



Psychosocial aspects of cancer need integration into the treatment trajectory—but how?

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There is a growing need to discern how health care systems in general and the oncology “world” in particular will care for cancer survivors. In all industrialized countries, the number of cancer survivors is growing exponentially. The result of many years of fruitful research and clinical work to raise life expectancy in cancer patients is finally reflected in survival statistics. In Canada, almost half a million people have experienced the diagnosis and treatment of a cancer and now have to live with that experience¹. Given longer survivals for cancer patients, more research and clinical work is needed in the area of the systematic development of guidelines for management of the late effects of the disease. The short-term, medium-term, and late effects all include challenges relevant to the patient and the family—but the health care system has been slow to respond.

The prevailing concept of clinical work with cancer patients has produced a division between the teams of health professionals providing physical treatment (surgery, radiation, chemotherapy), psychological treatment (psychological and psychiatric expertise), and social support and counselling (social workers). In addition, the cancer patient faces the challenges of falling between service “cracks”—that is, between the primary care physician, adjuvant health and community services, and the highly specialized oncology clinic. Further down the trajectory, cancer survivors face the reality that they will likely be diagnosed with another chronic disease that might result in significant comorbid complications.

The division of responsibility for patient care has evolved from power struggles within the health care professions, dividing efforts in the name of academic status, authority, legal concerns, and specialization. Specialization resembles a never-ending natural eruption occurring concurrently with the invention of innovative diagnostic procedures and treatments. On the other hand, no patient wants to be treated by a person who does not have a special interest, expertise, or ability to handle particular symptoms and problems.

Surmounting those aspects of modern world health systems, patients face the new and hitherto unspoken and neglected problem of social inequality in cancer survival. Several independent studies of cancer incidence and survival illustrate how social determinants play a major role in survival, even independently of known clinical prognostic factors². Generally speaking, cancer treatment is directed by the idea that “one treatment fits all.” In the name of equality, the industrialized and affluent countries, no matter the current financial crisis, have organized cancer treatment into standard protocols that, to obtain the expected result, must be strictly followed. Certain steps are currently being taken to address those issues, but despite the efforts, the overall picture shows that, even in well-organized societies, survival across all cancer sites with long traditions of public health care is determined by social class, no matter how “class” is defined.

One specialty that somehow still stands on the sideline—but is itching to get into the game—is psychosocial oncology. In principle, a cancer patient would hope that psychosocial issues are integrated into the overall management and treatment of the disease, but the system does not necessarily work that way at the present moment.

Psychooncology was originally developed as part of the psychiatric services provided to patients who typically might experience symptoms such as delirium after major surgery, or who were diagnosed with major clinical depression. Psychological support for existential problems or support from social workers to facilitate a return to work became interesting when survival curves began to reach years instead of months after diagnosis. This continuous characterization of psychosocial care as “additional services”—nice to have, but not absolutely needed—was reflected in the somewhat minimal resources allocated to it, but more importantly, in the way that oncology integrated (or did not integrate) with psychosocial aspects of cancer patient care. “Problem-based” medicine detects problems, sorting out what

can be done by an examination of objective signs of changes in bodily functions (in the broadest sense). The “problem” is only the apparent problem, and treatment is directed only toward that particular problem. For example, the patient is depressed, treat with antidepressants; the patient has worries about how treatment may influence a work situation, refer to the social worker; the patient complains about fatigue, refer to the hospital’s Web site to find and print a flyer about fatigue. How the history, anamnestic aspects, and linkages between the actual problem and other problems pertain was largely uninteresting to the oncologist³.

Psychosocial oncology advocates itself as a subspecialty in oncology to be advocated and organized around a broader perspective in the clinical determination of how and when problems should be addressed. For that reason, the psychosocial aspects of cancer management should usually be integrated into the overall treatment plan from the first diagnostic consultation, through treatment planning, and into discussions of life as a cancer survivor. But psychosocial oncology cannot stand alone; most cancer survivors suffer from comorbid conditions that require special attention (for example, obesity, diabetes, cardiovascular disease). In addition, the vast literature on cancer survival as related to physical activity⁴ and physical interventions is rarely integrated into the psychosocial paradigm—as if the mind works independently of the body. These disconnects must be repaired if the quality and quantity of life are both to be improved.

In summary, the number of cancer survivors is increasing, and concurrently, specialization within the health sector has fostered a culture of independent, potentially noncoherent, and isolated treatment prescriptions. In addition, cancer patients vary with regard to socioeconomic resources. Psychological and social aspects of the patient and family experience are somehow not yet fully integrated into overall cancer care, because “problem-based” medicine resists fully integrating those issues into the overall diagnosis and management. The situation is inconsistent with “whole patient” care as advocated by numerous organizations and policy initiatives (for example, the U.S. Institute of Medicine), and action plans to change the situation on the ground must continue to develop and be implemented.

In this issue of *Current Oncology*, the paper by Turnbull Macdonald and colleagues⁵ illustrates how a group of clinicians, scientists, and opinion leaders convened and arrived at a framework for integrating the psychosocial care of cancer patients. The framework’s development process appears to be well thought through, with the use of careful methodology

and an iterative process that culminated in a set of principles and recommendations that are organized into a clear, action-oriented plan. The only major flaw was that just 13% of the 488 clinicians surveyed took the time to respond to a 3-item survey! That response rate unfortunately undermines the reliability and credibility of the framework to an important degree. As expected, three quarters of the 13% who responded reported that they would recommend the framework’s use. However, what message does that response send with respect to support for and implementation of the framework? As long as the views of the remaining 87% of that large group remain unknown with respect to this psychosocial framework meant to guide practice in the psychosocial care of cancer patients, the answer remains elusive.

CONFLICT OF INTEREST DISCLOSURES

The authors have no financial conflicts of interest to declare.

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