

Letter from the editor

Supportive and palliative care

The introduction of the Supportive and palliative care section in *BMJ Clinical Evidence* is timely, as it comes exactly 40 years after the opening of St Christopher's Hospice in London, and 20 years after the establishment of the medical speciality of palliative medicine in the UK. These two historic events are significant in that they have, in different ways, helped to set in motion the scientific basis of supportive and palliative care. The systematic reviewing of the evidence base behind supportive and palliative care is the rationale for this section. The section also contributes to the growing evidence base for the discipline highlighted in the National Knowledge Week on Pain in Palliative and Supportive Care recently held by National Library for Palliative and Supportive Care.[1]

The modern hospice movement, created by Dame Cicely Saunders through St Christopher's Hospice, and her inspiring writing, opened up the possibility of applying modern methods of medicine and nursing to the care of terminally ill cancer patients.[2] Dr Robert Twycross, who conducted randomised studies of opiates for pain — including Brompton's cocktail and diamorphine solution — while a Research Fellow at St Christopher's, was among the first to bring scientific rigour to this field. In recent years, the hospice concept has evolved into something much wider than institutional resting places for those dying of cancer and other terminal diseases. 'Hospice' now embraces aspects of health, social, and spiritual care delivery systems in the community as well as hospital sectors. However, palliative care — a phrase born originally as a euphemism for hospice care — remains to this day sharply focused on the terminal phase of chronic and progressive illnesses.

The World Health Organization has recently updated and expanded its definition of palliative care to encompass care that improves quality of life from the outset of a life-threatening disease. [3] In practice, palliative care becomes activated as a healthcare system after disease-directed therapies such as cancer treatments, or COPD pulmonary rehabilitation, have been attempted and failed.

However, from a humane point of view, in chronic illnesses, it seems unreasonable to ignore the patient's subjective suffering and the family's distress while the disease is still in the early stages and is being managed actively.[4] Furthermore, there has been increasing recognition of the iatrogenic burden of disease-orientated treatment toxicities. In the field of cancer management, there has therefore been an expansion of measures aimed at reducing adverse effects of treatment, and at increasing the ability of patients to withstand ever more aggressive regimens. This growth industry has been termed 'supportive care' and has been embraced by the UK's National Institute for Health and Clinical Excellence.[5]

The distinctions from palliative care are immediately apparent: supportive care starts at the same time as diagnostic and curative or life-prolonging therapy, helping the patient to tolerate the twin burdens of disease and treatment adverse effects. The blurring of boundaries between supportive and palliative care comes in the later stages of illness, when life cannot be prolonged and the patient is preparing for death. In some parts of the world, supportive care services are restricted only to cancer patients. In other parts, resources are biased towards disease-directed therapies, and palliative care of terminally ill patients is still rudimentary. The ideal balance is one in which both supportive and palliative care are provided by the same service, thus offering patients and families a seamless continuity of holistic care from diagnosis to demise.

A new client group is emerging for supportive, as opposed to palliative, care. This is the increasing number of patients who have come through cancer treatment successfully and achieved long-term or permanent remission or 'cure'. We now understand that these so-called survivors are far from healed — they carry the 'late effects' of both disease and treatment sequelae, including long term adverse effects of treatment, fear of recurrence, and financial challenges.[6] Few centres can currently provide diagnostic and caring supportive care for this group of cancer patients. It is probable that, as treatments are developed for what are currently regarded as inevitably life-limiting chronic conditions, medicine may be faced with the need to support more of these patients, and for longer.

The new Supportive and palliative care section of *BMJ Clinical Evidence* boldly attempts to embrace this broad span of healthcare. We will do this for a wide range of chronic diseases, such as cancer, COPD, heart failure, and long-term neurological disorders. Although, historically, much of the approach to supportive and palliative care has come from oncology, this is being challenged by a new generation of chest physicians, cardiologists, neurologists, and nephrologists, to name a few, who want to offer more than high-tech life-prolonging medicine to their patients. We hope the initial reviews in this first issue — Constipation in people prescribed opioids, Delirium at the end of life, and Nausea and vomiting in people with cancer and other chronic diseases — adequately reflect this range and stages of diseases and these broad therapeutic aims.

The speciality of palliative medicine in the UK is now 20 years old. We are two physicians who have entered the speciality at opposite ends of this time span. We are keen to extend the contribution of palliative medicine into supportive care, and are committed to examining critically the evidence base for our clinical practice in diseases such as cancer, and to evaluating how this evidence can be applied to a wider group of patients.

While assembling our reviews, we were struck by the paucity of the evidence base for palliative care interventions, even in cancer medicine. In general, we found that although palliative treatment for advanced cancer is enshrined in numerous textbooks of palliative care, evidence for such care from RCTs and systematic reviews is sorely lacking. Paradoxically, some of the better researched clinical areas are not in palliative care but in supportive care of cancer patients, for example, anti-emetics for chemotherapy-induced nausea and vomiting.

For this reason, we have added 'Clinical guides' to the core RCT evidence we present, to try to reflect the best current consensus among specialists in supportive and palliative care, even when evidence is absent. We trust that, in future updates, these gaps in the evidence base will be filled in — if not from research in cancer care, then from other branches of medicine which are taking on the supportive care mantle. Thus, although opioids are now well established clinically as a treatment for dyspnoea in cancer patients, the evidence base for this is limited compared with the evidence for opioids prescribed for cancer pain. However, well-designed studies are emerging in the literature describing the benefits and adverse effects of opioids in people with heart failure, COPD, and other conditions. These studies will form a new layer of our evidence pyramid, reinforcing the expert opinion of our clinical guides, and laying the foundation for systematic reviews and meta-analyses in the future.

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