

**THE CHARTERED SOCIETY OF PHYSIOTHERAPY**

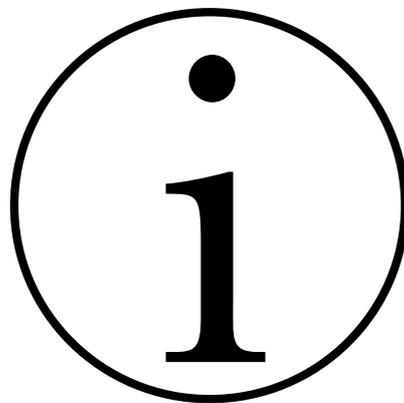
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# **The Role of Physiotherapy for People with Cancer - CSP Position Statement**

CSP

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Physiotherapy is an autonomous profession concerned with the care, management and rehabilitation of patients. These principles apply to the management of patients with cancer through all care and rehabilitation programmes from diagnosis to the end of life.

Physiotherapists conduct ongoing assessment of the needs of this patient group and their carers, in order to apply skilled interventions, which are vital for patients' independence, functional capacity and quality of life.

The role of the physiotherapist, as an essential member of the multi-disciplinary team is key to the successful rehabilitation and management of patients with cancer and palliative care needs. The absence of physiotherapy intervention would be detrimental to patient care and the ability of the patient/family to cope with the effects of the disease or its treatment on their functional capacity and quality of life.

## 1. Introduction

- 1.1. Services for people with cancer have been the focus of a range of policy developments in recent years. The Calman-Hine report (NHSE 1995) highlighted the inequities in the delivery of cancer services across England and Wales, for example, in terms of access, quality and outcomes. Subsequently, the public health agenda has targeted cancer along with coronary heart disease and stroke, mental health and accidents. Saving Lives: Our Healthier Nation (DoH 1999) (and the equivalent public health documents for Northern Ireland, Scotland and Wales) propose action on cancer at four levels: reducing risk; early recognition; more effective treatment; and integrated action.
- 1.2. The publication of the NHS Cancer Plan (DoH 2000) is a clear indication of the Government's commitment to reducing mortality from cancer and to modernise the services offered to people with cancer and their carers. The plan also recognises the need for investment – in staff, equipment and research: an extra £570million/year will be allocated to cancer services by 2003/4. The Plan recognises the diversity of the cancer workforce: physiotherapists are named as having a role to play within the cancer workforce for 'some cancer patients' (para 8.9).
- 1.3. Physiotherapy has a key role to play in the management of clients throughout the cancer journey: from diagnosis through to the end stages of the disease. The aim of the physiotherapist working with people with cancer is:

'to minimise some of the effects which the disease or its treatment, has on them. It is often possible to improve their quality of life regardless of their prognosis by helping them to achieve their maximum potential of functional ability and independence or gain relief from distressing symptoms'

Association of Chartered Physiotherapists in Oncology and Palliative Care (1993)

- 1.4. The current policy agenda therefore offers significant opportunities to the physiotherapy profession. In order to maximise these opportunities, it is vital for the profession to articulate its added value in this field. This paper was drafted in response to chartered physiotherapists' perception that the role of physiotherapy in cancer needs clarifying and publicising.
- 1.5. It is probable that this perceived lack of clarity about the role of physiotherapy for people with cancer reflects a number of issues including:
  - Physiotherapy involvement in the management of people with cancer is a relatively new specialism;
  - Some of the skills used by physiotherapists working in cancer care settings are shared with other professionals within the team (e.g. massage with aromatherapy oils, use of behavioural approaches to enable people to manage dyspnoea): the added value of physiotherapy in this field, may therefore be less apparent;
  - In a healthcare service that attaches significant value to evidence-based practice, the absence of high quality research to back physiotherapy in this field, as highlighted by Joliffe & Bury (2002), may limit new development.

Whilst the arguments in this position statement are backed by evidence, this does not represent a systematic review of the evidence base.

## 2. Rehabilitation for people with cancer

- 2.1. Rehabilitation is finally enjoying a high profile on the UK health and social care agenda. The Latin roots of the verb to rehabilitate imply that the end point of the activity is restoration of skill/ability. Within the context of cancer, the primary goal of rehabilitation is to assist the person with cancer in achieving maximum physical, psychological and vocational functioning within the limits imposed by disease or treatment (Küchler & Wood-Dauphinée 1991). Adopting a rehabilitative approach shifts the focus from a preoccupation with the disease to one which is needs-led (Fulton 1994).
- 2.2. Rehabilitation programmes for people with physical limitations as a result of cancer have been slow to develop (Sliwa & Marcinak 1999). The reasons suggested by the authors included the nature of cancer and its treatments (deficits can be progressive) and the emotional impact of a diagnosis of cancer (the disease is perceived as terminal). Fulton (1994) believes that the main barriers to effective implementation of cancer rehabilitation are the result of attitudinal problems, poor knowledge about cancer and rehabilitation and poor detection of rehabilitation problems.
- 2.3. The cancer rehabilitation team typically includes chaplain, occupational therapist, oncology nurse, pharmacist, physician, physiotherapist, psychologist, social worker, and speech and language therapist (Brenana et al 1996).
- 2.4. Given the interprofessional nature of rehabilitation, some skills/roles will be common across the oncology team e.g. communication, a whole-person approach. Reflection from the literature in this field would suggest that professional boundaries should be blurred in order to achieve a truly client-centred approach (Brenana et al 1996, NCHSPC 2000). Despite the blurring of boundaries and sharing of skills, the contribution of each profession to the rehabilitation team will be unique.

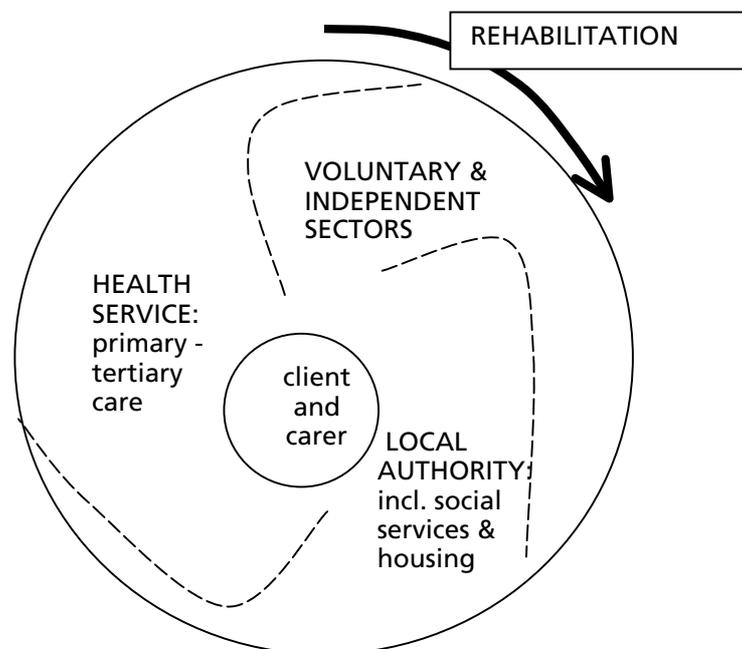


Figure 1: model of rehabilitation for people with cancer

- 2.5. The model illustrated in Figure 1 places the client and their carer(s) at the centre of service delivery. McDonnell & Shea (1993) argue that an interprofessional client-centred approach is necessary because of the complex medical and psychosocial needs of the individual. An interprofessional approach ensures that the client and carer have access to a comprehensive range of services/agencies which are co-ordinated to reduce duplication/overlap. Rawson (1996) notes that effective interprofessional collaboration is valuable to the client as it has a multiplicative effect: the whole being greater than the sum of its parts.
- 2.6 A client-centred approach ensures that the skills and knowledge of the interprofessional team are focused on the needs of the client-carer unit. The active involvement of individual team members would therefore depend on the needs of the client-carer unit at any point in time: the intensity and mix of intervention is responsive to the presenting needs. As the client becomes more independent, the focus of service provision would reflect this, e.g. reduction in amount of acute healthcare service needed with an increase in social care provision (shift from acute oncology unit to supported care at home for example).

Taking this model a stage further, it is arguable that the rehabilitation team should work to co-ordinate the transition of care across agency boundaries; as highlighted by the Calman-Hine report (1995), and the National Cancer Plan (DoH 2000).

- 2.7 Given the different underpinning philosophies adopted by the range of professionals and agencies involved with a person with cancer, the whole team must have a clear vision as to the outcome of rehabilitation in order to ensure a consistent approach. This demands not only effective interagency working, but also client-centred goal setting.
- 2.8 A goal-oriented approach to rehabilitation help produce the best outcome (Wade 1998). The team must set meaningful medium and long-term goals in partnership with the client. Given the changing needs and aspirations of clients over time, it is vital that a flexible approach is adopted. Goal-setting for the person with cancer is determined by a combination of factors relevant to the individual including age, type and stage of neoplastic disease, the presence of other disease, inherent physical ability and socio-economic factors (Dietz 1985).

### 3. Physiotherapy within the context of rehabilitation

#### 3.1.

'Physiotherapy is a health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core'.

CSP (2002)

- 3.2. The Calman-Hine report (NHSE 1995) highlighted the need for rehabilitation for people with cancer: from diagnosis through to the end stages of the disease. Physiotherapy has a significant part of play in the rehabilitative process of people throughout their cancer journey.
- 3.3. The role of physiotherapy in cancer is integral to the seven principles of cancer rehabilitation outlined by Habeck et al (1984) (cited in Fulton 1994):
- Comprehensive care is provided to address the needs (economic, physical, psychological and social vocational factors) of the whole person;
  - A team approach is used to achieve co-ordinated interprofessional care;
  - The unit of care includes both the client and family;

- Goals for rehabilitation are derived from the effects of the medical problem in accordance with prognostic expectations;
- Intervention occurs as soon as the likelihood of disability is anticipated;
- Rehabilitation needs must be reassessed on a continuing basis and met throughout all phases of care;
- Education is a major component of the rehabilitation process.

3.4. Physiotherapy aims to:

'optimise the patient's level of physical function and takes into consideration the interplay between the physical, psychological, social and vocational domains of function.... The physiotherapist understands the patient's underlying pathological condition, but this is not the focus of treatment. The focus of physiotherapy intervention is, instead, the physical and functional sequelae of the disease and for its treatment on the patient'

Fulton & Else (1997 p817)

- 3.5. Within the context of cancer, physiotherapy offers a unique perspective developed from detailed knowledge of functional anatomy and ergonomics. By using this knowledge base, often subconsciously, the physiotherapist constantly analyses movement and posture and the relationship of the observed individual to their environment (Robinson 2000).
- 3.6. People with cancer may present with a wide range of needs, including respiratory, neurological, lymphatic, orthopaedic, musculoskeletal and pain, that may benefit from physiotherapeutic intervention (ACPOPC 1993). McDonnell & Shea (1993) state that the role of physiotherapy in oncologic rehabilitation includes restoring function; reducing pain; reducing disability; increasing conditioning and mobility; and ultimately improving quality of life. Rashleigh (1996) reflects that physiotherapists have a large preventative, educative and supportive role to play in the management of the person with cancer, as well as providing independent and complementary therapies for physical debility and pain.
- 3.7. The Regional PAMs Forum on Cancer Services in Northern Ireland (1998) state that physiotherapeutic interventions for people with cancer will include use of:
- Positioning, movement, mechanical therapies, acupuncture and electrophysical agents to relieve and control pain;
  - Respiratory care: management of dyspnoea, removal of secretions, nebulised drugs and oxygen management;
  - Neurological rehabilitation techniques;
  - Complex physical therapy (a combination of physical therapies e.g. manual lymphatic drainage, compression bandages and garments, exercises and skin care – Boris et al 1997) to control lymphoedema;
  - Education of client, e.g. in care of limb post-surgery, in energy conservation or adaptive strategies, in appropriate handling strategies;
  - Education of carer(s) in appropriate handling skills
  - Exercise therapy to improve flexibility, strength and function;
  - Relaxation techniques to reduce levels of anxiety.

Physiotherapy is an integral part of the service offered at the Young Oncology Unit at Christie Hospital, Manchester. Adolescents with bone and soft tissue tumours are offered support and active treatment from the physiotherapist from the time of diagnosis throughout the entire treatment journey to full rehabilitation. In the event of disease recurrence, support continues and physiotherapy

aims to maintain best function and quality of life for as long as possible.

At time of diagnosis, information and support is vital. The fact that these adolescents are facing several months of chemotherapy and/or radiotherapy and usually major surgery, as well as the direct effect of immobility due to pain, means that muscle wasting, joint stiffness as well as deconditioning and fatigue is inevitable. These problems can be minimised by appropriate explanation regarding treatment and information about maintenance exercises at an early stage.

- 3.8. McDonnell & Shea (1993) argue that clients with cancer perceive physiotherapy treatment as a hopeful event; intervention could lead to greater physical activity and an increased sense of well-being, with opportunities to attain functional independence. Within the context of palliative care, realistic joint goal-setting gives the client a measure of control, often at a time when they are experiencing helplessness and loss of independence (Robinson 2000).
- 3.9 Physiotherapeutic objectives will be diverse (Küchler & Wood-Dauphinée 1991), but will be determined by a whole-person approach to assessment (physical, psychological, social and spiritual) followed by appropriate goal setting in partnership with the client (ACPOPC 1993).

Catherine, aged 33 and married to John, was diagnosed with cancer of the left breast when she was pregnant with their first child in September 1999. Soon after the birth of their second child in November 2000, Catherine was also diagnosed with liver and bone metastases in the jaw and right hip. She subsequently fractured this hip and had surgery for a right hip replacement.

In March 2001, Catherine started attending Trinity Hospice Day Care Centre where she requested physiotherapy treatment for lymphoedema for her left upper limb as she was very distressed by this symptom. She had the size of her limb assessed and monitored and a compression sleeve fitted. She was also given advice on the management of the affected arm with regard to skin care, positioning, exercises, activities of daily living and caring for her two children. The post operative management of Catherine's right hip was also reviewed. Catherine was given some strengthening exercises for her hip muscles along with some gait re-education.

In November 2001, Catherine was admitted to hospital for left discectomy at L4/5 and radiotherapy. She was diagnosed with brain metastases. Around this time she developed further weakness and used a wheelchair for mobility as she was unable to walk.

Two months later, Catherine was admitted to Trinity hospice for psychological support and symptom control. She presented with bowel problems, immobility, low mood, pain in her lower back and a non-productive cough.

Following assessment, Catherine set a goal with the physiotherapist to achieve independent transfers using a transfer board. Catherine achieved this with one person, but shortly after became very unwell from meningeal irritation which made her hypersensitive to touch. She recovered and the new agreed goals of physiotherapy were to maintain joint range and muscle length to allow Catherine to be washed, moved and sit out in her wheelchair comfortably. At all times, Catherine's psychological needs were taken into consideration when planning treatment with her. A few days later she died peacefully, a month after her admission.

- 3.10 Küchler & Wood-Dauphinée (1991) propose that physiotherapists must think beyond the physical restoration of the client and incorporate elements of psychosocial support to minimise problems and facilitate rehabilitation. This argument is supported by a qualitative study by Mackey & Sparking (2000) who draw physiotherapists' attention to the individual, non-physical aspects of client care. These authors suggest that physiotherapists need to be able to identify psychosocial needs and provide some of the necessary psychological support, and that they have an obligation to develop this ability in an effort to maximise the benefits of rehabilitation. Many physiotherapists working in oncological rehabilitation are currently adopting a biopsychosocial approach to treatment. Implementation of the NHS Cancer Plan (DoH 2000) should ensure that this becomes customary: the Plan states that staff working with cancer clients will receive additional training in communications skills and provision of psychological support.

The physiotherapist is a key member of the Breast Cancer Team right from diagnosis through to treatment at the end of life with palliative care. The physiotherapist is involved immediately post-surgery in the assessment and treatment of any respiratory problems. Intervention continues in the form of exercises to regain shoulder movement and function and advice about the risk of lymphoedema and skin care. Approximately 20% of women with breast cancer develop lymphoedema. These women are often seen by a lymphoedema specialist (who may be a physiotherapist or another healthcare professional) for support and advice on management which will consist of compression sleeves or multi-layer bandaging, lymph drainage, exercise and skin care. It is a chronic condition and clients are followed up and treated over many years

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A report published by the CSP (Joliffe & Bury 2002) focuses on the problems experienced by the older person requiring palliative care (related to cancer and non-malignant disease). This report will be of interest to physiotherapists working with older people and to those working with any adult with cancer or non-malignant disease.