To cure sometimes,  
To relieve often,  
To comfort always.  

Anonymous physician, 16th century

This aphorism is as timely today as when it was first written. Although dramatic progress has occurred on some fronts, cure rates for many forms of adult cancers have not improved significantly in 50 years. In the absence of a cure, what does modern medicine have to offer the patient with cancer? This issue of Cancer Control seeks to answer that question by describing recent developments in the field of palliative care.

The origins of palliative care as a medical subspecialty are intertwined with those of the modern hospice movement. The establishment of the first medically staffed hospice programs in the late 1960s and early 1970s brought together professionals from many disciplines who were committed to improving the physical and psychologic well-being of dying patients and their families. Ronald S. Schonwetter, MD, reviews the brief history of hospice care in the United States and identifies the similarities and differences between hospice care and palliative care. Although the major goal of both forms of care is to relieve suffering, the field of palliative care has expanded to include the treatment of patients who have life-limiting diseases but are not imminently dying.

Control of pain and other physical symptoms is considered one of the cornerstones of palliative care efforts. Nearly 75% of patients with advanced cancer will suffer from pain.[1] It is estimated that in more than 80% of cases, this pain could be controlled through relatively simple means.[2] Unfortunately, many patients experience chronic, severe pain because they fail to receive adequate therapy. Drawing on clinical reports and research findings, Carla Ripamonti, MD, and Eduardo Bruera, MD, offer specific recommendations for the pharmacologic management of pain in patients with advanced disease. The authors devote considerable attention to the use of opioid analgesics, which they view as the principal form of therapy for chronic pain associated with cancer. Methods for controlling other distressing symptoms that are common among patients with advanced disease (eg, dyspnea, cachexia) also are described.

The potential sources of suffering for patients with advanced disease are not limited to pain and physical symptoms. William Breitbart, MD, and I describe how psychosocial and psychiatric symptoms, as well as existential distress, also can result in suffering. Anxiety, depression, and cognitive impairment are common characteristics among patients with advanced disease but can be difficult to recognize and manage without specialized knowledge. Existential distress also is common as patients with advanced disease deal with their regrets about unfulfilled aspirations, loss of physical integrity, and fears of death. We indicate how relief of these psychosocial sources of suffering can best be achieved through a multidisciplinary approach to patient care that incorporates mental health and pastoral care interventions.

The effectiveness of curative cancer therapy is typically measured by assessing such clinical outcomes as time to disease recurrence or length of survival. Palliative care, on the other hand, is primarily concerned with controlling symptoms and side effects and supporting overall quality of life in situations where cure or control of cancer is no longer possible. Consequently, the traditional measures of clinical outcome are of limited usefulness in trying to evaluate the effectiveness of palliative care interventions. In their search for appropriate clinical outcome measures, many workers in the field of palliative care have turned to questionnaires focusing on quality of life. Susan C. McMillan, PhD, RN, describes this assessment approach and identifies several instruments that can be used to measure quality of life in the palliative care setting.

The future of palliative care faces at least one major challenge to its continued development. Although effective means of relieving suffering in patients with advanced disease have been developed, these methods are often un-used or underused. Jill A. Rhymes, MD, identifies several barriers that currently exist to the more widespread use of palliative care interventions. One major barrier is that palliative care has yet to be fully integrated into the health care system. All too often, palliative care is provided only in hospice settings to patients who are near death. Another major barrier is the underuse of opioid medications for pain control due to regulatory obstacles as well as patient and physician misconceptions about the nature of addiction. Clearly, a major task for those involved in palliative care is to find effective means of disseminating the principles and practices of palliative care to both providers and consumers of health care. Along these lines, the recent publication and distribution of guidelines for the management of cancer pain is a notable achievement.[3]

A discussion of recent developments in palliative care would be incomplete without a consideration of the complex and controversial topic of assisted suicide. Recent legislative and judicial proceedings in Oregon and Michigan have heightened the public debate over the right of terminally ill patients to receive physician assistance in dying. As Joseph J. Fins, MD, observes in his contribution to this issue, these legal developments will have important implications for physicians who care for the terminally ill. If assisted suicide becomes legal, physicians will need to make important personal and professional decisions about how to provide optimal care to patients at the end of life. The author explores the challenging legal, ethical, and medical issues that physicians will confront in this new era.

This is an exciting time to be involved in the field of palliative care. From its origins within the hospice movement, palliative care has rapidly evolved into a specialty that seeks to relieve suffering and improve the quality of life of all patients diagnosed with cancer. The articles in this issue of Cancer Control provide a timely review of the origins of palliative care, its current practice and status, and its future prospects and challenges.

Paul B. Jacobsen, PhD

Program Leader,
Psychosocial Oncology Program,
H. Lee Moffitt Cancer Center & Research Institute
Associate Professor of Psychology,
University of South Florida,
Tampa, Florida
References