FCO • 15(1) • 2024 • 4–13
DOI: 10.2478/fco-2023-0038

sciendo

Forum of Clinical **Oncology**

The implementation of palliative care in Greece: a position paper by the Palliative Care Working Group of the Hellenic society of Medical Oncology (HeSMO)

Research Article

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Received 5 March 2024; Accepted 18 June 2024

Abstract: The global burden of cancer continues to rise, with projections indicating a 47% increase in new cases by 2040. The integration of oncology and palliative care has emerged as a vital approach to address the complex needs of cancer patients. This position paper, endorsed by the Palliative Care Working Group of the Hellenic Society of Medical Oncology (HeSMO), emphasizes the significance of early integration of palliative care with cancer-directed therapies. It highlights the benefits of this approach, including improved quality of life, symptom control, emotional well-being, and enhanced survival rates for patients. The paper also addresses the challenges of palliative care provision in Greece and advocates for comprehensive education for health-care professionals, especially oncologists and nurses, to effectively manage palliative care needs. The importance of multidisciplinary teams (MDTs), survivorship care plans (SCPs), home-based palliative care, and end-of-life care discussions is underscored. By aligning with international guidelines and recommendations, HeSMO strives to establish a supportive health-care system in Greece that offers equitable access to high-quality palliative care for all cancer patients, thus ensuring their well-being throughout their cancer journey.

Keywords: *palliative care • supportive care • Greece*

1. Introduction – Epidemiology

In 2020, there were approximately 19.3 million new cancer diagnoses and 10 million cancer-related deaths worldwide. Projections indicate that by 2040, the global number of new cancer cases will increase to 28.4 million, marking a significant 47% rise from 2020. Alongside this, the growing population of cancer survivors represents another major global challenge[1,2].

Numerous randomized trials have provided substantial evidence supporting the benefits of integrated oncology and palliative care (PC) for patients with cancer[3-12]. As a result, it is now widely recognized that PC should be integrated with cancer-directed therapy regardless of the treatment intent or prognosis to ensure optimal outcomes in patient care.

In 2014, the World Health Organization (WHO) recognized PC as a crucial medical and ethical necessity,

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emphasizing the importance of formulating and implementing policies to integrate effective PC plans into national health systems[13]. The WHO's promotive phrase for PC, "Leave no one behind," aims to inspire governments to establish PC policies that cater to the needs of the estimated 40 million individuals (including at least 20 million carers) worldwide, who will require PC support by 2030. Despite this initiative, less than 10% of patients in low- and middle-income countries who require PC receive it[14].

In Greece, there were approximately 64,530 new cancer diagnoses in 2020[2]. The Feasibility Study for Palliative Care in Greece estimates that each year, there is a need for PC services from 120,000 to 135,000 patients and their families. Notably, around 37% of this demand for PC in Greece is attributed to cancer patients[15].

This position paper was collaboratively prepared by the Palliative Care Working Group of the Hellenic Society of Medical Oncology (HeSMO). Its primary objective is to emphasize the significance of integrating cancer-directed and PC approach, thereby promoting and supporting patient-centered care. The paper also sets priorities for actions, endorsed by HeSMO, with the goal of establishing and maintaining a supportive system that ensures universal access to high-quality PC for all cancer patients in Greece.

2. Definition of PC and supportive care

The term "PC" is utilized across various disciplines with varying meanings. Commonly used terms such as "supportive care," "palliative care," and "hospice care" have historically been inconsistently defined in the literature and are still sometimes used interchangeably and imprecisely[16]. While differences of opinion persist, there has been increasing agreement on the importance of standardized terminology to enhance administrative, clinical, and research procedures[17].

According to the definition by WHO (2014), "*palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual.*"[18] This definition highlights the distinctive focus and holistic approach of PC, setting it apart from the conventional disease-centered management of chronic illnesses.

The definition provided by The Multinational Association of Supportive Care in Cancer (MASCC) states that "*supportive care in cancer is the prevention and management of the adverse effects of cancer and its treatment. This includes the management of physical and psychological symptoms and side-effects across the continuum of the cancer experience from diagnosis, through anticancer treatment to post-treatment care. Enhancing rehabilitation, secondary cancer prevention, survivorship, and end-of-life care are integral to supportive care*"[19].

The ESMO Supportive and Palliative Care Faculty, considering both definitions, strongly advocates for the provision of PC to all cancer patients, starting from the time of diagnosis and throughout the cancer care continuum, including survivorship and end-of-life (EoL) care. ESMO has proposed the term "*patient-centered care*" to encompass both supportive care and PC, moving away from a generalized "one size fits all" approach to a more personalized care plan. This individualized approach takes into account the diverse physical, psychologic, social, existential, and spiritual needs of patients, which may evolve over time and at different stages of the disease[20].

HeSMO acknowledges the significance of these definitions in enhancing the comprehension of the concept and values of PC. In Greece, the official – and commonly accepted – term for PC is "anakoufistiki frontida – ανακουφιστική φροντίδα," which implies the concept of relief rather than palliation. The term "palliative" may carry a negative connotation for patients and loved ones, potentially leading to delayed referrals or reluctance to accept interventions, especially in cases where there is insufficient education or awareness regarding the scope of supportive care and PC[21,22].

3. Benefits of PC in oncology patients

The benefits of PC have now been shown in multiple clinical trials demonstrating that cancer patients who receive early PC input experience a multitude of advantages, including improved quality of life (QoL), enhanced symptom control, emotional wellness, improved survival, and, most importantly, reduced use of unnecessary aggressive treatments at EoL (3-12, 23-26) (see Table 1).

In the literature, there has been a documented increase in patient and provider satisfaction, greater discernment of and respect for choices regarding the place of death, fewer and less-intensive hospital admissions in the last month of life, reduced anxiety and depression, and diminished caregiver distress, underlying the importance of PC in cancer patients[27]. Although the primary goal of PC is not to reduce health-

Table 1: Benefits of palliative care.

Bakitas et al. 2009 (3)	Improved QoL and mood
Temel et al. 2010 (4)	Improved QoL, longer survival. Lower risk for depression and less aggressive care at the end of life
Zimmerman et al. 2014 (5)	Improved QoL
Temel et al. 2017 (6)	Improved QoL and mood
Vanbutsele et al. 2018 (7)	Improved QoL
Maltoni et al. 2016 (8)	Significant impact on some indicators of EoL treatment aggressiveness
Grudzen et al. 2016 (9)	Improved QoL
Bakitas et al. 2015 (10)	Improved survival
El-Jawahri et al. 2016 (11)	Improved QoL
Jordhoy et al. 2000 (12)	More deaths at home as the preferred place of death
Higginson et al. 2015 (23)	Improved QoL and symptom control
Ferrel et al. 2015 (24)	Improved QoL and symptom control
Kavalieratos et al. 2016 (25)	Improved QoL and symptom control
Haun et al. 2017 (26)	Improved QoL and symptom control

care costs, well-developed and structured PC services can not only enhance patient care, but also result in health-care savings attributed to the optimal use of health-care resources[28]. These savings are linked to a decrease in the number of emergency department visits, hospital admissions, and shorter in-hospital stays[29,30], as well as a reduced use of aggressive treatments in terminally ill patients[4,8], yet positively influencing patients' QoL. A recent meta-analysis confirmed these findings as hospital costs were found to be lower for patients seen by a PC consultation team compared to patients who did not receive such care. The estimated association was more significant for those with a primary diagnosis of cancer and those with more comorbidities compared to the ones with a non-neoplastic diagnosis and/or with fewer comorbidities[31].

The growing recognition of the benefits, which show significant health gains and improved utilization of health-care resources, highlights the emerging priority of developing and implementing PC services in health-care systems worldwide. HeSMO strongly supports the early initiation of PC concurrently with the commencement of anticancer treatment, such as surgery, systemic therapies, and radiation, throughout the cancer patient journey, including survivorship, and EoL care. It is essential to view PC and conventional cancer treatment as complementary concepts rather than competing options. HeSMO advocates for research efforts aimed at addressing the needs and challenges of making PC widely accessible in the community and promoting the seamless integration of PC with oncology care. This approach ensures that all patients receive comprehensive and holistic support throughout their cancer care journey.

4. Models of integration of oncology and PC

Both conceptual and empirical models have been proposed for the integration of standard oncology and PC. The former outlines broad theoretical principles, while the latter depicts how these principles can be applied to specific health conditions and systems. There are three basic conceptual models for integrating PC into oncology based on timing, provider, and the structure that provides such services[32,33].

The time-based model contrasts the traditional provision of PC, which was previously offered only at EoL. In the modern approach, PC is introduced at the time of diagnosis and is gradually increased until the time of death and mourning. This model stresses the importance of providing PC throughout the patient's journey, ensuring that one's needs are met at every stage of the disease[34].

The second conceptual model is based on the provider of PC, dividing services into primary, secondary, and tertiary levels of care according to the complexity of the patient's needs. Each level involves different specialties and degrees of care. Tertiary care, for instance, is primarily provided by physicians with specialized training in PC. In some models, primary and secondary PC is delivered by general practitioners (GPs), while in others, oncologists may be involved[35].

The third conceptual model is centered around the environment in which PC is provided. PC can be offered in various settings, including inpatient hospital consultation, dedicated palliative medicine units, hospital units, outpatient clinics, assisted living, long-term care facilities, and home-based care. The ideal setting for patient care is proposed to be the community, with PC being provided close to or at home, with occasional care in the hospital or hospice if and when necessary. In this model, GPs play a crucial role, supported by a team of specialists, with an emphasis on facilitating transitions between available health-care facilities[36, 37]. This implies that GPs should possess basic PC skills to meet patients' needs. However, an Australian survey revealed that 31% of GPs felt they had inadequate training and insufficient resources to provide home-based care to patients with advanced cancer, underscoring the need for focused education on the topic[38].

None of the existing conceptual models specifically address the transition between different levels of PC and health facilities or offer guidance on effective communication among health-care professionals. To address this gap, in 2019, another model was presented aiming to enhance the integration of oncology and PC[39].

This model advocates for standardized care pathways and referral guidelines, ensuring timely access to appropriate care for cancer patients. It proposes that oncologists with advanced PC skills provide most stages of care in cancer patients, while GPs manage PC in the community. PC specialists would handle complex issues at the tertiary level. Successful implementations of similar models have been observed in different countries[40-42].

HeSMO strongly advocates for the comprehensive integration of oncology and PC in Greece tailored to the specific needs and available resources of the Greek health system. This integration can be achieved by defining the individual model for integrated care, defining the essential professional competencies and skills needed to administer PC, establishing clear procedures and referral guidelines, and fostering collaboration among various health-care professionals within a standardized care pathway. To ensure integration, the provision of optimal PC services throughout Greece must be anchored by health-care policymaking at all levels of health care and by adequate recourse allocation within a national cancer plan.

5. Multidisciplinary teams

The groundbreaking Calman–Hine Report (1995) in the UK highlighted the significance of MDTs in cancer services, resulting in improved outcomes and reduced inequalities for patients compared to those managed by single clinicians[43]. The composition of the MDT, as well as its tasks and responsibilities, should be tailored to meet the specific needs of each patient according to the available resources[44]. PC MDTs may (and should) include physicians, nurses, rehabilitation specialists (physical therapy, occupational therapy, or rehabilitation medicine), chaplains, psychologists, and social workers. The inclusion of PC specialists further enhances the holistic management of patients with cancer[45]. A diverse range of physical, psychological, social, and spiritual needs evolve at different stages of the disease, and the inclusion of both medical and nonmedical professionals in MTDs is of utmost significance to address these needs[46].

HeSMO acknowledges the challenges and strongly supports the establishment of formally regulated and mandatory PC MDTs for cancer patients in Greece. In cases where a cancer center lacks the necessary structure to fulfill the PC needs of the patients, appropriate referrals should be made to other centers or trained professionals, such as physiotherapists, psychologists, and social workers, to ensure access to necessary interventions.

6. The role of oncologists in PC provision

The care of patients with cancer includes the relief of suffering and distress of patients and as such, PC is a core element of oncological practice. The rapidly evolving field of oncology with new treatment modalities that extend patient survival results in increased demands for PC provision. Oncologists should actively participate in MDTs that address complex PC needs and should learn how to collaborate effectively with other specialists and coordinate PC services for oncology patients.

However, as the demand for PC services grows, along with the shortage of specialty-trained/certified PC providers, or in regions with limited access to PC services, oncologists will be expected to take more active role as primary PC providers to effectively address and manage basic PC needs and to refer to PC specialists appropriately. Therefore, it is imperative that oncologists are adequately trained in and educated around PC principles, so that they are able to deliver better care for their patients[47,48].

In 2003, the European Society of Medical Oncology (ESMO) conducted a survey on oncologists' practices and attitudes toward palliative management and supportive care for cancer patients. The study revealed that while most ESMO oncologists recognize the importance of palliative and supportive care for advanced cancer patients, many felt inadequately trained for these tasks, and as a result, their actual participation levels were suboptimal[49].

Similarly, in Greece, a survey conducted by HeSMO in 2021 among Greek medical oncologists showed that they recognize the significance of PC for advanced cancer patients. They acknowledge that PC is an essential element of oncology care and expressed the need for further training and competency development[50].

HeSMO suggests that Greek medical oncologists need to develop basic PC skills and practices during their training to enhance the QoL of cancer patients. Important competencies include a solid knowledge of PC principles and practices, the ability to assess prognosis, symptom burden, functionality, QoL, and patients' social support systems, proper techniques for managing cancer and treatment-related symptoms, recognition of psychological, psychiatric, and social concerns, understanding of the boundaries of care as EoL care, and finally communication skills to appropriately address prognosis and goals of care.

7. PC at home

PC at home is widely regarded as the preferred option for most patients facing a terminal illness. To ensure effective delivery of such services in the outpatient settings, it is essential to establish robust community-based services that can cater to the diverse needs of patients and their families[51]. Central to the provision of PC at home are well-trained GPs and community nurses. These professionals play a crucial role in providing continuous care, managing symptoms, and addressing the physical, emotional, and psychological aspects of the patient's condition[52].

In addition to GPs and community nurses, the development and availability of PC teams can significantly enhance the effectiveness of home-based PC. These teams typically consist of specialized health-care professionals in PC, social workers, psychologists, and other experts who collaborate to provide comprehensive care tailored to each patient's unique needs[53]. These teams bring a multidisciplinary approach to address the complex medical, emotional, and social challenges that arise in PC situations[54].

HESMO suggests training of community-based teams of GPs and nurses in the management of PC needs as the first step to create an effective PC service at home. The collaboration and integration between primary care providers and oncologists are essential. By strengthening community-based services, establishing PC teams, and promoting seamless communication between health-care professionals, it is hoped that patients will have access to high-quality PC at a place they feel most at ease – their home.

8. Survivorship

Survivorship in the context of oncology encapsulates the phase that follows active cancer treatment, spanning from the conclusion of initial therapies such as surgery, radiotherapy, and systemic treatments to the entirety of an individual's life[55]. This phase has gained prominence due to the increasing number of cancer survivors and the heightened awareness of the challenges persisting beyond treatment[56]. It recognizes that the journey does not conclude with the end of treatment, but instead ushers in a new chapter marked by its own set of physical, emotional, and social challenges[57].

SCPs are comprehensive, personalized documents that outline long-term follow-up care and support for cancer survivors after they have completed active cancer treatment[58]. SCPs have shown promising outcomes in enhancing survivors' adherence to medical recommendations and understanding of survivorship care and late effects, while also assisting in the transition from the treatment to the survivorship phase[59]. These plans encompass relevant information for check-ups, screening, lifestyle guidance, psychosocial support, and strategies for managing treatment effects[60]. Integrating SCPs into routine clinical practice could enhance patients' experiences, empower self-management pathways, and improve communication with other health-care professionals.

HESMO emphasizes the necessity for national programs to support cancer patient rehabilitation and the implementation of SCPs in everyday clinical practice. These initiatives underscore the commitment to providing comprehensive survivorship care and ensuring that survivors' needs are met throughout their cancer journey.

9. EoL care

The term EoL is frequently employed with varying definitions[61,62]. The guidelines of the European Society for Medical Oncology characterize EoL as the care tailored to individuals with advanced disease during a phase of rapid physical decline, typically occurring within the last few weeks or months of life[63].

Implementing advanced care planning early during treatments with palliative intent, coupled with transparent conversations regarding the natural progression of the disease and the dying process, emerges as an imperative approach and necessitates excellent communication skills[64, 65]. Oncologists bear the responsibility of navigating emotional conversations, ensuring clarity surrounding potential outcomes, including discussing the sensitive topic of death[66]. The emphasis should center on comprehending patients' and families' priorities, elucidating available choices, and facilitating considerate foresight and planning, inclusive of the right to decline further treatments[67].

HESMO stresses the importance of oncology professionals training in EoL care, along with fostering collaboration with established hospices and experts in the field for ongoing education.

10. Levels of education in PC

While educational programs exhibit variations across European countries and globally, there are fundamental principles that should underpin all forms and levels of PC education. Two working groups endorsed by

the European Association in Palliative Care (EAPC) have issued guidelines outlining three primary levels and essential specific components that ought to be integrated into educational programs[68,69]. Within each of these three levels of education (basic, general, and specialist), the EAPC has delineated the requisite level of knowledge, skills, interdisciplinary thinking and reflective practice. These guidelines provide a roadmap for those involved in developing training initiatives, aligning them with the diverse demands of PC training.

In alignment with the EAPC recommendations, HeSMO has organized educational events in recent years and nurtured the continued professional development of Greek oncologists in the field of PC. Notably, among the eight 3-day seminars hosted by the Hellenic Academy of Oncology – an extensively organized and structured 2-year master's program in oncology offered by HeSMO since 2007 – one module is wholly dedicated to supportive care and PC. Moreover, in collaboration with ASCO, HeSMO organized a well-attended workshop on "PC" that attracted both junior and senior oncologists.

HeSMO strongly advocates for the development of specialty-specific curriculum for PC education and suggests structured PC rotations for all trainees. HeSMO aims to foster educational programs for PC, involving PC specialists in didactics in an effort to cover gaps in PC education. It is imperative that both medical and nonmedical professionals engaged in the management of cancer patients receive relevant training. Particular emphasis should be placed on training PC nurses, along with providing training opportunities for GPs. Lastly, HeSMO firmly supports the establishment of PC as a subspecialization for oncologists or other medical professionals with a specific interest in the field.

11. PC research challenges

PC and EoL care are areas that have not received sufficient research attention and funding. An analysis of the cancer research database maintained by the National Cancer Research Institute (NCRI) indicates that research focused on PC and EoL care for conditions related to cancer has consistently accounted for less than 1% of the total spending on cancer research in the UK, despite the country having well-established PC services[70].

PC trials present inherent challenges, including the prevalence of primarily single-center studies, the rapid deterioration of participants' health, and the occurrence of missing data due to disease progression[71,72]. Achieving the "gold standard" of randomized controlled trials within this context proves to be a formidable task. The need for high-quality evidence to shape current practices is commonly acknowledged in the global landscape of PC research[73]. Through collaborative partnerships, and focusing on addressing crucial priorities, PC research holds the potential to drive significant improvement for patients' as well as their families' QoL[74-76].

HeSMO is firmly dedicated to support research initiatives in PC within Greece and generating the essential evidence required for enhancing patient-centered care.

12. Conclusion

HeSMO, an organization dedicated to advancing cancer care in Greece, is firmly committed to ensuring high-quality treatment for all cancer patients. Toward this end, HeSMO strongly advocates for the full integration of oncology and PC right from the early stages of cancer treatment. This integration is considered as a prerequisite for promoting treatment outcomes, enhancing patients' QoL, and addressing the needs of families involved. To actualize this vision, HeSMO calls for immediate health policy initiatives aimed at establishing a robust PC model in Greece. This model should ensure equitable access, appropriate reimbursement, availability of well-trained PC professionals, and standardized care pathways connecting specialized services within the Greek health system.

HeSMO recognizes the pivotal role of oncology health-care professionals in delivering PC to cancer patients. As such, the organization is dedicated in offering educational initiatives to support medical oncologists in managing this demanding task. Furthermore, HeSMO is actively engaged in raising awareness about the significance of PC among health-care professionals and patients and strives to identify and overcome obstacles that hinder the acknowledgment of PC as an integral part of continuous cancer care. By working collaboratively toward these goals, HeSMO aims to provide comprehensive care and support to cancer patients nationwide throughout their journey.

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