

## HotPick June 2006

### Clarifying the term 'palliative' in clinical oncology

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#### Abstract

"The objective of this study was to clarify the term 'palliative' in clinical oncology. A qualitative study design with in-depth interviews was applied. The study sample included 30 cancer patients and 16 physicians.

In clinical oncology, the use of the term 'palliative' to describe both anticancer treatments and palliative care may cause confusion and misunderstanding. Different aspects of palliative care, as expressed by the WHO definition, are not so easily recognizable with regard to palliative oncological treatments. Furthermore, the fact that the same anticancer treatments can be given to patients with palliative or curative intention is confusing. The distinction between curative and palliative oncological treatments is of crucial importance for the treatment decision-making process. Close consideration of the use of the term 'palliative' will help to clarify the various goals of treatment and care in oncological practice."

#### Patients and methods

Participants were:

- Patients who had refused a recommended oncological treatment, either in part or totality. Conducted in-depth interview were held in the patient's home, of 60-120 minute duration.
- Physicians, either GPs (8) or oncologists (8), who had recruited patients, with interviews lasting 30-60 minutes.

Observational studies of doctor/patient interactions were first conducted, to inform the topics of the in-depth interviews.

#### Results

Following are some themes identified by the qualitative analysis of the interviews.

**The term "palliative" in clinical oncology** - the authors found a difference in interpretation between GPs and oncologists, a difference which could lead to confusion for patients. They also found the stage of disease influenced the way the word "palliative" was used. These differences are summarised in Table 3 as shown.

#### Table 3

Summary of the differences between palliative care defined by the World Health Organization and palliative treatments in clinical oncology.

Palliative Care

Care directed to:

1. Persons with noncurable life-threatening stages disease

Palliative Treatments in Clinical Oncology

Treatments directed to:

1. Incurable patients (in all of the disease)

- |  |                                |
|--|--------------------------------|
| 2. (Relief of) symptoms  | 2. Tumour and symptoms         |
| 3. Quality of life, recognized by patients                       | 3. Quality of life, not always |
| 4. Neither hastening nor postponing death recognized by patients | 4. Life-prolonging             |

Other themes emerged about the lack of clarity of distinction of goals of care which arises out of the use of "palliative" in different contexts: Patient 8: 'At first, they indicated that they wanted to go for curative treatment. I think that if I had knew from the beginning that it was a palliative treatment, I would never have started treatment. [...] As long as you're in that procedure of chemotherapy and appointments to be operated, I had the idea it could be removed. Suddenly you notice that it is not like that'.

However, it was seen by physicians as important, to know whether a treatment is curative or palliative and to communicate this to the patient for three reasons:

1. It is an indication for patients to know in which phase of the disease they are; what their prognosis is.
2. It influences the grade of toxicity of a treatment that is acceptable for the doctor and for the patient.
3. It strongly influences the extent of pressure physicians will exert to persuade the patient to be treated as recommended.

Physicians indicated that they exert more pressure on patients to accept a curative oncological treatment, whereas, if the recommended treatment has a palliative goal, physicians indicated that they exerted less pressure.

Similarly, for patients, the underlying goal of treatment was important because of the wish to preserve and maximise quality of life. Patient 3: '...that I stand at risk due to the "pleasant" radiotherapy of suffering side effects that actually would diminish my quality of life, scared me to bits'.

In the discussion, the authors state "To forgo miscommunication between professionals from different disciplines, but also within one discipline, we believe that we should not use various definitions of the term 'palliative'. Therefore, we propose to reserve the term 'palliative care' for care that is directed to pain, nausea, fatigue, dyspnoea, diarrhoea, for example, for symptom therapy. When referring to anticancer treatments in the clinical oncological practice, we propose to distinguish between treatments with curative and non-curative goals."

### **Commentary: The problem of language**

Words become meaningless if they are given different meanings in different contexts. Perhaps a paucity of language available leads to the use of the same word to describe something which is similar or related but not the same. Or perhaps at times the meaning is deliberately subverted to suit the purpose of the user as is common in advertising or politics. To what extent is the word "palliative" becoming meaningless when for some it means care in the last hours of life and for others, chronic administration of bisphosphonates to a woman with breast cancer metastatic to bone with probable years of survival likely.

The authors argue for more clarity and intellectual rigour of terminology to avoid deliberate or inadvertent clouding of intent of therapy or goals of care. The use of "palliative oncological treatments" or more simply (but unappealing negative) "non-curative" treatments may improve communication between patients and

physicians. It may also emphasise to clinicians that such treatments are only a small part of the whole patient/family care that is palliative care.

## **Reviewer**

**Dr Odette Spruyt**

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Dr Spruyt trained in Palliative Medicine in the UK, completing her training in 1995. She was the first New Zealander to train in Palliative Medicine through the Specialist Advisory Committee, RACP. Her first consultant position was with the Central Sydney Palliative Care Service, where she was director of a 27-bed hospice and established the consultative service at Canterbury Hospital, CSAHS. She has been at Peter MacCallum since 1998, heading a consultative team with academic (education and research) interests and responsibilities. She has participated in a number of international studies in palliative care (methadone vs morphine as first line opioid analgesic; nebulised morphine vs subcutaneous morphine for relief of dyspnoea, Edmonton Classification System for Cancer pain validation study) as well as developing collaborative local studies for example in dyspnoea and pain management. Special areas of interest include palliative care for NESB patients, symptom management, particularly pain control and palliative care in the developing world. She was a member of BAHA, founded APLI and was an executive member of the IAHP. She is currently the Victorian representative on ANZSPM and is on the executive of Palliative Care Victoria.