ESMO PRECEPTORSHIP SUPPORTIVE & PALLIATIVE CARE
SESSION 2

“RECIPROCAL EDUCATION AND TRAINING BETWEEN ONCOLOGISTS AND PALLIATIVE, SUPPORTIVE AND REHABILITATIVE CARE”

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Role of oncologist in cancer care
Global curriculum
Integration of palliative, supportive and rehabilitative care in oncology
Integration models-learning from palliative care
Curricula – follow your passion(s)
Endeavour to find out

Friday February 1, 2019 / 11:20-11:45
Novotel Lugano
Institutional financial interests (KSSG): Unrestricted industry grants for clinical research: Helsinn, Celgene, Fresenius  Participation in company-lead clinical trial: Novartis

Leadership roles: Society on Sarcopenia, Cachexia and Wasting Disorders (SCWD): Board member – Swiss Society Medical Oncology: National representative oncological rehabilitation - European Society for Medical Oncology, Palliative and Supportive Care / Designated Centers Working Group: past Chair (2014-2017) - Swiss Group Clinical Cancer Research (SAKK), Working Group Supportive and Palliative Cancer Care: past Chair (2002-2016) - Multinational Association of Supportive Care in Cancer (MASCC), Working Group Nutrition and Cachexia: past Co-Chair (until 2016)

PUNCTUAL advisorship (advisory boards, expert meetings) that have been paid to my institution - not to me directly: Danone, Grünenthal, Helsinn, ISIS Global, Mundipharma, Novartis, Novelpharm, Obexia, Ono Pharmaceutical, Psioxus Therapeutics, PrIME Oncology, Sunstone Captial, Vifor
How does an oncologist think? ¹

- Understand mechanism to attack individually
- Make tumor visible: Spread & Activity
  
  - CEA
  - CA 19-9
  - NSE
  - Ca72-4
  
- Multidisciplinary cancer therapies: Surgery, Radiation, Drugs
  → Survival
  → Tumor control or «Response»

Waterfall-Plot: Tumorsize
\textbf{How does an oncologist think?} \textsuperscript{2}

\begin{itemize}
  \item \textit{Oncologist judges toxicity according to standards}
  \begin{itemize}
    \item The so called «\textit{clinical Benefit}» is often judged according to response (CR, PR, SD)
    \begin{itemize}
      \item To directly judge cancer-associated symptoms and syndromes, it may be better to assess: «\textit{patient-derived clinical benefit}»
    \end{itemize}
  \end{itemize}
  \item \textsuperscript{1}Ohorodnyk P, et al., Eur J Cancer 2009;45:2249-2252

\rightarrow But patient does not value how burdensome side effects are
\rightarrow Prolonged low intensity side effects can be more burdensome than short term severe
\end{itemize}
Problems of «pure» oncologist thinking

«sees the tumor often not the patient, being a whole person»

«main decisions rely on efficacy data from survival and tumor response, very rarely on patient-derived clinical benefit»

«Tumor response and symptoms are only partially linked»

«explicit goals of anticancer treatment (defined symptom[s], when, how measured) or concrete likelihoods are most often missing»
Problems of «pure» palliativist thinking
(*being oncology illiterate*)

«sees the (whole) patient, often not the patient living with the maybe by modern anticancer treatment influencable tumor»

«decisions often too end-of-life focused, too often advocating to stop futile treatment, (peaceful) death advocates in patients asking for hope»

«palliativist tools do not include mechanism-based (anticancer) tools»

→ Many patients are referred too late (US hospice 19 days before death), are afraid to enter Palliative RCT, attend «palliative» clinics
Oncologists perspectives of specialized Palliative Care

In-depth phone interviews (semi-strct) with 31 practicing oncologists
Snowball & maximum variation sampling*, purposeful national sample
Multiphase qual. analysis, matrix & thematic analyses, theme exhaustion

- PC appropriate throughout disease trajectory, largely provided at EOL
- Oncologists 3 schools of thought) no own PC, mixed, do PC alone
- Under-availability of outpatient PC
- Poor communication about prognosis & care plans: provider tension
- PC a “team of outsiders” with too narrow focus of care
- Academic-based PC evidence not generalize to community practices

Improve interface Onc/PC: clear division of responsibility, in-person collaboration, sharing of non-physician palliative team members

## Oncologists referral to outpatient specialist palliative care (academic, U.S.)

Semi-structured interviews of 74 medical oncologists and survey from 4 centers*

<table>
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<tr>
<th>Main oncologist barriers to subspecialty palliative care referrals¹</th>
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<td>• persistent conceptions of palliative care as an alternative philosophy of care incompatible with cancer therapy</td>
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<td>• predominant belief: providing palliative care is an integral part of oncologist’s role</td>
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<td>• lack of knowledge about locally available services (all have outpatient pall care)</td>
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<th>Hematology-Onco rarely refer patients (40%), believe Pall Care is mainly EOL care</th>
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<td>Solid-Onco more often refer patients (74%), Pall Care assist with complex cases²</td>
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| Patients with unmet physical / emotional needs: specialized Pall Care highly needed³ |

→ Different «types» of oncologists (maybe generation, maybe training)  
→ Requires clinical triggers when referral to specialist Pall Care is needed

* 3 NCCN-Compr Cancer Cntrs, 1 academic CC outpatient Pall Care

Challenges of a total integration model between oncology and palliative care

Competence

- Oncologist: competence in palliative care
  - Palliative medicine: competence in oncology
- Competence of palliative care and oncology care in community health care level is limited

Patient mix

- Curative, life-prolonging, and palliative care in the same clinics
- Volume of palliative care in community health care specifically for the general practitioners (0-3 patients per year)

Level and amount of availability from the hospital palliative care team to home care is limited

Reimbursement: 2 levels of economy

- Budgets for primary and specialized care separate
- Professionals hired by different bodies
Who should deliver which Palliative Care Interventions? Medical Oncologist Role different from Pall Care Specialist?

Figure 2. Elements of palliative care (PC) vs oncologic care visits at clinical turning points. EOL indicates end of life.
Multidimensional symptom management and communication including illness understanding, decisions, EOL and rehabilitation, patient and family integration of palliative interventions in multidisciplinary routine care.
Role of Oncologist from patient-perspective

Cancer patients trust their doctors¹:
Oncologists inform patients & facilitate EOL-Decision making²

Roles are debatable: primary physician or oncology team or palliative care specialist³

Pts’ preferences for physician behaviours: knowing me - family roles, life history and values and priorities; conditional candour - assess pts’ readiness, invited to conversation, sensitive information delivery⁴

1,231 pts with direct cancer: EOL-discussion (DNR or hospice) wt physician (88%)⁵
Less aggressive EOL (p<.001; Chemoth <14days 16%, acute care <30days 40%, no hospice 42%)

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.

Palliative Care Specialists: **Encourage** oncologists to deliver Pall Care
Patients with advanced cancer should receive palliative care services, which may include referral to a palliative care provider.

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

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

**Palliative Interventions**

- Family support
- Symptom Mgmt
- Illness & Prognosis
- Decision process
- EOL-prepare, Spiritual
- Decision process
- Continuity of care
- Continuity of care
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)

- Illness understanding (prognosis, mechanism, trajectory)
- Symptom control (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, ..)

Onco-Pivotal Pall Interventions
Palliative-Pivotal Pall Interventions

3728 pts & caregiver rated **26 concerning issues** of support related to their cancer\(^1\). 91% „making decisions“ about care in top categories important & very important. Lung cancer rank 3/26, breast cancer 4/26.

Syst Lit Rev 5 databases decision making\(^2\) 37 articles (original research, western, adult) Majority pts **want participate** in DM process Most not achieve level of involvement:
.- Decisions are delayed
.- Alternative treatment options not discussed

Anticancer treatment close to end-of-life «aggressive», if no spec. Pall Care unit\(^3\)

**Decision support Intervention**

**Preparing the decisional encounter**\(^4\)
.- Consider emotional burden of patient
.- Assess illness & prognosis understanding
.- Check individual meaning of hope
.- Relate symptoms to cancer disease
.- Address family emotional / logistic burden
.- Discuss preparation for End-of-Life
.- Ask for preferred decisional involvement

**Decision**\(^4\)
.- Define specific goal, when & how measure
.- Inform about non-abandonment if no Tx
.- Prepare worst & best case scenarios
.- Empower pts to cope with & report toxicity

1: Gralla RJ Supp Care Cancer 2011;19(S2);S160
4: Ribi K [...] Strasser F; submitted
Preparing for End-of-life Intervention

Evidence That Early Communication About Goals of Care and End-of-Life Preferences Improves Care

End-of-life conversations are associated with better quality of life, reduced use of life-sustaining treatments near death, earlier hospice referrals, and care that is more consistent with patient preferences.

Patients who received early palliative care showed significant improvements in quality of life and mood, and survived 25% longer.\(^b\)

Patients who engaged in advance care planning were more likely to have their wishes known and followed.

Preparation for the end of life is associated with improved bereavement outcomes for family.


Introduction is (cost-) effective\(^1\)

- Discuss living will, DNR, value-based diagnostic / therapeutic interventions
- Solve legal and financial issues
- Support concrete legacy work (dignity therapy\(^2\), narratives, books)
- Use of remaining life time & finish business: dreams, duties, people, etc.
- Support pre-mortal grief work
- Preferred place of death, funeral
- Care in dying phase (awakeness, skin care, pastoral care, catheter, etc.)
- Prepare family for after death roles

1: Zhang B Arch Int Med 2009;169:480-8
2: Chochinov HM Lancet Oncol 2011;12:753-6
Martinez M Palliat Med 2016 Aug 28
Patient needed palliative interventions are delivered by a specialist palliative care who is at the same time a medical oncologist (or lots of expertise)
### Processes of Palliative Care Programmes at ESMO Designated Centres

#### Delivery of primary palliative care by outpatient oncologists

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<th>N</th>
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<tr>
<td>Routine symptom screening available in oncology clinics</td>
<td>118</td>
<td>78</td>
</tr>
<tr>
<td>Proportion of patients with documented prognostic/illness understanding, median (IQR)</td>
<td>60</td>
<td>25-80</td>
</tr>
<tr>
<td>Proportion of patients with goals of cancer treatment explicitly stated, median (IQR)</td>
<td>80</td>
<td>50-95</td>
</tr>
<tr>
<td>Proportion of patients with end-of-life discussions documented in chart, median (IQR)</td>
<td>30</td>
<td>15-50</td>
</tr>
<tr>
<td>Proportion of patients with advance care plans documented in chart, median</td>
<td>20</td>
<td>10-40</td>
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**99 (65%)** of ESMO-DCs: **double-boarded** physicians medical oncology & palliative medicine

**Oncologist (at ESMO DC Cntrs…) do and want to provide palliative care interventions**

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How does an palliative oncologist think? 1/3

- Does the patient understands illness and prognosis?

  «tell in own words, what you did understand how is your situation» worst case and best case scenario and its concrete meaning for the patient: days-weeks-months-years

- How does the cancer makes the patient sick? Are the symptoms cancer-disease related or not?

  Systematic assessment: proactive, quantiative, multidimensional
  Symptoms in relation to cancer-localisation and -dynamic
How does an palliative oncologist think? 2/3

- *Is concrete preparation for end-of-life, using of remaining life time thematisized according to patients will?*
  → *does the patient postpones important processes for «unpecific» hope?*

Advanced directives
Testament, legacy work, using of remaining life time, «again..»
Premortal grief work with important people
Prepare family members to the postmortal role
What gives meaning and joy in life?
How does an palliative oncologist think?

- How is the tumordynamic and how likely is it influencable by anticancer treatment?
  Tumorbiology and modern anticancer agents
  Dynamics symptoms & syndromes, markers, imaging

- Which decision criteria for chemotherapy in palliative Intention (CPI) are considered?
  Individual meaning of cancer-associated symptoms
  Concrete meaning of considered prolongation of life time
  Individual significance of ALL side effects cancer therapy

- How likely are which toxicities expected? (= supportive care)
  Required to apply cachexia-based dosing of chemo?
  Co-morbidities tailored chemodosing
What is required to improve oncologists delivery of all palliative interventions and adequate (based on patient- and family needs) early referral to specialist palliative care?

**Structured education of oncologist in palliative care** → 3 months rotation in a specialized palliative care service providing main clinical structures (palliative unit, consult team, outpatient clinic, community care)

**Collection of quality care data** (to convince directors & policy makers)
- Patient and family satisfaction & Quality of life
- Anticancer treatment effectiveness & toxicities, survival
- Health services use: unplanned hospitalisations, ER, ICU

**Structured oncology education for palliative care specialists**
- Oncology training of >= 1 year
- Joint continuous education oncology and palliative care
Reciprocal education rehabilitation & supportive care and oncology

Structured education of oncologist in cancer rehabilitation \(\rightarrow\) 3 months rotation in a inpatient cancer rehabilitation clinic and/or joint curricula: 40/60% in oncology and in rehab

Structured education of oncologist in supportive care \(\rightarrow\)
Few options in structures: rotate international, or ESMO DC

Structured oncology education for cancer rehabilitation specialists
- Oncology training of \(\geq\) 1 year (or more)
- Joint continuous education oncology and rehabilitation
Conclusion

As oncologists patients expect them to deliver palliative, supportive and rehabilitative interventions, so training is needed.

Also palliative care specialists and cancer rehabilitation clinics need mandatory oncology training and continuous education, ideally joint.

Palliative and rehabilitative oncologists may become a «new brand».