EAPC news and views

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The 58th World Health Assembly resolution on global cancer control

In May 2005, the 58th World Health Assembly adopted a resolution on cancer prevention and control, which will clearly place cancer care on the health agenda for the future. The World Health Assembly, a body of international experts who propose key targets on which the World Health Organization (WHO) should focus its efforts, agreed this resolution on 25 May 2005 in Geneva, Switzerland. The resolution calls for action by the WHO and member states to address the increasing burden of disease due to cancer and emphasises the reinforcement of national programmes that include early detection, prevention, improved treatment and palliative care. To meet this need, the Director General of the WHO has advocated a global cancer control strategy, which translates cancer control knowledge into public health action, provides a sound evidence-base for best practice and develops dedicated support groups to ensure the administration and implementation of the strategy. These expert groups will work in an advisory capacity at the national and international level to prepare reports and technical working papers relative to the overall strategy.

Palliative care remains a visible force within the agenda and its inclusion as an integral part of the overall global programme indicates a growing international view of its importance in the delivery of healthcare. It is clear from this resolution and other WHO briefings that for the majority of cancer patients in the world, their first meeting with a medical professional is usually when their disease is already in the advanced stages. The broad multidisciplinary approach advocated in palliative care is seen by the WHO as a way of addressing not only the clinical burden but the psychological and social burden of cancer care. It can be implemented in resource-poor situations relatively simply and inexpensively, and can substantially improve quality of life for patients and families. In the global context, given limited access to treatment and late presentation to medical services as already suggested, palliative care may be the realistic option for many people and therefore is considered integral, and not an adjunct to, cancer control practice.

Despite the evident benefits of this approach, the report also indicates the significant barriers that impact on implementation. In point 9 of the Cancer Control report that forms the basis of this resolution, the problems facing palliative care development are outlined: lack of political will; insufficient education; and insufficient information to the general public and healthcare providers. Despite the clear evidence that morphine remains the gold standard for pain relief and may be administered safely and with relatively little expense, excessive and unnecessary regulation of opioids still prevents its use where it is most needed. Notably, this does not only apply to resource-poor countries, and it challenges palliative care providers to strengthen the agenda for palliative care at the political level.

The resolution that has been adopted has clear resonance for those of us involved in the delivery of palliative care in all its varied disciplines and levels. The report calls on us to recognise the suffering of cancer patients and families and the burden, both personally and economically, it places on them. It states that palliative care is not simply an additional support service to cancer care, but 'an urgent, humanitarian responsibility'. It calls on its member states to develop systematic and equitable strategies that incorporate palliative care as a key element in the continuum of cancer care. The evaluation of such programmes is essential to ensure sustainability where resources are limited and need to be used to the benefit of an entire population and not just a limited group within. Finally, it urges compliance with WHO strategies for the provision of essential drugs, including opioids, to reach at least a minimum standard in each local situation.

The message of this resolution is clear. Partnership between active and palliative treatment programmes is an essential requirement for quality of life and health policy in cancer care. The EAPC has always recognised this link and supported WHO initiatives through our work with the Council of Europe. The expert skills of Board members who have links with the WHO, notably Professor Stein Kaasa from Norway, have also contributed to this. The fact that this resolution recognises that the implementation of palliative care is an issue for highly resourced countries, as well as resource-poor ones, calls for a political stratagem that supports the idea of 'One voice – one vision' for all people who are in need of palliative care. The International Hospice and Palliative Care Day on 8 October offered an opportunity to address the political agenda and was an ideal opportunity to make a stance in support of the 58th World Health Assembly resolution.

Further information about this resolution can be obtained from: www.who.int/nmh/a5816/en

Philip J Larkin, Vice-President, EAPC

Paediatric palliative care

The specialty of palliative care in children is very different from its adult counterpart. It is a much younger specialty, having begun to develop some 20 or 30 years after the adult specialty was recognised. Perhaps this is because paediatrics has always tried to maintain the vision that palliative medicine strove to recapture in adults: holistic care that put patient and family at the centre of decision-making.

In most countries, paediatric palliative care has evolved not from adult palliative care, but from paediatrics itself. This is in keeping with the UN convention on the rights of the child, which insists that those working with children should first and foremost be trained in the care of children and young people. It is perhaps particularly important in palliative care: the more holistically one looks at a child, the less he or she resembles an adult.

One result is that the specialty does not focus on cancer, nor on distinct specialist inpatient units, such as hospices. Although there are children's hospices in many countries in Europe, and they are extremely important, the main emphasis is on developing services that can reach children wherever they are needed. The exact pattern of service development depends on the culture of each country. In the UK, most families wish their child to die at home and the responsibility of palliative care is to facilitate this. In countries where this is less acceptable, the focus may be on providing palliative care in a hospital, school, orphanage or hospice.

The palliative phase in children is often much longer than in adults. Four categories of life-limiting conditions are recognised in childhood. Children with cancer account for perhaps one in three of those who need palliative care. The others will suffer conditions ranging from cerebral palsy and muscular dystrophy to mucopolysaccharidoses and neurodegenerative conditions. While cancer in children, as in adults, usually ends in a recognisable palliative phase lasting weeks or months, most other conditions are more unpredictable in their prognosis and can persist for years or even decades. The paediatric specialty is therefore very different from the adult specialty.

What has become increasingly clear over recent years, however, is that the paediatric specialty has a great deal to learn from what has already been achieved in the adult specialty. Particularly in the field of symptom control, there is an increasing body of experience, expertise and published evidence underpinning the management of dying adults. The aim of the EAPC Children's Task Force is to find ways of bringing together existing children's palliative care services across Europe, and to bring them into contact with those working in the adult specialty. Our intention is to help develop for dying children in Europe services that are appropriately grounded in paediatrics but also informed by palliative medicine.

Richard Hain, LATCH Senior Lecturer and Honorary Consultant in Paediatric Palliative Medicine, Cardiff, UK

Recording memories in palliative care

Working as a nurse in a hospital palliative care team, I am often asked how we can improve the quality of life of patients in hospital. In effect, it is commendable to ensure comfort and quality of life but it seems to me a pity that we cannot offer patients an incentive to plan ahead.

From my personal experiences and from reading articles on the subject, I would like to offer patients the opportunity to record a CD that they can give to their loved ones. The aim is not necessarily to recount their whole life story but rather to record stories for their grandchildren or songs or anecdotes.

This could be something positive for the patients to fight against the feeling of uselessness that I often encounter, as well as providing families with something to remind them of their loved one.

This project is only in its early stages and it would be useful for me to receive information from people who have had similar experiences. If this is the case, please email me at: erika.emcsp@laposte.net or send a letter to Erika Le Mérer, EMCSP, Centre hospitalier Louis Pasteur, Av, Alphonse Daudet, 30200 Bagnols sur Cèze, France.

Erika Le Mérer, Nurse, France

A subjective history of palliative care

On the occasion of the first World Hospice and Palliative Care Day, Carole Roussopoulos, director of a number of videos, including ones on palliative care, and Brigitte Berthouzoz, manager of the Centre François-Xavier Bagnoud de soins palliatifs à domicile, decided to make a film about palliative care. As well as discussing the two pioneers of palliative care, Elisabeth Kübler-Ross and Cicely Saunders, the film also describes the development of palliative care in France and Switzerland. It finishes with a look at the future of palliative care within budgetary restrictions, the risk of specialisation and professionalisation of death.

We are not claiming to provide an exhaustive history of the modern palliative care movement, but rather pay homage to the people who have made their mark on the movement.

The film was meant to be shown at a special evening organised by the Centre François-Xavier Bagnoud on 8 October, the first World Hospice and Palliative Care Day. Unfortunately, due to technical reasons, it was not possible to finish the film for that date and it will be shown at a later date.

Brigitte Berthouzoz, Centre François-Xavier Bagnoud, Switzerland