Introduction

Cancer is a multi-system disorder that influences all aspects of the life of affected individuals and their caregivers. Aside from the magnitude of the physical aspect of the disease and treatment there are complex sequela that must be dealt with. This may include social interactions, family relations, peer interaction, intimate relationships, education, employment, spiritual attitudes and navigating the complexities of the health care system, providers and their ancillary functions. As the disease progresses there is a need for acceptance and adaptation to end of life issues and symptom management. The integration of palliative care within the context of psychosocial oncology is an integral part of the Comprehensive Care of cancer patients and their families.

Implicit in the training of physicians and other health care workers is a need to effectively communicate the reality of diagnosis, disease status and prognosis. This includes being able to accurately describe diagnostic procedures and treatment goals and what benefit and/or risk is involved. Helping patients and families make decisions about what constitutes good quality of life and when to discontinue aggressive treatment is one of a physician's most difficult tasks [1]. Despite diagnostic and therapeutic advances in oncology, many patients ultimately die of their disease, which is often stressful and emotional for the treatment team. Additionally practitioners currently get little to no formal training on the subject and very little is written in regards to how to say goodbye to a patient or the negative impact miscommunication has on that last interaction.

Unfortunately, many patients may have difficulty in accepting the gravity and import of a life limiting diagnosis. This can result in a lack of focus and, more critically, the inability to achieve appropriate goals. Coping with a life limiting disease is never simple or easy; the clinician must have a multitude of strategies to deliver information about the disease process, treatments, and prognosis. Often using traditional communication strategies and methods will be insufficient. Unless approached appropriately previous coping strategies such as minimizing, deflecting or rationalizing can become so deeply entrenched that patients and their loved ones can lose the opportunity to complete necessary end of life communications.

The main goal of Psycho-Social Oncology is to provide an infrastructure to deliver better emotional care to patients and their families who are dealing with cancer. This PSO model presents a continuum of care beginning with the cancer diagnosis and following through to grief and bereavement services for survivors. Methods of coping with the treatment process are offered and implemented in multiple milieus. The process of dealing with palliative care and end of life should be offered in context of the continuum of care. This PSO model also addresses the issue of caregiver burden treating the entirety of the family as a holistic unit. Being able communicate effectively means being able effectively elicit concerns, fears and hopes from the patient and all 'stakeholders' in the patient's life.

Psychosocial oncology/palliative care is the provision of specific empirically validated treatments to those patients diagnosed with life limiting oncological disorders. Palliative care including symptom management, psychosocial counselling, and discussion about treatment goals and expectations should be incorporated into oncology care beginning at the time of diagnosis, particularly for patients with aggressive disease or high symptom burden.

The concept of palliation of symptoms and quality of life has continued to evolve since Dame Cicely Saunders founded the hospice movement. With the growth and advent of psychosocial oncology the nature and implementation of the continuum of oncology services and ultimately palliative services has changed. With advanced disease the patient's experience will change and vacillate in response to symptom burden, medication effectiveness, familial response (or lack of response) and myriad of other variables.

Comprehensive care of the patient with a life limiting condition necessitates the integration of psychosocial aspects of care into the overall assessment and management plan. A growing body of scientific evidence demonstrates that the psychological and social (“psychosocial”) problems created or exacerbated by cancer (e.g., depression, other emotional problems, or a lack of information or skills needed to manage illness) can be effectively addressed by a number of services and interventions [2-6]. Data is unequivocal that psychosocial interventions can improve the quality of life in cancer patients [7-18]. The intensity of intervention mimics the paradigm presented in the world health organization's pain ladder [19-22].

Communication is the cornerstone of good multidisciplinary medical care. There can be many communication challenges regardless whether the clinician is a General Practitioner, Oncologist, or a Palliative consultant. In this regard, the title of psychosocial oncology is not limiting but rather inclusive by nature. Communication challenges can include strong demands from patients' relatives, strong emotions, troublesome doctor-patient relationships, insufficient clarification of patients' problems promises that could not be kept, helplessness; too close involvement, and insufficient anticipation of various scenarios [23]. Without clear, goal directed communication, care losses it purpose. When the purpose of care (whether it be aggressive treatment or preservation of quality of life), becomes muddied or even lost in an unfortunate battle of wills distress is certain to occur in the patient, family, and care givers.

The ideal bio-psycho-social approach requires a fully multidisciplinary, multidimensional approach. From a psychosocial perspective, distress and symptom management are a cornerstone of comprehensive palliative cancer care. A cornerstone of quality care is a solid grounding in a comprehensive theoretical orientation. This
grounding should transverse disciplines. Sound communication fundamentals help a psychosocial oncologist navigate difficult transitional milestones in the trajectory from diagnosis to death.

References
1. Lo B, Quill T, Tulsky J (1999) Discussing palliative care with patients. ACP-ASIM End-of-Life Care Consensus Panel. American College of Physicians-American Society of Internal Medicine. Ann Intern Med 130: 744-749.
2. Ilincik A, Farber J, Cheang M (1994) A randomized controlled trial of psychotherapeutic intervention in cancer patients 93.
3. Isikhan V, Guner P, Komurcu S, Ozet A, Arpaci E, et al. (2001) The relationship between disease features and quality of life in patients with cancer-I. Cancer Nurs 490-495.
4. Newell SA, Sanson-Fisher RW, Savolainen NJ (2002) Systematic review of psychological therapies for cancer patients: overview and recommendations for future research. J Natl Cancer Inst 94: 558-584.
5. Smith SM (2007) Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. Cochrane Database Syst Rev 18: 3.
6. Trijsburg RW, van Knippenberg FCE, Rijpma SE (1992) Effects of psychological treatment on cancer patients: a critical review. Psychosom Med 54: 489-517.
7. Andersen B (1992) Psychological interventions for cancer patients to enhance the quality of life. J Consult Clin Psychol 552-568.
8. Antoni MH, Lehman J, Kilbourn K, Boyers AE, Culver JL (2000) Cognitive-behavioral stress management intervention enhances optimism and the sense of positive contributions among women under treatment for early-stage breast cancer. Health Psychol 20: 20-32.
9. Blake-Mortimer J, Gore-Felton C, Kimerling R, Turner-Cobb JM, Spiegel D (1999) Improving the quality and quantity of life among patients with cancer: a review of the effectiveness of group psychotherapy. Eur J Cancer 1581-1586.
10. Canadian Association of Psychosocial O: Standards of Canadian association of psychosocial oncology, 1999
11. Carlson LE, Ursulaak Z, Goodey E, Angen M, Speca M (2001) The Effects of a Mindfulness Meditation Based Stress Reduction Program on Mood and Symptoms of Stress in Cancer Outpatients: Six Month Follow-Up. Support Care Cancer 9: 112-123.
12. Classen C, Butler LD, Koopman C, Miller E, DiMiceli S, et al. (2001) Supportive-Expressive Group Therapy and Distress in Patients With Metastatic Breast Cancer: A Randomized Clinical Intervention Trial. Arch Gen Psychiatry 58: 494-501.
13. Fawzy FI, Fawzy NW, Arndt LA, Pasnau RO (1995) Critical review of psychosocial interventions in cancer care. Arch Gen Psychiatry 52: 100-113.
14. Fawzy FI, Fawzy NW, Canada AL (1998) Psychosocial treatment of cancer: an update. Current Opinion in Psychiatry 11: 601-605.
15. Greer S (1995) Improving quality of life: adjuvant psychological therapy for patients with cancer. Support Care Cancer 248-251.
16. Meyer TJ, Mark MM (1995) Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments Health Psychol 14: 101-108.
17. Schneiderman N, Antoni MH, Saab PG, Ironson G (2001) Health psychology: psychosocial and biobehavioral aspects of chronic disease management. Ann Rev Psychol 52: 555-580.
18. Trijsburg RW, Van Knippenberg FC, Rijpma SE (1992) Effects of psychological treatment on cancer patients: a critical review. Psychosom Med 489-517.
19. Mack JW, Grier HE (2004) The Day One Talk. J Clin Oncol 22:563-566.
20. Jadad AR, Browman GP (1995) The WHO analgesic ladder for cancer pain management. Stepping up the quality of its evaluation. JAMA 274: 1870-1873.
21. Azevedo Sao Leao Ferreira K, Kimura M, Jacobsen Teixeira M (2006) The WHO analgesic ladder for cancer pain control, twenty years of use. How much pain relief does one get from using it? Support Care Cancer 14:1086-1093.
22. Rana S, Gupta R, Chaudhary P, Khurana D, Mishra S (2011) Cancer pain management: basic information for the young pain physicians. Indian J Palliat Care 17:127-130.
23. Slort W, Blankenstein AH, Deliens L, van der Horst HE (2011) Facilitators and barriers for GP-patient communication in palliative care: a qualitative study among GPs, patients, and end-of-life consultants. Br J Gen Pract 61:167-172.