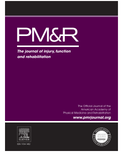

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Contemporary Issues in Cancer Rehabilitation

Integrating Function-Directed Treatments into Palliative Care

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Abstract

The growing acceptance of palliative care has created opportunities to increase the use of rehabilitation services among populations with advanced disease, particularly those with cancer. Broader delivery has been impeded by the lack of a shared definition for palliative rehabilitation and a mismatch between patient needs and established rehabilitation service delivery models. We propose the definition that, in the advanced cancer population, *palliative rehabilitation* is function-directed care delivered in partnership with other clinical disciplines and aligned with the values of patients who have serious and often incurable illnesses in contexts marked by intense and dynamic symptoms, psychological stress, and medical morbidity to realize potentially time-limited goals. Although palliative rehabilitation is most often delivered by inpatient physical medicine and rehabilitation consultation/liaison services and by physical therapists in skilled nursing facilities, outcomes in these settings have received little scrutiny. In contrast, outpatient cancer rehabilitation programs have gained robust evidentiary support attesting to their benefits across diverse settings. Advancing palliative rehabilitation will require attention to historical barriers to the uptake of cancer rehabilitation services, which include the following: patient and referring physicians' expectation that effective cancer treatment will reverse disablement; breakdown of linear models of disablement due to presence of concurrent symptoms and psychological distress; tension between reflexive palliation and impairment-directed treatment; palliative clinicians' limited familiarity with manual interventions and rehabilitation services; and challenges in identifying receptive patients with the capacity to benefit from rehabilitation services. The effort to address these admittedly complex issues is warranted, as consideration of function in efforts to control symptoms and mood is vital to optimize patients' autonomy and quality of life. In addition, manual rehabilitation modalities are effective and drug sparing in the alleviation of adverse symptoms but are markedly underused. Realizing the potential synergism of integrating rehabilitation services in palliative care will require intensification of interdisciplinary dialogue.

Introduction

It is ironic that although the maintenance of functional independence is central to the quality of life (QoL) of patients with cancer, its loss remains poorly recognized and undertreated [1,2]. This disjuncture arises from a number of causes, including the fact that physicians and patients alike often do not discuss its occurrence in their conversations, see treatment of the cancer as the most effective way to address its presence, and may view its progression as an inevitable consequence of cancer. This situation is particularly unfortunate, because effective, established, and often relatively simple rehabilitation treatments are widely available. An additional complication is that rehabilitation services tend to be more effective in the early stages of cancer-related functional loss, a time when patients and clinicians are focused on treatment of the malignancy and not the remediation of its functional effects.

The picture is, in some ways, better in the later stages of disease, when losses are frequently obvious and often devastating. Oncologic clinicians and most patients support conventional rehabilitation in hospitals (eg, consultation liaison services), as well as in post—acute care settings such as inpatient rehabilitation facilities and skilled nursing facilities. Even here, the picture is mixed, as rehabilitation clinicians faced with patients with far advanced disease may question the appropriateness providing intensive and costly services at the terminal stages of a disease [3].

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The recent ascendance of palliative care, fueled by evidence that its provision improves care and lowers costs [4], has created a climate that may provide an opportunity for the broader integration of rehabilitation services into the continuum of cancer care. In particular, Temel et al's 2010 report that the provision of palliative care to patients with newly diagnosed stage IV lung cancer not only increased survival but also was accompanied by improvements in their QoL and other important clinical outcomes [5] triggered a radical attitudinal shift. In fact, in 2016, the American Society of Clinical Oncology published a recommendation that all patients with advanced cancer be referred for interdisciplinary palliative care [6]. Although subsequent work has not replicated palliative care's survival benefit, it has reinforced its ability to improve QoL and to reduce health care use [7-9].

As yet, the growing acceptance of palliative care has not been associated with a documented commensurate increase in the use of rehabilitation services. Regrettably, functional maintenance and rehabilitation receive only cursory mention in palliative care fellowship curricula and textbooks. It is telling that less than 2% of the content the Hospice and Palliative Medicine Board Examination relates to rehabilitation service provision [10]. The result is that a majority of palliative medicine practitioners have had, at best, limited exposure to rehabilitative interventions and minimal training in when or how to request them.

Fortunately, recognition of the importance of maintaining functional independence has reached the point where it is spurring widespread efforts to highlight the need for evidence-based cancer and palliative rehabilitation [11,12]. This article targets the latter and is designed to further this goal by looking at palliative care and rehabilitation through the prism of the advanced cancer population and doing the following: (1) proposing a definition of "palliative rehabilitation"; (2) reviewing palliative rehabilitation care delivery models; (3) providing an overview of the barriers that sustain an underuse of rehabilitation services; and (4) describing the strengths and weaknesses of our current rehabilitation interventions, as well as strategies to adapt them to palliative contexts.

Definition of Palliative Rehabilitation

Although it may seem pedantic, a definition of what palliative rehabilitation entails is necessary to facilitate discourse regarding its clinical and research applications. This exercise is necessary, in part, because the field has redefined itself over the almost 50 years that have passed since Dietz distinguished "palliative rehabilitation" from restorative, supportive, and preventive rehabilitation, as function-directed care delivered to patients with cancer in the far-advanced stages of their illness. Effectively, patient characteristics—prognosis and extent of disease—were Dietz's proposed basis for distinguishing "palliative" from other forms of rehabilitative care. In recent years, palliative medicine has extended increasingly into earlier stages of illness, with some advocating that it be introduced at initial diagnosis. This reconceptualization has expanded the populations, contexts, and goals of palliative care such that in its broadest view, palliative care is essentially QoL-directed supportive care delivered at any point along the trajectory of a progressive illness. This report is focused on patients with advanced, and usually incurable, oncological disease.

The peer-reviewed literature offers some indication of the clinical situations in which the delivery of rehabilitation services may benefit patients with advanced disease and/or intense or refractory symptoms. Specifically, conventional conditioning and resistive exercise can improve physical function and, in some contexts, fatigue. However, whether general conditioning activities for high-performing patients with stage III and IV cancer, for example, Eastern Cooperative Oncology Group (ECOG) 0-1 patients who are experiencing little to no manifestation or associated disablement, should be considered "palliative rehabilitation" is questionable. On the other hand, to confine "palliative rehabilitation" to function-directed services delivered to patients who are imminently dying is to short-change its potential.

Between these ends of the spectrum, uncertainty persists as to where the boundaries that define and distinguish palliative rehabilitation should be drawn. In essence, there is no consensus as to whether palliative rehabilitation should be defined by: (1) the characteristics of the patients it treats, for example, prognosis, cancer stage, level of disablement; (2) the training and skill set of its practitioners; (3) the settings where it is practiced, for example, a hospice; (4) the intense or refractory nature of its therapeutic targets; (5) the frequently limited and transient nature of its goals; or (6) the therapeutic modalities and types of rehabilitation service that are used. In summary, the goal of clearly defining the nature of palliative rehabilitation is not a trivial taxonomic exercise. The lack of a definition results in poorly framed clinical discourse, unfocused goals, and a lack of shared understanding that impairs both care and research.

Examining what palliative rehabilitation is not may help to establish its scope and to highlight its unique dimensions. Palliative rehabilitation, for example, is rarely predicated on conventional models of impairment-driven disablement (eg, the Nagi Model in Figure 1), which implies that disablement and handicap are the end-products of one or a limited number of discrete impairments. Although these models do a good job of explaining the downstream functional consequences of "single hit" focal traumatic, ischemic, and musculoskeletal injuries, they are simplistic and poorly

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