INTEGRATED ONCOLOGY AND PALLIATIVE CARE

An update

Rita Canário MD MSc

Florian Strasser MD ABHPM
OVERVIEW

- Approach to the patient with incurable cancer
- Contents and timeframe of Palliative Care
- Benefits of early Palliative Care
- The role of the Oncologist in Palliative Care provision
- Barriers and challenges for PC integration
APPROACH TO THE PATIENT WITH INCURABLE CANCER

What matters to people when approaching the End-of-Life (EoL)?

- Being involved in decisions about care
- Being comfortable with controlled symptoms
- Recognition of impending death and a sense of closure
- Affirmation/value of the self, with beliefs and values honoured
- Trust in care providers
- Relationships optimised with family and friends, burden minimised to family
- Family cared for, including bereavement support
- Death in preferred place of care
- Religious prayer or meditation
- Personal affairs in order
- Leaving a legacy

APPROACH TO THE PATIENT WITH INCURABLE CANCER

Where do people want to be taken care and die?

When faced with life-threatening illness, most people would rather die at home.

APPROACH TO THE PATIENT WITH INCURABLE CANCER

Healthcare resources use and costs in the EoL

Chastek B, et al., J Oncol Practice (2012);8:75-80. Reprinted with permission © 2012 American Society of Clinical Oncology. All rights reserved
APPROACH TO THE PATIENT WITH INCURABLE CANCER

Total pain

“Suffering that encompasses all of a person’s physical, psychological, social, spiritual and practical struggles.”

Dame Cicely Saunders

Dr Saunders with a patient at St Christopher’s Hospice
APPROACH TO THE PATIENT WITH INCURABLE CANCER

Palliative care needs in oncology

OVERVIEW

- Approach to the patient with incurable cancer
- Contents and timeframe of Palliative Care
- Benefits of early Palliative Care
- The role of the Oncologist in Palliative Care provision
- Barriers and challenges for PC integration
CONTENTS AND TIMEFRAME OF PALLIATIVE CARE

Palliative care
Supportive care
Hospice
Hospital-at-home
End-of-life care
Terminal care
Advanced care planning
Home
“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

http://www.who.int/cancer/palliative/definition/en/ By permission of the World Health Organization
CONTENTS AND TIMEFRAME OF PALLIATIVE CARE
ESMO definition (2003)

Diagnosis  Potentially curable  Incurable  Terminal  Bereavement

Supportive Care

Palliative Care

End-of-life Care

CONTENTS AND TIMEFRAME OF PALLIATIVE CARE
EAPC white paper (2009)

HAYWARD MEDICAL COMMUNICATIONS LTD.

Radbruch L, et al., European Journal of Palliative Care, 2009; 16(6); 278-289. White Paper on Standards and Norms for Hospice and Palliative Care in Europe: Part 1, by permission of Hayward Medical Communications Ltd.
“(...) combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden.”
CONTENTS AND TIMEFRAME OF PALLIATIVE CARE

Key Palliative Care values & principles

- Promoting dignity and autonomy
- Optimise quality of life
- Supporting decision-processes, advanced care planning and preparing transitions
- Multidimensional assessment and management of patient and caregivers
- Multi-professional approaches
- Relief of suffering across the trajectory of disease, continuous coordination of services including end-of-life & bereavement care

CONTENTS AND TIMEFRAME OF PALLIATIVE CARE

Cancer-specific symptoms & complications

Supportive Care: anticancer treatments side-effects alleviation or prevention

Cancer-“specific” palliative care issues

Anticancer interventions to improve symptom control

Cancer-specific communication processes
CONTENTS AND TIMEFRAME OF PALLIATIVE CARE

Key Palliative Care values & principles

Cancer-“specific” Palliative Care issues
OVERVIEW

- Approach to the patient with incurable cancer
- Contents and timeframe of Palliative Care
- **Benefits of early Palliative Care**
- The role of the Oncologist in Palliative Care provision
- Barriers and challenges for PC integration in Oncology
BENEFITS OF EARLY PALLIATIVE CARE

150 newly diagnosed metastatic NSCLC patients

1:1 Randomisation

Early palliative care + standard oncology care (n=77)

Meet the Palliative Care team 3 weeks after randomisation and at least monthly

Meet the Palliative Care team upon request

Standard oncology care (n=74)

Primary endpoint: QoL

Secondary endpoint: overall survival, mood, use of healthcare services, aggressiveness in the EoL

BENEFITS OF EARLY PALLIATIVE CARE

Study results:

Improved QoL in the intervention group for the total FACT-L scale, the LCS, and the Trial Outcome Index

Lower depression scores in the intervention group measured by HADS and PHQ-9

More aggressive end-of-life care in the control group (54% vs. 33%, p = 0.05)

Less advanced care planning documentation in the control group (28% vs. 53%, p = 0.05)

BENEFITS OF EARLY PALLIATIVE CARE

24 oncology clinics

1:1 cluster randomisation
Stratification by tumour site

Early palliative care + standard oncology care
Meet the Palliative Care team within 4 weeks after randomisation; monthly follow-up for 4 months

Standard oncology care
Meet the Palliative Care team upon request; follow-up as required

Primary endpoint: QoL
Secondary endpoint: symptom control, communication with healthcare providers, patient and caregiver satisfaction with care and caregiver quality of life

BENEFITS OF EARLY PALLIATIVE CARE

- Non-significant difference in change score for FACIT-Sp between intervention and control groups
- Significant difference in QUAL-E and FAMCARE-P16 favouring early PC group
- No difference in ESAS or CARES-MIS between intervention and control groups

**BENEFITS OF EARLY PALLIATIVE CARE**

**ENABLE II trial**

- **322 patients with newly diagnosed advanced cancer**
- **1:1 randomisation (patient and caregiver)**
- **Palliative Care intervention + standard oncology care**
- **Standard oncology care**

Meet the Palliative Care team within 4 weeks after randomisation; monthly follow-up for 4 months

Meet the Palliative Care team *upon request*; follow-up as required

**Primary endpoints**: patient-reported quality of life (QoL), symptom intensity, and resource use

**Secondary endpoint**: mood

_Bakitas M, et al., JAMA, August 19, 2009; 302 (7): 741-749_
BENEFITS OF EARLY PALLIATIVE CARE

Patient outcomes

### QoL

**Functional Assessment of Chronic Illness Therapy for Palliative Care**

- **Time (months):** BL 1, 4, 7, 10, 13
- **Score:**
  - **Intervention:** Mean 130, 140, 150
  - **Usual care:** Mean 120, 130, 140

### Symptom control

**Edmonton Symptom Assessment Scale**

- **Time (months):** BL 1, 4, 7, 10, 13
- **Score:**
  - **Intervention:** Mean 140, 150, 160
  - **Usual care:** Mean 130, 140, 150

### Mood

**Centre for Epidemiological Studies Depression Scale**

- **Time (months):** BL 1, 4, 7, 10, 13
- **Score:**
  - **Intervention:** Mean 140, 150, 160
  - **Usual care:** Mean 130, 140, 150

### Patients, No.

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<tr>
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<th>Usual care</th>
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</tbody>
</table>

Bakitas M, et al., JAMA, August 19, 2009—Vol 302, No. 7
BENEFITS OF EARLY PALLIATIVE CARE

ENABLE III trial

Patients’ outcomes:
- QoL
- Symptom control
- Mood
- 1-year survival
- Resources use
- Place of death

Caregivers’ outcomes:
- QoL
- Depressed mood
- Burden

Screen, recruit, consent PTs & CGs
Baseline demographics and questionnaires
Random assignment

EARLY GROUP
- Week 1 PC consult
- PT CYC 1 → CG CYC 1
- PT CYC 2 → CG CYC 2
- PT CYC 3 → CG CYC 3
- PT CYC 4
- PT CYC 5
- PT CYC 6
- Monthly follow-up calls

DELAYED GROUP
- Usual oncology care
- Week 1 PC consult
- PT CYC 1 → CG CYC 1
- PT CYC 2 → CG CYC 2
- PT CYC 3 → CG CYC 3
- PT CYC 4
- PT CYC 5
- PT CYC 6
- Monthly follow-up calls

Week 6 questionnaires
Week 12 questionnaires
Week 18 questionnaires & repeated every 8 weeks
For PTs who died, CG bereavement call
After-death questionnaires 12 weeks after death

BENEFITS OF EARLY PALLIATIVE CARE
ENABLE III trial

Patients’ outcomes:
- No differences in PROs (HQoL, mood, symptom control) at 3 months from enrolment
- 15% difference in 1-year survival for early PC group
- No differences in resources use (hospital admission, emergency visits or ICU admission)
- No differences in the place of death

Caregivers’ outcomes:
- Lower depression scores in the early PC group (mean difference, 3.4; SE, 1.5; d .32; P .02)
- No differences in QoL (mean difference, 2; SE, 2.3; d .13; P .39)
- No differences in demand burden (objective burden, stress burden and demand burden)

Bakitas M, et al., JCO 2015. 33 (13) 1438-1445
BENEFITS OF EARLY PALLIATIVE CARE

Early Palliative Care may **improve:**
- Patients’ and caregivers QoL and preparation of the EoL period
- Symptom control (physical and psycho-spiritual distress)
- Survival
- The likelihood of respecting patients’ preferences

Early Palliative Care may **reduce:**
- Use of healthcare resources (and indirectly costs) in the EoL
- Aggressive EoL care
OVERVIEW

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THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Models of Palliative Care integration

Solo Practice Model

Congress Practice Model

Integrated Care Model

Bruera E, et al., J Clin Oncol, 2010; 28 (25): 4013-4017. Reprinted with permission ©2010 American Society of Clinical Oncology. All rights reserved
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Core competencies in Palliative Care (EAPC 2013)

1. Apply the core constituents of palliative care in the setting where patients and families are based
2. Enhance physical comfort throughout patients’ disease trajectories
3. Meet patients’ psychological needs
4. Meet patients’ social needs
5. Meet patients’ spiritual needs
6. Respond to the needs of family careers in relation to short-, medium- and long-term patient care goals
7. Respond to the challenges of clinical and ethical decision-making in palliative care
8. Practice comprehensive care co-ordination and interdisciplinary teamwork across all settings where palliative care is offered
9. Develop interpersonal and communication skills appropriate to palliative care
10. Practice self-awareness and undergo continuing professional development

### The Role of Oncologists in Palliative Care Provision

**Skills (ESMO / ASCO 2016)**

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<tr>
<th>Supportive Care</th>
<th>Palliative Care</th>
<th>End-of-Life Care</th>
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<tbody>
<tr>
<td>Preventive and therapeutic strategies for common side effects of therapy</td>
<td>Recognizing patients in need for Palliative Care and triggers / criteria for referral to SPC</td>
<td>Disclosing prognosis in order to prepare patients to the dying process</td>
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<tr>
<td>Management of all cancer-related symptoms of any tumour entity</td>
<td>Pathophysiology of common cancer syndromes and pharmacology of medications used to treat main symptoms and to prevent toxicities</td>
<td>Communicate the benefits / limitations of anti-cancer therapies</td>
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<tr>
<td>Counseling on side effects of therapy</td>
<td>Plan and coordinate care in a MDT</td>
<td>Run effective family care conferences</td>
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<tr>
<td>Management of oncological emergencies</td>
<td>Comprehensive assessment of patients with complex symptoms</td>
<td>Establish patient preferences</td>
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<tr>
<td></td>
<td>Compassionated communication with patients and families</td>
<td>Identify refractory symptoms that require SPC, namely palliative sedation</td>
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<tr>
<td></td>
<td>Personal plan to self care and to prevent burnout</td>
<td>Coordinate referrals to home care, nursing homes and hospice</td>
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</table>

ESMO / ASCO Recommendations for the Global Curriculum in Medical Oncology – edition 2016
THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

High-quality palliative care in oncology practice (ASCO / AAHPM guidance statement 2015)

1. Symptom assessment and management
2. Psychosocial assessment and management
3. Spiritual and cultural assessment and management
4. Communication and shared decision-making
5. Advance care planning, including ethical and legal issues
6. Coordination and continuity of care
7. Appropriate palliative care and hospice referral
8. Caregiver support (family/caregiver and staff)
9. End-of-life care

Bickel KE, et al., J Clin Oncol 33, 2015 (suppl 29S; abstr 108)
Levels of Palliative Care provision

- **Specialist Palliative Care**
  - Provided in services whose main activity is the provision of palliative care

- **General Palliative Care**
  - Provided by primary care professionals and specialists treating patients with life-threatening diseases.

- **Palliative Care approach**
  - Provided in settings not specialised in palliative care. Core medical training

Radbruch L, et al., European Journal of Palliative Care, 2009; 16(6); 278-289
THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Disease-modifying management in advanced and incurable cancer

- Pain
- Local pressure
- Obstruction
- Bleeding

- Radiation oncologist
- Interventional radiology
- Surgeons
- Medical oncologist

- Bleeding
- Obstructive symptoms
- Functioning metastasis
- Wounds / Fistulae
- Malignant effusions
- Splenomegaly
THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Treatment-related decision-making process in advanced cancer

- OS
- PFS
- RR
- etc.

Disease control

Toxicity

- Doctors graded-symptoms
- Lab results
- Imaging criteria
- Physical exam
THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Treatment-related decision-making process in advanced cancer

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Magnitude of Clinical Benefit Scale (ESMO 2015)

THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Anti-cancer treatment to alleviate or prevent cancer-related suffering

THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

Anti-cancer treatment to alleviate or prevent cancer-related suffering

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<tr>
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<th>Prevented</th>
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THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

“Best supportive care” arm in clinical trials

Four domains for delivery BSC in clinical trials:

- Multidisciplinary care, documentation, symptom assessment and symptom management

THE ROLE OF ONCOLOGISTS IN PALLIATIVE CARE PROVISION

“Best supportive care” arm in clinical trials

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<td>Conformance to BSC consensus standards in clinical trials</td>
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<td>Standardized BSC across sites if multisite</td>
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<td>BSC delivery standardized</td>
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<td>Clear description of BSC</td>
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<td><strong>Symptom assessment at regular intervals</strong></td>
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<td>Symptom management is evidence based</td>
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<td>Reported educating patients about symptom management</td>
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<tr>
<td>Reported educating patients about goals of therapy</td>
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</tr>
<tr>
<td>Provided access to palliative specialists</td>
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<tr>
<td>Provided access to support services</td>
<td>11%</td>
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<tr>
<td>Education about goals, importance of symptom assessment/management</td>
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| Conformance to consort checklist for RCT’s | |
| Eligibility criteria | 100% |
| Documentation of settings | 11% |
| Interventions described sufficiently | 0% |
| Generalizable results (must have met all three of the above CONSORT criteria) | 0% |

Abbreviations: BSC = best supportive care; RCT = randomized controlled trial.

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BARRIERS AND CHALLENGES FOR PC INTEGRATION

Attitudes of medical oncologists towards Palliative Care

ESMO Taskforce on Palliative and Supportive Care survey (2003)

The majority of the oncologists agreed that:

- All advanced cancer patients should receive concurrent palliative care, even if they are receiving antitumour therapies
- All cancer centres should have a palliative care service
- Medical oncologists should coordinate the care of cancer patients at all stages of disease, including end-of-life care
- Medical oncologists should be expert in the management of the physical and psychological symptoms of advanced cancer
- I am usually successful in managing my patients’ pain

There were polarised answers:

- I received good training in palliative care during my oncology fellowship
- I feel emotionally burned out by having to deal with too many deaths
- Most medical oncologists I know are expert in the management of the physical and psychological symptoms of advanced cancer
- A palliative care specialist is the best person to coordinate the palliative care of patients with advanced cancer
- Palliative care physicians do not have enough understanding of oncology to counsel patients with advanced cancer regarding their treatment options

Cherny NI, and Catane R, Cancer, 2003; 98(11):2502-10
BARRIERS AND CHALLENGES FOR PC INTEGRATION

Oncologists’ factors that may influence referral

Oncologists’ views of palliative care
- Alternative to anti-cancer therapy
- Complementary to anti-cancer therapy
- Evolving views of palliative care

Oncologists’ self-defined professional role
- Includes providing palliative care
- Focused on anti-cancer therapy

Knowledge of available services of Palliative Care

BARRIERS AND CHALLENGES FOR PC INTEGRATION

Possible barriers to integration of Palliative Care for haematologic cancers

Unpredictable disease trajectory

Different languages between palliative care and haematologists

Unclear treatment goals / focus on healing

Hyper-Optimistic care / unclear boundaries between curative and palliative

Unawareness of goals of palliative care for haematologic cancers

Oncologist remains involved in care until patient’s death and beyond, co-ordinating in a responsible, committed, skilled manner.

Palliative Care Specialists needed:
- Policy
- ASCO
- ESMO
- Co-management (shared-care), education, academic palliative care

Challenge:
assure both broad care AND high quality
BARRIERS AND CHALLENGES FOR PC INTEGRATION

Actions to support the extension and strengthening of services for palliative care:

- National policies that integrate evidence-based palliative services into the continuum of care
- Promote universal health coverage and essential medicines policies
- Education about palliative care to students in undergraduate medical and nursing schools
- Adequate access to controlled medicines
- Access to all aspects of palliative care, under the supervision of trained health care professionals, as appropriate
- Ethical guidance related to the provision of palliative care, in areas such as equitable access, respectful care and community involvement in policies and programs
- Working in partnership with different sectors to foster operational research in palliative care, including the development of cost-effective models of such care
- Committed leadership

WHO report “Strengthening of palliative care as a component of integrated treatment throughout the life course” (2013).
By permission of the World Health Organisation
BARRIERS AND CHALLENGES FOR PC INTEGRATION

Major indicators of integration of Palliative Care into Oncology

1. Presence of palliative care inpatient consultation team
2. Presence of palliative care outpatient clinic
3. Presence of interdisciplinary palliative care team
4. Routine symptom screening in the outpatient oncology clinic
5. Routine documentation of advance care plans in patients with advanced cancer
6. Early referral to palliative care
7. Proportion of outpatients with pain assessed on either of the last two visits before death
8. Proportion of patients with 2 or more emergency room visits in last 30 days of life (negative indicator)
9. Place of death consistent with patient’s preference
10. Didactic palliative care curriculum for oncology fellows provided by palliative care teams
11. Continuing medical education in palliative care for attending oncologists
12. Combined palliative care and oncology educational activities for fellows/trainees
13. Oncology fellows have routine rotation in palliative care

Patients with incurable cancer present palliative care needs throughout the continuum of their disease.

There is increasingly robust level 1 evidence of the benefit of palliative care for patients and caregivers.

Oncologists must acquire core competencies to provide generalist palliative care.

Overlapping roles and unclear goals of care are among the barriers to integration.
YOUR SKILL AND COMMITMENT DESERVE RECOGNITION. JOIN ESMO: THE EUROPEAN REFERENCE FOR ONCOLOGY.

For more information about ESMO please visit esmo.org
THANK YOU!