



Editorial

The Rise of Supportive Oncology: A Revolution in Cancer Care

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Advances in oncology have seen the emergence of populations no longer fully served by the traditional palliative care model. This has created a new language in the terms used to describe cancer care, and a need for clarity on how these should be defined. The term 'supportive care' is commonly used and is inclusive of palliative care and survivorship. However, it is often confused with 'best supportive care' or used as a euphemism for palliative care. We therefore propose 'supportive oncology', an umbrella term echoing the Multinational Association of Supportive Care in Cancer (MASCC) definition [1], describing a multidisciplinary group of health professionals involved in the prevention and management of the adverse effects of cancer and its treatment, across the whole spectrum of the disease. Optimal supportive oncology requires a multitude of specialties (e.g. cardio-oncology, onco-endocrinology, acute oncology, palliative care) to assist accurate diagnosis and management, and ultimately improve outcomes. Hence, this editorial focuses on its development as an emerging specialty/sub-specialty and asks: who is the workforce;

what skills do they need and what training is required to fully meet patient/carer needs?

Decades of investment into cancer research are paying off. The push to improve survival, our application of cancer genomics, coupled with the explosion of targeted systemic anti-cancer therapies, has transformed oncology. Where the presence of metastases once heralded a prognosis of months, in many cases people now live much longer. People receiving treatment might now reasonably expect several years living with cancer, with therapies continued for as long as is effective and/or tolerated. The lives of some patients with metastatic disease such as melanoma or stage 4 lung cancer may expect a longevity never before imagined, with some achieving complete remission. Furthermore, the effectiveness of some therapeutic strategies increases the chance of cure from the disease. For some, this can have significant implications as they transition back to normal life. These improved prognoses are welcomed, but addressing the host effects of therapy is as critical as addressing the effects on the tumour.

With a few notable exceptions, the number of people being newly diagnosed with cancer continues to rise alongside an ageing population. The ever-changing cancer demographic is leaving the system unprepared to provide comprehensive, patient-centred care; the unmet needs of

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people living with metastatic disease are complex and prevalent, demonstrating an urgent need to rethink, redesign and fix the care systems [2].

Traditionally, the focus of cancer care has largely been on initial diagnosis and treatment, and end of life care [3]. Patients who are fortunate enough to be cured of their cancer may find themselves in 'cancer purgatory', no longer warranting therapeutic attention from oncology and not meeting the criteria for specialist palliative care. Curative therapies rarely render survivors symptom free. The consequences of surgery, radiotherapy, chemotherapy, immunotherapy, targeted therapies and combined therapies require specialist multidisciplinary care to minimise the impact on quality of life during and after treatment. Care and long-term support for these largely predictable sequelae are inconsistent across regions. Their long-term care will probably fall under their family physician or general practitioner, whom, as always, is able to manage general complaints but is less familiar/confident to manage more specialist issues [4]. Bespoke survivorship clinics are in short supply, and there are few national strategies addressing the needs of cancer survivors [5].

In the three decades since palliative medicine was first recognised as a medical speciality, it has facilitated the extension of services beyond hospices and into hospitals. Good quality research has supported widespread recognition that cancer patients have complex symptoms throughout the cancer continuum and could benefit from these being addressed independent of prognosis. However, many palliative care services are still focused on (or being resourced to only focus on) the very end stages of life, with limited available resources being prioritised in anticipation of the predicted increases in numbers of deaths in homes/care homes in coming decades [6]. Some palliative care teams have successfully extended their services to support patients living with advanced cancer and provide exemplar models of integrated care in this area [7,8].

Close working between palliative care and oncology has proved invaluable in helping patients maintain good quality of life and, in some instances, to withstand the very therapies that hope to sustain or cure them. However, to expand this approach and provide 'supportive oncology' for all patients who need it requires a significant overhaul of the current systems and substantial investment in resources and training.

Just as palliative care developed as a specialist field in response to a paradigm shift in how we manage terminal illness, the need for 'supportive oncology' – which encompasses the entire cancer spectrum – has developed in response to this changing patient demographic and rise in said populations. Sadly, in many centres the expansion in patient numbers has not been met with clinical expansion to support them, leaving existing services to pick up the work. Alongside this, research and sub-specialist training to help guide clinical practice is distinctly lacking. For example, how should we manage pain in patients who may live with cancer for many years, or in those who have survived cancer? How do we minimise polypharmacy and engage patients in proactive, non-pharmacological and

self-management strategies to improve symptom burden and wellbeing? For those who provide cancer survivorship care in specialist and primary care settings, what is the sustainability and implementability of such offerings across different health systems/countries? Can palliative care models for pain and symptom control be easily transposed to other parts of the cancer spectrum? Can current oncology or palliative care training/services be adapted to adequately manage these new and growing patient populations?

Supportive oncology cannot be provided by a single clinical specialty alone; however, as with other cancer multidisciplinary teams, a dedicated core team is needed to manage everyday problems, with input from other disciplines as the need arises [9]. This model is adopted in some US cancer centres, with supportive oncology physicians providing 'day to day' care at all stages of treatment, including curative treatment, rehabilitation and survivorship care.

So, whose responsibility is supportive oncology and how can this be sustainably provided to the vast numbers of patients who would benefit? Cancer clinicians must already cope with significant demand, not least medical and clinical oncologists.

Palliative care professionals, many of whom now have increasing input in non-malignant disease, are similarly over-stretched. It is important to recognise though that many supportive oncology services are evolving from palliative care services. And yet, palliative care healthcare professionals have traditionally had limited formal training in supportive oncology. It is often not appropriate to extrapolate data/experience from patients with advanced cancer to patients receiving anti-cancer treatment, or cancer survivors [9]. For the first time though, the new UK palliative medicine training curriculum (2022) has recognised the 'new discipline of supportive care', raising the assumption that skills learned in palliative care might be transferrable to other parts of the cancer spectrum. An increasing number of palliative care physicians, especially those working in cancer centres, have extended their scope of practice, adding 'supportive care physician' to their title. Coinciding with this is the growth in cancer survivorship programmes, acute oncology, integrative oncology, cancer rehabilitation, geriatric oncology and supportive oncology programmes, many of which are inclusive of palliative care specialists. Palliative medicine, with some 'tweaking' and interest [10], may provide the leadership needed to assist in the growth/development of these services. Just as acute oncology developed out of need from a pool of limited clinical resources, palliative medicine would need to reconfigure itself alongside these changing times and encourage interested clinicians to help meet new service demands. Development of supportive oncology should prospectively incorporate service evaluation and research. Lessons should be learned from palliative care where this has previously been lacking and undertaken retrospectively (e.g. The Liverpool Care Pathway [11]). In essence, we should not push innovation forward without the supporting data.

Although some may question the rapid growth of supportive oncology, including the launch of the UK Association of Supportive Care in Cancer (UKASCC) and Enhanced Supportive Care (a programme to help implement earlier integration of physical symptoms, psychological and functional support to patients with cancer), innovative thinkers and clinicians are certain that this is what is needed to ensure our patients receive the best care possible.

What is Needed now is a Wake-Up Call

If the COVID-19 pandemic has taught health care anything it is this; faced with a rapidly emerging global health catastrophe we can mobilise resources to unify in meeting the unprecedented and largely unanticipated challenge. In cancer we now have a much anticipated 'positive' global challenge: more people live longer because of better treatments. We must now ensure that they can live well, with access to timely and appropriate care and, through investment in supportive oncology, provide infrastructure across the entire spectrum of the disease needed to support them. In short, a revolution is needed to continue to meet the central tenet of what we strive to achieve, excellence in cancer care.

Conflicts of interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

R. Berman reports a relationship with Supportive Care UK Ltd that includes: board membership, employment and equity or stocks. R. Berman reports a relationship with UK Association of Supportive Care in Cancer that includes: board membership and non-financial support. M. Lustberg reports a relationship with Multinational Association of Supportive Care in Cancer that includes: board membership. F. Scotte reports a relationship with Multinational Association of Supportive Care in Cancer that includes: board membership.

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