **Syndrome**: «objective» Mechanisms for Symptoms ***Edmont Classific System-Cancer Pain***
  - Bsp. Painsyndrome, Fatiguesyndrome ***Single Item Fatigue***
- **Patient Reported Outcome** (PRO)
  - Term often used «only» for Symptom ***EORTC-QLQ-C30***
  - but all what is coming «from Patient»: e.g. physical Function ***KPS***

→ *What tell these Data me (Clinician), if Patient requires a (medical) Intervention?*	*Estimation of Priority, of Distress related to need, and of available Interventions*

- Need: ability to profit from medical Intervention
  - May be dependent of available «Menu» (*e.g.: experience new Spice*)
  - expressed need, felt need, comparative need, normative need (Bradshaw)

Types / Taxonomy of needs

Directly from the patient after a request
felt *need*

Inferred from patient-reported events, triggers or contexts
comparative* or *normative *need*

Spontaneously
expressed *need of any kind*

→ **felt**: Answer a concrete question
Probably best reflecting Patient wish
→ **comparative**: compared to other patients with the «same» Situation, this patient could also profit (Bsp. Pain 5/10)
→ **normative**: Defined Standard (in Clinik)
→ **expressed**: spontaneous wish of Patient

Bradshaw, J. *A taxonomy of social need.* New Soc 1972;30:640-3

That means for
daily oncology practice:

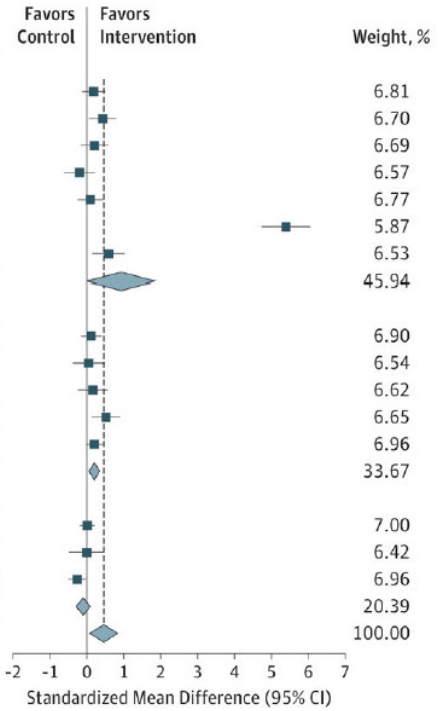
- Ask patients (and family members) about their needs
- Be aware of standards your patient may profit from
- Assess patients with concrete tools for symptoms and for other needs (e.g. distress thermometer, newer tools)

Then deliver an (palliative) intervention

Current evidence of (specialized) Palliative Care

Systematic literature review: 49 RCTs, 19 only cancer pts

Source	No. of Patients: Intervention	Control	Setting	Instrument	Disease	Standardized Mean Difference (95% CI)
High risk of bias						
Bakitas et al,[20] 2015	72	83	Home	FACIT-Pal	Cancer[a]	0.19 (-0.13 to 0.50)
Clark et al,[35] 2013	54	63	Ambulatory	FACT-G	Cancer[b]	0.42 (0.06 to 0.79)
Given et al,[54] 2002	53	59	Home	SF-36	Cancer[c]	0.21 (-0.16 to 0.58)
McCorkle et al,[51] 2015	36	56	Ambulatory	FACT-G	Cancer[d]	-0.20 (-0.62 to 0.22)
Northouse et al,[32] 2005	69	65	Ambulatory	SF-36	Cancer[e]	0.09 (-0.25 to 0.43)
Sidebottom et al,[9] 2015	79	88	Hospital	MLHFQ	Heart failure	5.39 (4.74 to 6.05)
Wong et al,[10] 2016	43	41	Home	MQOL-HK	Heart failure	0.58 (0.15 to 1.02)
Subtotal (I^2 = 97.4%, P = .000)						0.93 (-0.00 to 1.85)
Low risk of bias						
Bakitas et al,[57] 2009	108	97	Home	FACIT-Pal	Cancer[f]	0.12 (-0.16 to 0.39)
Higginson et al,[12] 2014	42	40	Ambulatory	EQ5D	Mixed[g]	0.05 (-0.38 to 0.49)
Rummans et al,[59] 2006	47	49	Ambulatory	Spitzer	Cancer[d]	0.16 (-0.24 to 0.56)
Temel et al,[60] 2010	60	47	Ambulatory	FACT-L TOI	Cancer[h]	0.52 (0.13 to 0.90)
Zimmermann et al,[8] 2014	140	141	Ambulatory	FACIT-Sp	Cancer[i]	0.21 (-0.03 to 0.44)
Subtotal (I^2 = 0.0%, P = .500)						0.20 (0.06 to 0.34)
Unclear risk of bias						
Bekelman et al,[13] 2015	172	180	Home	KCCQ	Heart failure	0.01 (-0.20 to 0.22)
Grudzen et al,[11] 2016	39	30	Hospital	FACT-G	Cancer[j]	-0.01 (-0.48 to 0.47)
Northouse et al,[31] 2013	198	104	Ambulatory	FACT-G	Cancer[k]	-0.26 (-0.50 to -0.02)
Subtotal (I^2 = 33.3%, P = .223)						-0.10 (-0.30 to 0.09)
Overall (I^2 = 94.8%, P < .001)						0.46 (0.08 to 0.83)



Kavalieratos D et al. JAMA 2016; 316(20):2104–14

Metaanalysis
Statistically and clinically significant improvement of patient QoL and symptom burden at 1-3 mts
No consistent association of PC with survival

Narrative synthesis
PC consistently associated with improvement of advanced care planning, patient and caregiver satisfaction, lower health care utilization

Gärtner J et al. SLR & Meta-analysis BMJ 2017;357:j2925

Cochrane review: early palliative care may have more beneficial effects on quality of life and symptom intensity than usual care

Haun MW et al. Cochrane Database Syst Rev. 2017 Jun 12;6:CD011129

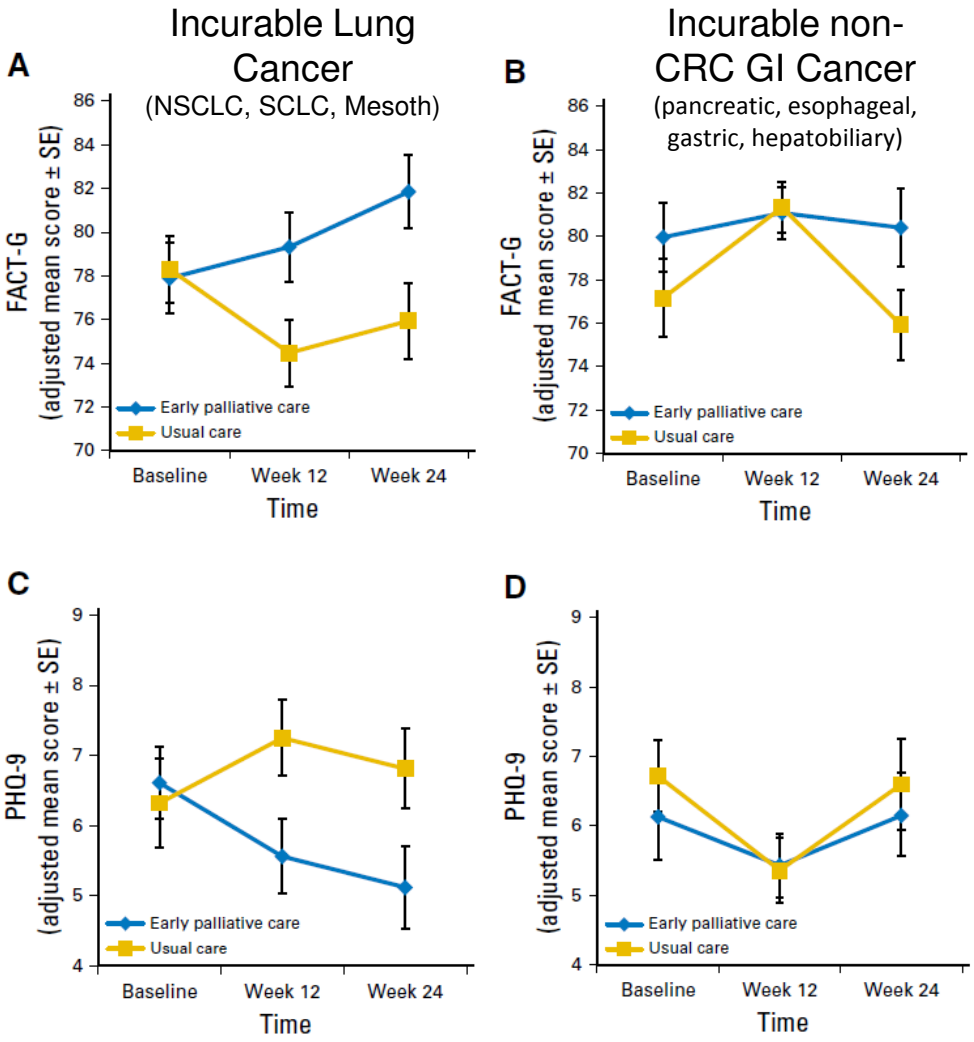
ASCO GUIDELINES™

Ferrrel BL et al. JCO 2017;35:96-112

The Integration of Palliative Care into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

"Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, *intellectual*, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice."

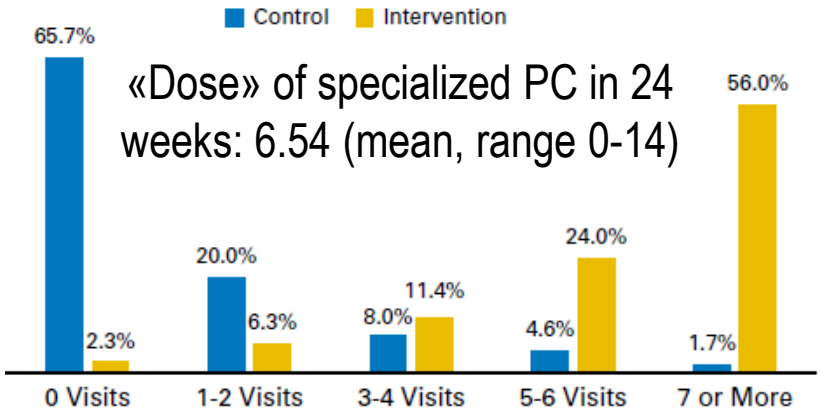
	Type	*Evidence Quality*	*Recommendation level*
Patients with advanced cancer	***Evidenced-based***		
- shall **be referred** to **inter**disciplinary palliative care teams		*intermediate*	*strong*
- consultation available **both in**patient and **out**patient care		*intermediate*	*strong*
- **early** in the course of disease, **alongside active** treatment		*intermediate*	*moderate*
Newly diagnosed pts, referral < 8 weeks	***In-formal consensus***	*intermediate*	*moderate*
Cancer patients with **high symptom burden** and/or **unmet** physical or psychosocial **needs** outpatient cancer care programs shall use dedicated resources	***Evidence-based***	*intermediate*	*moderate*
For family caregivers in outpatient setting nurses, social workers, and other professionals shall deliver caregiver-tailored Pall Care support	***Evidence-based***	*low*	*weak*



Effects of specialized Palliative Care are different in incurable

350 Lung and non-CRC GI Cancer Patients

(of eligible pts 20% refused, 24% not enrolled)



→ Once a month: recommended dose*

Temel J et al. JCO 2016; Dec 28

Ferrrel BL et al. JCO 2017;35:96-112

ASCO GUIDELINES™

The Integration of Palliative Care into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Ferrrel BL et al. JCO 2017;35:96-112

Patients with advanced cancer should receive palliative care services, which ***may*** include referral to a palliative care provider

Palliative Interventions

Essential components of **palliative care** may include:

• Rapport and relationship building with patients and family caregivers	Family support
• *Symptom*, distress, and functional status management (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)	Symptom Mgmt
• Exploration of understanding & education about *illness* and *prognosis*	Illness & Prognosis
• Clarification of [anticancer] treatment *goals*	Decision process
• Assessment and support of coping needs (eg, dignity therapy)	EOL-prepare, Spiritual
• Assistance with medical *decision* making	Decision process
• Coordination with other care providers	Continuity of care
• Provision of referrals to other care providers as indicated	Continuity of care

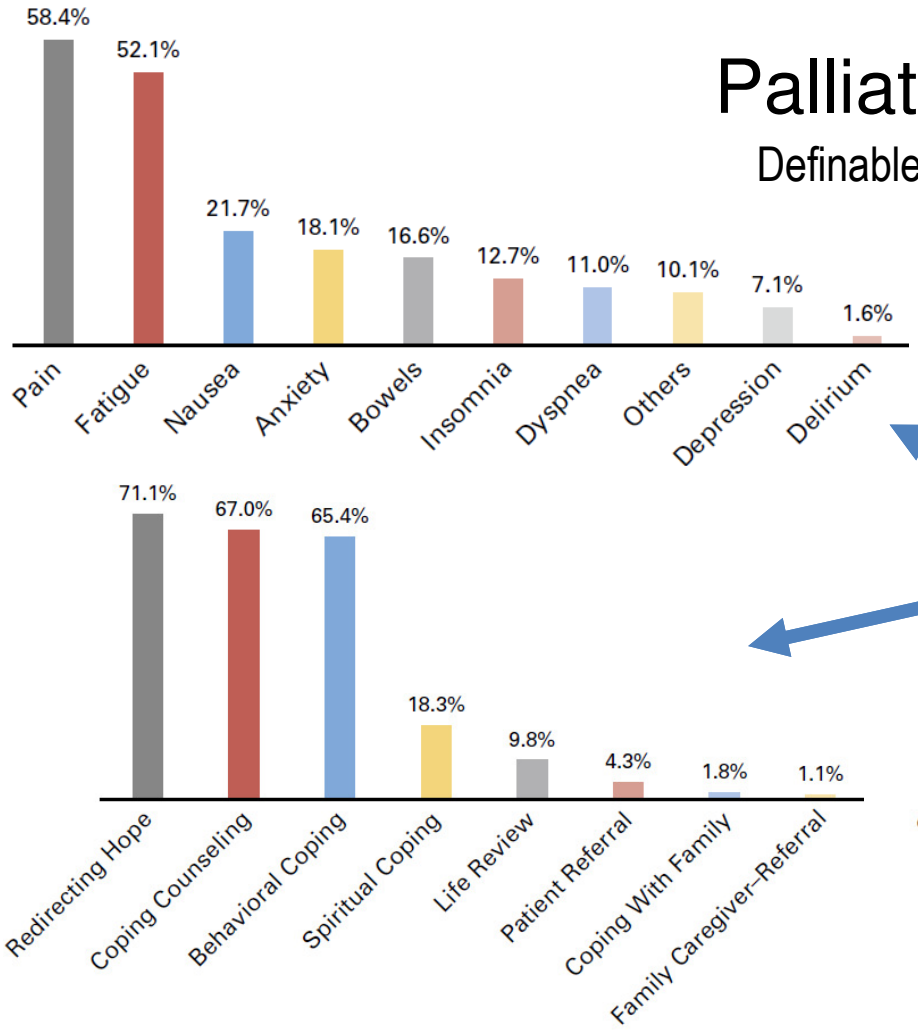
→ May adapt to local settings, may brand it «**Supportive & Palliative Oncology**» Service

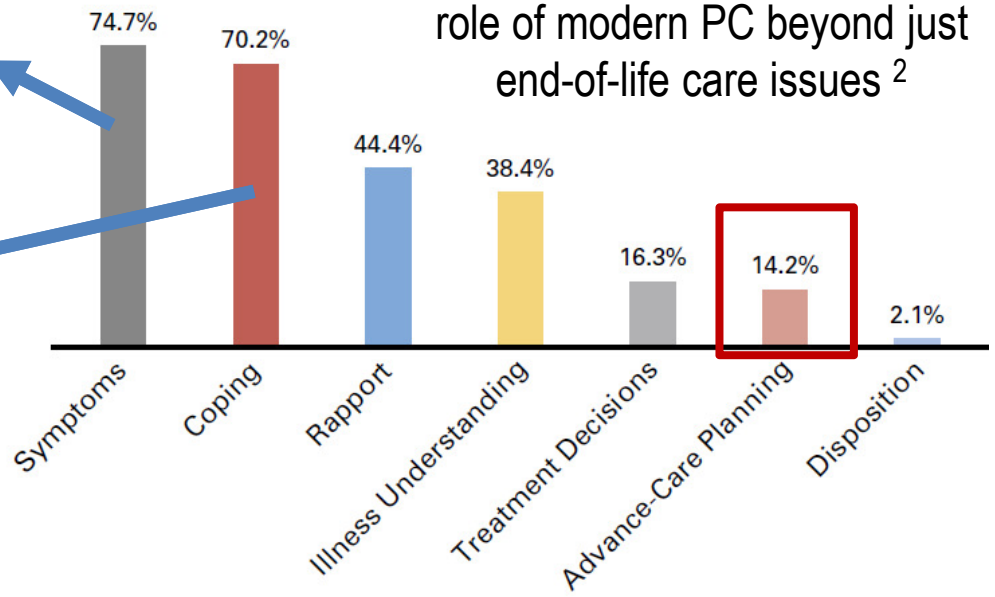
Palliative Care Interventions (PCIs)

Definable interventions as part of the specialist PC «package»

From the US Mass General RCT: documented PCIs[1]

Few AdvCarePlan: expanded role of modern PC beyond just end-of-life care issues [2]





1: Temel J et al. JCO 2016; Dec 28
2: Roeland EJ JCO 2017;1-3

Palliative Care Interventions

Pharmacological	
Procedural	(e.g. pleural pct)
Educational	(e.g. prognosis)
Counselling	(e.g. decisions)
Coaching, Empower	(e.g. prompt list)
Psychological	(e.g. behavioural)
Coordinative	(e.g. HCP network)
…	

«Onco-Pivotal» Pall Interventions

«Palliative-Pivotal» Pall Interventions

Palliative Care Key Interventions based on & adapted by Kalbermatten N et al from: Temel NEJM 2010; Jacobsen J Pall Med 2011; Yoong JAMA Int Med 2013; Zimmermann Lancet 2014; Bakitas JCO 2015; Dionne-Odom JCO 2015

- **Illness understanding** (prognosis, mechanism, trajectory)
- **Symptomcontrol** (bio-psycho-social-spiritual)
- **Decision processes** (cancer-specific Tx, nutrition, ...)

- **Continuity of care Network** (various HCP, home-out- inpat)
- **Care of family members** (incl. premortal grief, coaching)
- **End of life preparation & care** (family; double way, legacy, dying)
- **Spirituality** (meaning, transcendence, ..)

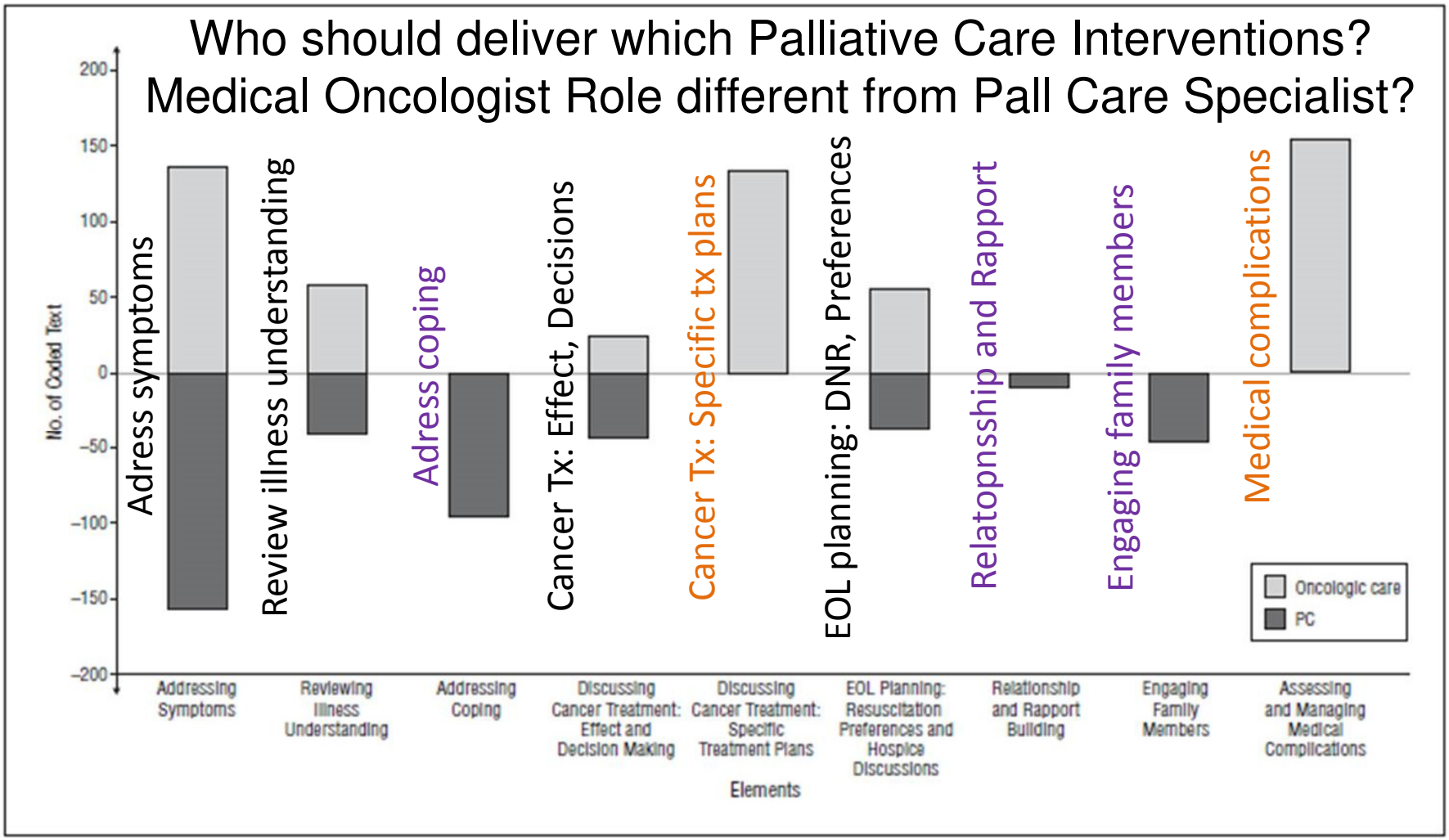


Figure 2. Elements of palliative care (PC) vs oncologic care visits at clinical turning points. EOL indicates end of life.

Yoong et al. JAMA IM 2013;173(4)

Open Access Special article

ESMO / ASCO Recommendations for a Global Curriculum in Medical Oncology Edition 2016

4.4.2 Palliative care
Timothy Moynihan
Florian Strasser
Jamie Von Roenn

Objectives

- To be able to screen for, assess, prevent and manage symp… such as pain, fatigue, anorexia, anxiety, de…
- To co… ing with it, progn…
- To rec…
- To rec… s
- To unc… …disciplinary cancer care
- To rec… …burnout, compassion fatigue and depression

Medical Oncologist are expected to deliver many palliative interventions

Multidimensional symptom management and communication including Illness understanding, decisions, EOL and rehabilitation, patient and family
Integration of palliative interventions in multidisciplinary routine care

Illness & Prognosis understanding

In modern oncology is the double way (*double awareness*)[1] becoming increasingly important:

Dealing with finitude and preparation for end-of-life gives strenght to live engaged and powerful with cancer

Prognosis-Talk

Never say a median number! Ev. explain Surprise-Question[2]

If it goes (5%) bad – worst case (Complications, …): timespan A
If it goes (5%) good – best case (modern oncology): timespan B

A: what do I then concrete? Preparation for End-of-Life
B: what do I then concrete? Continue to live, fight, enjoy

Normalization of ambivalence, of healthy denial & collusion
Acknowledgment of tough, emotional path; You do so well!
Concretization of professional help and continuity

The Communication-Intervention Prognosis-talk can (and must) be defined for mandatory (evidence-based) keyelements

1: Epstein RM et al. JAMA Oncol 2016 Sep 9
2: Hamano J e tal. Oncologist 2015

Many symptoms are still poorly controlled

- insufficent **access** to drugs (e.g., opioids)[1]
- no proactive **screening**
- **non-specialized** setting[2]
- **silent** symptoms (fatigue, depression) neglected

Monitoring incl. **coaching**[3] or symptom **mgmt drugs**[4] or **email alerts** to HCPs[5] improve outcomes

1: Cherny N Ann Oncol 2013;S11:xi7-13
2: Greco MT JCO 2014;32:4149-54
3: Berry DL JCO 2014;32:199-205
4: Strasser F Ann Oncol 2016;27:324-32
5: Basch E JCO 2016;34:557-65

Symptom Control Intervention(s): Key principles

Manage symptoms & syndromes **multidimensional**
- physical, emotional, intellectual, social, spiritual

Define **Syndrome** and **risk factors**
- Pain: incident, neuropathic, cognitive, emotional[6]
- Cachexia: concurrent malnutrition, constipation[7]
- Depression: concurrent delirium, dementia

Management by **drugs, education, counseling,** etc.[8]
- always consider mechanism, ev. location
- always ask for impact of symptom on quality of life
- pharmacological management: Guidelines[8]

6: Nekolaichuk CL J Palliat Med 2013;16:516-23
7: Aapro M Ann Oncol 2014;25:1492-9
8: Sheinfeld Gorin S et al. *JCO 2012; 30:539-547*

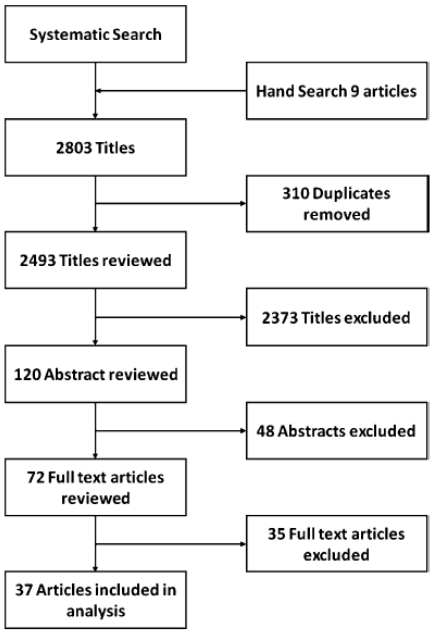
Continuity of care Network Intervention

Prepare with the multiprofessional team a **concrete care plan** for community-based patients
- what symptoms are expected, what drugs needed
- who will assess patient, who gives drugs, how?
- who cares for the patients‘ care needs?
- which phone numbers 1st – 2nd -3rd to call? 24/7

Care of family members Intervention

Discuss & acknowledge family members double role
- carer, advocate, „nurse“, coordinator,..
- own burden, grief work, prepare role after death

Bakitas J Clin Oncol 2015;33:1438-45; Ferrel BR J Clin Oncol 2017;35:96-112



Lamb BW et al. Ann Surg Oncol 2011;18:2116–2125

Team work: what is the evidence?
Systematic Literature Review

What is the quality of care decisions via the effect of MDTs on care management, % cases?

MDTs changed cancer mgmt by individual physicians in 2–52% of cases

Failure to reach a decision at MDT discussion: 27–52%

Decisions could not be implemented in 1–16%

Team decisions are made by physicians, using clinical information. Nursing personnel do not have an active role.

Patient preferences are not discussed

Time pressure, excessive caseload, low attendance, poor team-working, lack of leadership
→ lead to lack of information & poorer decision-making.

Conclusions

Patient needs are often underestimated and require proactive assessment in daily care

Palliative interventions include pharmacological, procedural, communicative, coordinative, educational, and counseling and shall be delivered both by oncologists and PC Specialist

Teamwork demands a passion to understand thinking and approach of other professionals /disciplines

Palliative needs-related sessions at Preceptorship:

Needs → PRO vs CRO	→ KJ S1
Integration Oncology & Pall Care	→ SK S7
Communication (BBN, Fam, BO, DHD)	→ LT S5
Advanced Directives	→ FS S3
Fatigue	→ JA S2
Pain	→ JW S5
Delirium, Dyspnea, Ascites	→ JW S6
Cachexia	→ JA/FS S6
Coordination Pall Networks incl. Oncol	→ JW S3
Collaboration nurses & doctors	→ AY S6
Planning, organization, pt mgmt EOL	→ SK S3

Gracie

Florian.strasser@kssg.ch

Fragen zum Unterstützungsbedarf (Supportive Care Needs Survey – SCNS-SF34-G)[1]

WIR MÖCHTEN GERN ERFAHREN, ob und in welchem Ausmaß Sie Unterstützung beim Umgang mit verschiedenen Aspekten ihrer Erkrankung benötigen. Bitte geben sie dazu für jeden der unten aufgeführten Aspekte an, ob sie während des letzten Monats Unterstützung benötigten. Kreuzen Sie bitte die Antwortmöglichkeit an, die am besten ihr Bedürfnis nach Unterstützung beschreibt.

		kein Bedürfnis nach Unterstützung		Bedürfnis nach Unterstützung		
	Während des **letzten Monats:** Wie groß war Ihr Unterstützungsbedarf im Hinblick auf…	habe hier kein Problem	werde bereits unterstützt	gering	mittel	hoch
1.	Schmerzen	❍	❍	❍	❍	❍
2.	Müdigkeit und Erschöpfung					
3.	Unwohlsein (meiste Zeit des Tages)					
4.	Arbeit im Haushalt					
5.	Erledigung von Alltagsangelegenheiten					
6.	Angst					
7.	Niedergeschlagenheit oder Depression					
8.	Traurigkeit					
9.	Ängste vor dem Wiederauftreten/Fortschreiten der Krebserkrankung					
10.	Sorgen darüber, das Ergebnis der Behandlung nicht kontrollieren zu können					
11.	Ungewissheit über die Zukunft					
12.	Erlangung eines Gefühls von Kontrolle über die Situation					
13.	Erhalt einer positiven Sichtweise					
14.	Gedanken über Tod und Sterben					
15.	Veränderungen in der Sexualität					
16.	Veränderungen in der Partnerschaft					
17.	Gedanken über Sorgen Ihrer Angehörigen/Freunde					
18.	Freiheit bei der Wahl des behandelndes Arztes					
19.	Freiheit bei der Wahl des Krankenhauses					
20.	Verständnis und Wertschätzung der medizinischen Behandler (z.B. Ärzte, Pflegende) für Ihre Gefühle					
21.	Behandlung körperlicher Probleme					
22.	Berücksichtigung Ihrer emotionalen Reaktionen während des Kranken-hausaufenthaltes					
23.	Erhalt von schriftlichen Informationen über zentrale Behandlungsaspekte					
24.	Erhalt von Informationen (schriftlich, Abbildungen etc.) zum Umgang mit der Erkrankung und möglichen Behandlungsnebenwirkungen für zu Hause					
25.	Erklärungen von Untersuchungsergebnissen					
26.	Erhalt von umfassenden Informationen zu Wirksamkeit und Nebenwirkungen der Behandlung vor Beginn					
27.	schnellstmögliche Information über Testergebnisse					
28.	schnellstmögliche Information über Tumorfreiheit bzw. Kontrolle der Krebserkrankung					
29.	Information über mögliche Verhaltensänderungen, die das Wohlbefinden steigern					
30.	Zugang zu professioneller Beratung (z.B. Psychologe, Sozialarbeiter) für Sie oder Angehörige					
31.	Erhalt von Informationen über Sexualität					
32.	Behandelt zu werden wie ein Mensch, nicht wie ein „Fall“					
33.	Behandlung in einem Krankenhaus mit freundlicher Ausstattung					
34.	fester Ansprechpartner für alle Fragen zur Erkrankung, Behandlung und Nachsorge					

Lehmann C, Koch U, Mehnert A.
Validation of the German version of the
Short-form Supportive Care Needs Survey
Questionnaire (SCNS-SF34-G).
Supportive Care in Cancer , 2012

Evidence of Palliative Care: specialized teams

US Lung Cancer (**Temel**, NEJM 2010)	QoL, Depression, Survival
US Lung & non-crc GI (Temel, JCO 2016)	QOL Lung wk 12/24, GI wk24 Prognostic awareness
US Hemonc trspl. (El-jawahri JCO 2016)	Qol wk 2
Canadian (**Zimmermann**, Lancet 2014)	QoL, EOL burden
ENABLE I, II, **III** (**Bakitas**, JCO 2015)	QoL Pat & Caregiver, Survival
Japan (**Nakajima** JPSM 2014)	Communikation, QOL
Denmark (**Groenvold**, Pall Med 2017)	negativ (Intensity PC too low)
Italy (**Franciosi** ESMO 2016)	negative (contamination?)
Italy Pancreas (**Maltoni,** Eur J Cancer 2016)	QoL, aggressive EOLC
US (**Ferrel**, JPSM 2015)	Family QoL, Survival
Japan (**Murakami** BMC Pall 2015)	Survival
England (**Higginson** Lancet Resp 2015)	Qol, Survival

Early integrated Palliative Care improves Qol of patients *and* family members, prognostic awareness & depression and patient survival

Integration of PC into cancer care: where were the RCTs made?

Source	No. of Patients		Setting	Instrument	Disease
	Intervention	Control			
High risk of bias					
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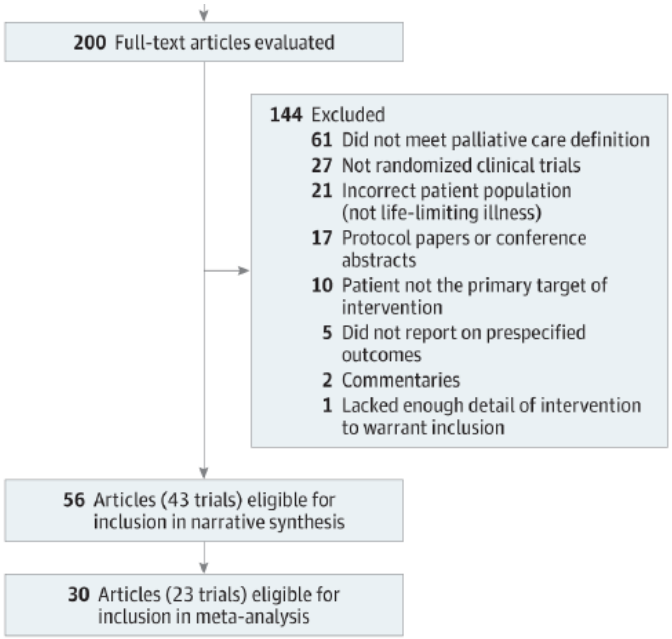
Wong et al,[10] 2016	43	41	Home	MQOL-HK	Heart failure
Subtotal (I^2 = 97.4%, P = .000)					
Low risk of bias					
Bakitas et al,[57] 2009	108	97	Home	FACIT-Pal	Cancer[f]
Higginson et al,[12] 2014	42	40	Ambulatory	EQ5D	Mixed[g]
Rummans et al,[59] 2006	47	49	Ambulatory	Spitzer	Cancer[d]
Temel et al,[60] 2010	60	47	Ambulatory	FACT-L TOI	Cancer[h]
Zimmermann et al,[8] 2014	140	141	Ambulatory	FACIT-Sp	Cancer[i]
Subtotal (I^2 = 0.0%, P = .500)					
Unclear risk of bias					
Bekelman et al,[13] 2015	172	180	Home	KCCQ	Heart failure
Grudzen et al,[11] 2016	39	30	Hospital	FACT-G	Cancer[j]
Northouse et al,[31] 2013	198	104	Ambulatory	FACT-G	Cancer[k]
Subtotal (I^2 = 33.3%, P = .223)					
Overall (I^2 = 94.8%, P < .001)					



Kavalieratos D et al. JAMA 2016;316(20):2104–14

Verheissungen auf das «Wundermittel», gepaart mit der Schwierigkeit als Onkologe Voraussagen über das Ansprechen zu machen können (?) frühe Vorbereitung aufs Lebensende behindern

Doctors want to give their cancer patients every chance. But are they pushing off hard talks too long?

By BOB TEDESCHI @bobtedeschi
SEPTEMBER 1, 2017

Schönes Denk-Paper:
Schilling G, Schulz-Kindermann F. Recent Results Cancer Res 2018;210:181-190

Bernard "Biff" Flanagan, 78, was diagnosed with esophageal cancer in late 2015 and later tried immunotherapy.
SANDY HUFFAKER FOR STAT

Aber: wahrhaftige Information reduziert Hoffnung nicht

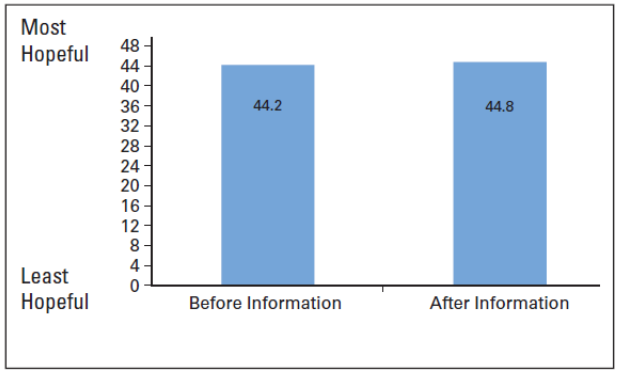


Fig 1. The effect of truthful information on the Herth Hope Index. Hope does not change with honest cancer information about prognosis and options. Data adapted with permission.[2]

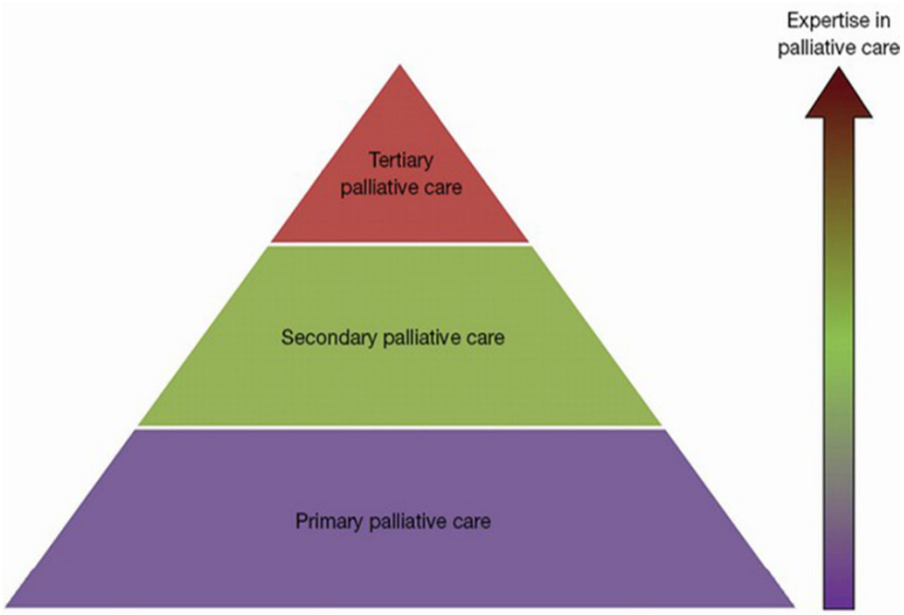
Smith T. Oncology 2010;24:521-5

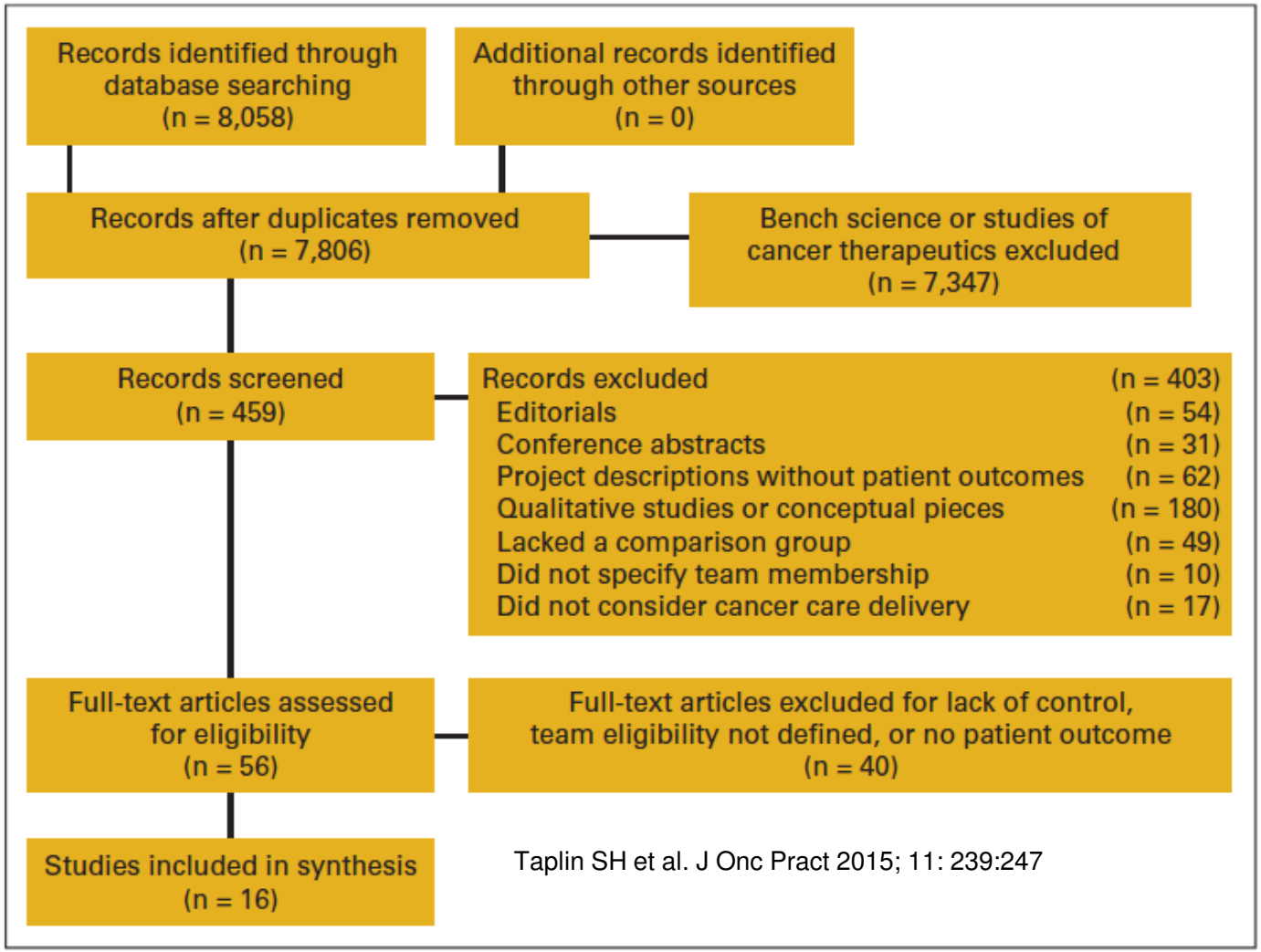
Optimistisch geprägte versus weniger optimistische Aussagen können Einschätzung von Patient über die Compassion des Arztes und Kompetenz (Wahl als primary oncologist) beeinflussen [1]
Weniger wenn eine (wirklich) schlechte Nachricht überbracht werden muss [2]

1: Tanco K et al. JAMA Oncol 2015;12:176-83 2: Tanco K et al. Oncologist 2018;23:375-82

→ Optimismus, resp. konkrete Hilfestellungen sind wichtig: z.B. EOL Preparation

Conceptual model of palliative care delivery based on provider expertise





Taplin SH et al. J Onc Pract 2015; 11: 239:247

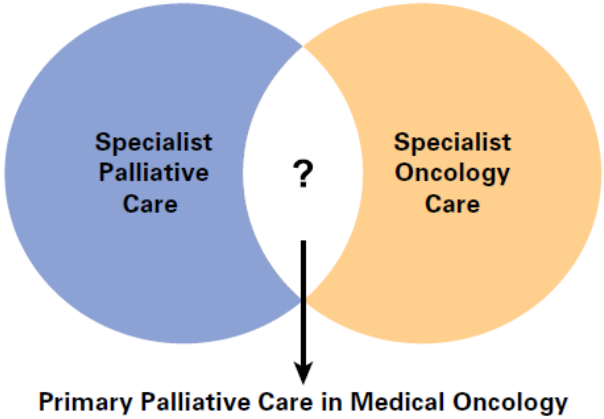
Another SLR on Teams

Teams improved screening use and reduced time to follow-up colonoscopy

Discussion of cases within MDTs improved planning of therapy, adherence to pre-operative assessment, pain control, and medications

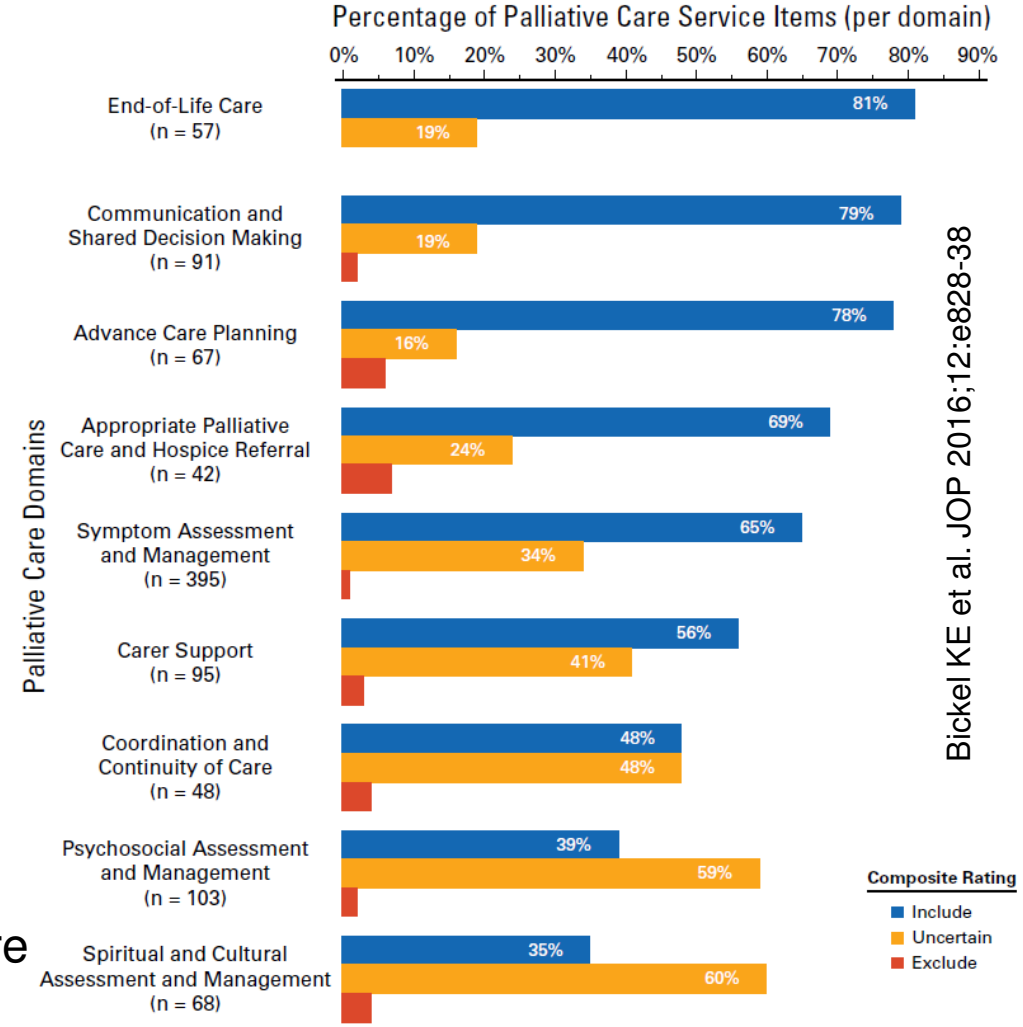
No convincing evidence
- that MDTs affect patient survival or cost of care,
- how or which MDT processes and structures were associated with success

Oncologists shall deliver which topics of specialized PC?



966 PC service items as candidate elements of primary PC for pts with advanced cancer or high symptom burden. Modified Delphi by 31 experts: importance, feasibility, scope within medical oncology practice.

Encourage oncologists to deliver Pall Care



Processes of Palliative Care Programmes at ESMO Designated Centres

Delivery of primary palliative care by outpatient oncologists	
Routine symptom screening available in oncology clinics	118 (78)
Proportion of patients with documented prognostic/illness understanding, median (IQR)	60 (25-80)
Proportion of patients with goals of cancer treatment explicitly stated, median (IQR)	80 (50-95)
Proportion of patients with end-of-life discussions documented in chart, median (IQR)	30 (15-50)
Proportion of patients with advance care plans documented in chart, median	20 (10-40)

Oncologist do and want to provide palliative care interventions

99 (65%) of ESMO-DCs: double-boarded physicians medical oncology & palliative medicine

Hui D, Cherny N, Latino N, Strasser F. Ann Oncol 2017 in press

Interdependency in Teams

Term	Definition
Group	Two or more people contributing to a common product who each perform their own specific work relatively independently of each other and do not depend upon the work of the other to complete their task[6]
Team	Two or more people who interact dynamically, interdependently, and adaptively to achieve a common valued goal, shared within the context of some larger group or organization[7]
Interdependency	The situation in which people are mutually reliant on one another in order to complete their work and achieve their goals[15]
Teamwork	The knowledge, behavioral skills, and attitudes that team members use to manage these interdependent tasks[14]

Taplin SH et al. J Onc Pract 2015; 11: 231:239