

## THE INTERFACE BETWEEN PALLIATIVE CARE AND CANCER CARE: A NURSING PERSPECTIVE



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On the surface at least the key interface between palliative and cancer nursing centres on the similarities of the patient population served – people with cancer. Other images appear to imply vastly different knowledge and skills: the palliative care nurse exuding quiet calm and peaceful nurturing of the patient and family as death approaches; the cancer nurse skilled in the delivery of toxic substances, the management of complex central lines and dealing with life-threatening complications such as gram-negative sepsis. This image of the palliative care nurse as nurturer rather than skilled professional is reinforced by descriptions of palliative care nursing as epitomising the 'quintessential' spirit of nursing<sup>1</sup>.

While it is rightfully accepted that palliative care nursing offers patients excellence in good nursing care, this is not the same as suggesting that highly technical skills and physiological knowledge are not required to deliver good palliative nursing. However, the unskilled nurturer image was recently reinforced when a nurse seeking to enter palliative care after a life-time in the operating suite could not understand why she could not get a job in community palliative care and was advised to initially work in an inpatient hospice unit where she would be better supported to gain the necessary skills before working alone in the community. Her response – "But isn't it mainly holding hands and giving comfort?". Thus the common image of the interface between palliative and cancer nursing is that the former picks up when skilled care is no longer required. In contrast cancer nurses are often portrayed as unable to provide for the palliative needs of dying patients and indeed acute cancer services are often criticised for 'hanging on to their patients' and for 'treating beyond any reasonable expectation of benefit'.

To challenge these images this short paper will explore the changing nature of cancer care by examining traditional and contemporary views from a nursing perspective. The aim is to demonstrate that what separates these two areas of nursing is increasingly less important than what they share and that the ultimate aim of any consideration of the interface between cancer and palliative care services must be a closer working relationship for the benefit of people with cancer.

### The traditional view

The goal of care, cure or palliation, used to be the key to determining the difference between cancer and palliative care nursing. Cancer care was about cure and has been defined as the application of "knowledge and understanding of the biology of malignant disease, its natural history, and the

efficacy of different treatment modalities to the clinical management of malignant disease"<sup>2</sup>. The aim of this work and the expectation of the patient is that everything possible will be done to cure the disease or prolong life, despite the reality that this will not always be possible. The nurse's role was principally to deliver curative treatments safely, to prevent and detect treatment complications, to educate the patient and family about self-care to minimise the negative sequelae of treatment and to provide supportive care to assist the patient to cope, both physically and emotionally, with the effects of cancer and its treatment. More recently this role has extended to include prevention and early detection activities. While cancer nursing is not itself focused on the cure of disease but on the care of people experiencing treatment, nurses do contribute to survival outcomes. Nurses play a key role in the prevention and early detection of life-threatening complications of cancer treatment, a role that has contributed significantly to lower mortality rates in areas such as bone marrow transplantation and high dose chemotherapy.

In contrast to the cure focus of cancer care, palliative care is defined as "the active total care of patients whose disease is not responsive to curative treatment"<sup>3</sup>. The early hospice movement, the precursor to palliative care, largely developed as a reaction against the tendency to see death as avoidable, with the dying person cast as a failure of modern medicine<sup>4</sup>. However, increasingly palliative care is understood as having a role in the care of people earlier in the disease trajectory when outcome is unknown. This role centres on the reality that many people undergoing curative treatment still experience complex symptoms and face issues of meaning that may benefit from palliative expertise. Nurses working in palliative care have predominantly understood their role as commencing when curative attempts cease. Indeed some commentators argue for a clear separation between palliative and terminal care so that there is clarity of goal and a clear confrontation of the reality that the individual is going to die<sup>5</sup>. Palliative nurses therefore have principally undertaken roles in symptom assessment and management, therapeutic communication to assist dying people and their families to face their impending death, provision of physical care as the patient becomes more incapacitated, assisting the family to manage this care, and support of the family following the death of the patient.

Thus cancer and palliative care nursing were complementary, located at different ends of the disease trajectory, the latter becoming increasingly important as curative treatment options became exhausted. Palliative care nurses working in hospital consultancy teams had the most interaction with patients receiving active disease-modifying treatment and hospice nurses the least. However, there were and remain some significant tensions between the two fields of care and between nurses working in them. These tensions largely surround issues such as:

1. When is a cancer treatment such as chemotherapy or radiotherapy warranted in the palliation of someone no longer able to be cured?
2. Is it appropriate to refer a patient with a high need for palliative expertise to palliative services when active attempts to control or even cure the disease continue?
3. How can appropriate palliation be undertaken with minimal understanding of the underlying disease process?

The cancer treatment system is often criticised for treating beyond the possibility of benefit and for denying the reality that the patient is going to die. The palliative care system is often criticised for failing to understand the difficulties, for patients, family members and health professionals, associated with treatment cessation or for failing to draw on cancer-treatment expertise when appropriate for palliation, eg the use of radiotherapy for a painful bone metastasis.

### A contemporary view

The various views of palliative care traditionally represent either an add on once cure is no longer possible, or an increasing involvement over time (see Glare in this issue). These views fail to capture the changed trajectory of cancer to one of ongoing attempts to control the disease with periods of remission/disease control alternating with crises of increased disease activity or treatment complications, any of which may result in the death of the patient<sup>6</sup>. This changing disease trajectory portrays disease control as a key focus of cancer treatment, makes the transition to palliative care less distinct than ever and necessitates an increasing presence of specialist palliative care within acute cancer services. The distinction between cancer and palliative nursing also becomes increasingly blurred as palliative care is increasingly required by patients who continue to have life-prolonging treatments, yet face living with all of the complications of having advanced disease while preparing for a future death.

What does this mean for nursing in cancer and palliative care? For cancer nurses there is an increasing need to incorporate palliative care skills as core aspects of practice competence. The patients who present for cancer treatment are sicker, more physically dependent and face their impending death over longer periods of time with a chronic cycle of hope and uncertainty. This type of disease trajectory calls for a high level of continuity in service provision, the ability to recognise the limits of practice knowledge and a willingness to refer patients to those with greater skill in some aspects of the patient's care. It also means an increasing need for routine integration of allied health support into cancer care provision. Perhaps most important is a willingness by the cancer team to examine the outcomes of care in those situations where the transition to palliative care is imprecise, for example in bone marrow transplantation<sup>7</sup> and paediatric oncology<sup>8</sup>. Cancer care practitioners need to hear the questioning voice who asks why Mrs Jones, the 35 year old with metastatic melanoma, is being

offered more treatment when there was no response to the last treatment and her cancer continues to advance rapidly. They must also not be frustrated when an answer of "because she is 35" is thought to be insufficient justification for treatment continuation and willing to learn from others how to talk to the patient about reaching the end of disease-modifying options. A key benefit of true integration of palliative care in the acute cancer treatment setting is the provision of this kind of questioning, not as criticism, but as an opportunity to sit back and reconsider our approach to assisting patients with their treatment decisions.

For palliative care nurses this changing cancer trajectory brings challenges around the disease and treatment knowledge needed to provide safe and informed care for patients who might be receiving palliative care while continuing with disease-modifying treatments. This also involves accepting that patients and their families may want to continue with active treatment, perhaps in the form of a phase 1 or 2 clinical trial, despite knowing it is unlikely to benefit them directly.

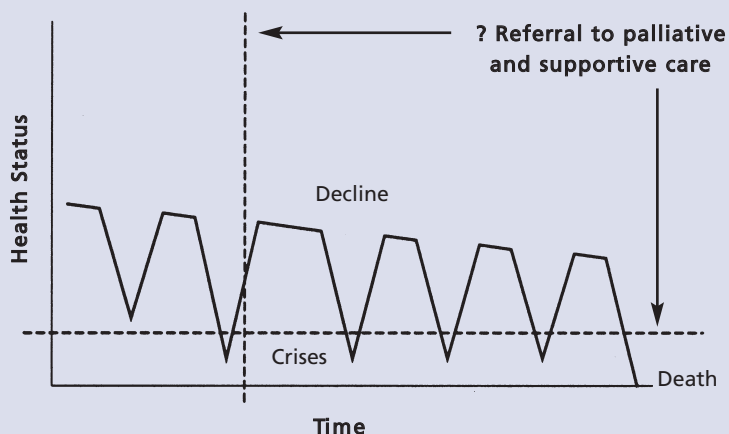
The key to enhancing the care of patients, particularly those with advanced cancer, is improved communication between practitioners in cancer and palliative care. In addition, increased communication will be required between the two service systems to ensure that the patient's needs are fully communicated and that the patient is skillfully assisted to make decisions regarding ongoing treatment. These changes will also necessitate the development of roles that work across both service systems, particularly ensuring continuity of care into the patient's home.

### Some professional challenges

Some professional challenges arise as this increasingly integrated care system evolves. Specialist nursing education is largely separate, with little crossover between cancer and palliative care. Education of cancer and palliative care nurses into the future will require a flexible curriculum that both allows subspecialisation (for example in malignant haematology or community-based palliative care) but also enables nurses wishing to work at the intersection of the two specialisations to be adequately prepared to do so.

A further challenge is the current difference in professional status between cancer and palliative care nursing. Cancer nursing in Australia is well organised and well represented in both cancer and nursing policy development. Palliative nursing is far less organised and is professionally isolated with the voices of palliative care being around service delivery (through Palliative Care Australia [PCA]) or medically-focused (through the Australian and New Zealand Society of Palliative Medicine). Palliative care nurses have been loathe to build their identity outside of PCA, laudably reinforcing the multidisciplinary nature of palliative care and the need to offer a united voice. However, this emphasis on a united voice has been at a cost to palliative nursing and contributes to the specialisation's low profile in nursing and lack of national voice in healthcare. A partnership between cancer and palliative nurses at a national and local level is essential for the future development of palliative nursing and for both specialisations to retain contemporary relevance in the care of people with cancer.

#### Advanced illness marked by slow decline with periodic crises and "sudden" death



## Summary

The interface between cancer and palliative care nursing has traditionally centred on caring for a similar population of patients but at different parts of the disease trajectory. Changes in the cancer disease trajectory, brought about by an increased ability to provide non-curative but disease-modifying treatments has increased both the length of the disease trajectory and its chronic nature. This is also an area of increasing consumer participation in healthcare decision-making and improved patient access to information that increases their expectations around quality care, including service continuity. As a consequence future health services will require closer integration of cancer and palliative services that allows patients receiving disease-modifying treatments equal access to the benefits of specialist palliative care. Thus nurses in cancer and palliative care will need to work more closely together if continuity and excellence of care are to be achieved.

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