The growth and development of research in palliative care: a personal odyssey and reminiscence of people, places and ideas*

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I am extremely honoured to have been invited to give the first Vittorio Ventafridda lecture. It is difficult to express in words how this touched me as I had been very close to Vittorio, a man of great charisma, intelligence and humanity. I have been his pupil, colleague and successor as Chief of the Pain, Palliative Care and Rehabilitation Division in the National Cancer Institute in Milan. In his memory I will try to describe some special moments in the history of palliative care and focus on some key milestones in the development of research in palliative care.

It is almost half a century since the publication of an early paper by Cicely Saunders with the title ‘A patient’ in which she outlines the philosophy of care which has underpinned the subsequent development of hospice and palliative care. It cannot be categorized as a scientific article according to today’s standards, but it was certainly revolutionary and groundbreaking. It reminds us that whilst scientific research and evidence are essential for continuing progress in palliative care, there are also other ways of influencing care and changing medical practice. It is noteworthy that this paper was published in a nursing journal. In the early days of palliative care, many of the new initiatives and services were nurse-led and the support of senior nurses in hospitals and the community was crucial to the success of these radical developments in care for patients with advanced and terminal disease.

Palliative care is difficult to define and is not just another speciality in medicine. One of the reasons that it is difficult to define is the complexity of caring for patients with advanced disease and their families. The special nature of palliative care is captured in a recent definition elaborated by one of the other pioneers of palliative care, Professor Balfour Mount of Montreal: ‘The term “palliative care” implies a personalised form of healthcare. It extends the healthcare professionals’ mandate beyond the biomedical model to the wider horizon necessary if one is to attend to suffering as well as the biology of disease. The patient and family or significant others are taken together as the unit of care in assessment of needs related to illness. The aim of palliative care is to support optimal quality of life and to foster healing – that is a shift in response towards an experience of integrity and wholeness on the continuum of the quality of life’.

It may be difficult for some readers to comprehend today that the change in approach and philosophy proposed by Saunders met quite some resistance. The centrality of the patient and the respect for his or her autonomy and decisions were revolutionary ideas. At that time healthcare professionals were more used to categorizing patients as a particular pathology, or a case number. In a technology-oriented society, discussions about death and dying and the dignity of the human being were not high on the agenda. Communication between doctors and patients was kept brief and to the point. The use of incomprehensible jargon allowed healthcare professionals to hide behind a barrier which patients and their families rarely surmounted. It was with this background that hospice and palliative care emerged in the late 1960s with the opening of St Christopher’s Hospice, widely acknowledged as heralding the beginning of modern palliative care.

Research in palliative care: the early days

One of the features that differentiated St Christopher’s Hospice from other existing hospices and homes for the terminally ill was that its aim was to integrate...
and by the oral route is a pro-drug for morphine. Diamorphine is de-acetylated to morphine and monoacetylmorphine. When given by mouth to treat cancer pain. Diamorphine is rapidly absorbed and has a shorter duration of action than morphine when given by the oral route and is a pro-drug for morphine.

There were campaigns in some countries to have the 'best' drug to relieve the distress of dying and diamorphine had acquired a mythical reputation as the opioid most widely available around the world. At the time that these initial studies were being carried out in St Christopher's there were other related developments. The treatment of chronic pain evolved as a legitimate strategy for clinicians and researchers for at least two decades before the opening of St Christopher's in 1967. John Bonica was one of the pioneers and leaders in this field and his first book on pain therapy was published in 1953. Pain clinics started to appear at a similar time to hospices though their emphasis on interventional and procedural treatments for chronic pain, both cancer pain and non-cancer pain, highlighted a fundamental difference in approach and philosophy from hospice care. However, there was very little work focused specifically on the relief of pain and other symptoms in patients who were dying.

The work on opioid analgesics in cancer pain continued at St Christopher's with the appointment of Declan Walsh as a research fellow to take the place of Robert Twycross. In Oxford, Geoffrey Hanks joined Robert Twycross at the Churchill Hospital and his work focused on the clinical and pharmacokinetic evaluation of controlled-release morphine. This work started in the late 1970s and although hospice and palliative care were now beginning to expand not just in the UK but across Europe and further afield there was still very little research being carried out. Walsh and Hanks were the only full-time researchers working in palliative care in the late 1970s in the UK and their research overlapped: both had an interest in opioid clinical pharmacology and also in nutritional supplements for cachectic patients.

The WHO analgesic ladder

A crucial step in the development of current methods of pain control in cancer and in the organization of large-scale clinical research in patients with advanced disease came with the development of the WHO analgesic ladder. Vittorio Ventafridda and John Bonica organized the First World Congress on Cancer Pain in Venice in 1978. This was with the help of Virgilio Floriani who had sought advice from Ventafridda for his brother who was dying from lung cancer and who had been suffering great pain. Vittorio Ventafridda was able to improve his symptoms considerably and as a result of this experience the Floriani family launched the idea to create a Foundation to support the care of patients with advanced cancer. The Floriani Foundation was instrumental in supporting the Venice Congress on Cancer Pain and also played a pivotal role in setting up a model of home care for advanced cancer patients that was subsequently adopted in many other parts of Italy and in other European countries.
The introduction of home care was an important turning point for the development of palliative care in Italy. We had not yet gained enough knowledge of the treatment of pain using opioids; there were few publications and at that time it was not easy to find them. The management of cancer pain was largely based on intervention with neuroablative techniques and Vittorio and I were both trained in performing these techniques. However, we started to follow up patients more closely and we set up a home care team which enabled patients to be seen in their own home by a nurse and physician. We began to understand the complex needs of these patients and we discovered that many of them did not maintain their apparently satisfactory response to neuroablative treatments in the long term.

As a result of the congress in Venice, Ventafridda decided with Jan Stjernsward, who was the Chief of the WHO Cancer Unit, that there was an urgent need to develop guidelines on cancer pain treatment especially dedicated to the countries of the developing world. Four years later, in 1982, the Floriani Foundation organized a meeting in the Castle of Poerio where Stjernsward and Ventafridda assembled a committee who created the WHO Cancer Pain Relief guidelines. The members of this group were Kathy Foley from the United States (the Chair), Anders Rane from the Karolinska Institute in Sweden, Mark Swerdlow, one of the leading pain specialists in the UK, Robert Twycross from Sir Michael Sobell House in Oxford, Jesmond Birkhan, a pain specialist from Israel, PB Desai from India, Miriam Martelete, a pain specialist from Brazil, F Takeda, an oncologist from Japan, and Robert Tiffany, a leading cancer nurse from the Royal Marsden Hospital in the UK (Figure 1). I was privileged to play an important role in this meeting as the driver of the minibus taking this group to the Castle.

The WHO cancer pain relief programme was the first attempt to provide guidelines for clinicians which would enable them to achieve pain control in the majority of patients with cancer pain. The central idea of the WHO method was the ‘analgesic ladder’

Figure 1. Photo of the WHO Committee.
which provided a framework for choosing appropriate analgesics based on the severity of the patients’ pain (Figure 2).

There had not previously been explicit guidance on cancer pain management. The usual approach had been to use intermittent intramuscular (IM) injections of strong opioids such as morphine ‘as required’. This invariably resulted in inadequate control of pain and patients fluctuated between experiencing severe pain and being asleep because of excessive doses of morphine. An alternative strategy was to use oral mixtures of morphine or other opioids with a sedative antiemetic, a psychostimulant and alcohol (for example, the Brompton Cocktail) administered frequently to keep the pain under control.

The WHO method was published in 1986 in a booklet entitled Pain Relief in Cancer and it had a remarkable impact. More than 250,000 copies of the booklet have been distributed around the world and to every country in the world. It is published in more than 20 languages and is in fact the second most translated publication in WHO history.

Vittorio Ventafridda was given the responsibility for organizing the field-testing of the new WHO guidelines and our unit in Milan was appointed the WHO Collaborating Centre for Cancer Pain Relief. Considerable discussion ensued about the design of the field-testing studies, which later became known as the ‘validation’ studies of the WHO ladder. There were several major difficulties. There had not previously been a ‘standard’ method for controlling cancer pain and the approach to this problem varied enormously, not just within individual countries but from country to country. It was thus difficult to decide what control treatment would be used if a controlled study was to be carried out.

The efficacy of existing treatments for cancer pain was not well documented. The WHO method was not a single drug but an approach to management of cancer pain involving different classes of analgesics and adjuvants and based on careful assessment and diagnosis of the mechanisms underlying each patient’s pain. The WHO method could be described as a ‘complex intervention’ to use modern terminology. There was little experience of undertaking studies of such treatments particularly in vulnerable patients.

Statistical advice for the field-testing studies was provided by the WHO Collaborating Center for Cancer Biostatistics Evaluation at Harvard. The protocol makes it clear that the objectives of the study are limited to feasibility, compliance and effectiveness within individual patients. No attempt was made to compare the guidelines with current practice or to determine whether introducing the guidelines has an impact on the general quality of life for cancer patients with pain. These questions were to be addressed by other protocols at a later stage.

The WHO guidelines were designed to be applicable both in the Western world and also in developing countries. The aim of the field-testing of the guidelines was to demonstrate that this was indeed the case and that the guidelines could be applied in different countries and in different circumstances and still be effective. However, the organization of such a multicentre and multinational study had not been attempted previously. There was no existing network of clinicians and researchers who could be called upon to consider taking part in the study. Involvement in the studies depended on personal contact and Vittorio Ventafridda set out on a worldwide campaign to encourage and persuade prospective collaborators to join the venture.

The studies in different centres differed considerably in size and duration although the methodology was reasonably uniform. The whole exercise was
remarkably successful: studies were completed in many different countries and involved thousands of patients. The WHO method was widely disseminated and this marked a turning point in the management of cancer pain.

Many lessons were learned about the difficulties of carrying out large international studies. Even communicating with the different centres was much more complicated than today. There was no email or telephone conference calls or mobile phones or fast portable computers with the capacity to store large amounts of data. The main initial WHO validation studies are shown in Table 1.15-22

There has been debate and criticism of these studies23 because of the limited quality of the evidence that they provide in assessing just how much the WHO method has improved the treatment of cancer pain. Whilst acknowledging these limitations it is important also to recognize that this was the first attempt to undertake such a study in patients with pain and cancer, on such a large scale. Countries such as India and Vietnam took part and for many such places it was a real struggle to recruit patients. Given the limited experience, manpower and resources the WHO validation studies were a remarkable achievement.

One of the consequences of the WHO validation studies and the designation of the Milan unit as a WHO Collaborating Centre for cancer pain relief was that the unit at the National Cancer Institute in Milan became widely known as a centre for pain relief and palliative care. Jan Stjernsward and other colleagues involved in developing the WHO guidelines were very effective in disseminating this information around the world. It seemed natural therefore that the next important step in developing possibilities for research in palliative care and in facilitating communication between clinicians, researchers and scientists who were already starting to come into the field should take place in Milan. Thus was born the first Europe Congress on palliative care in 1988, again with the support of the Floriani Foundation. As a direct result of this highly successful congress Vittorio Ventafridda and colleagues from across Europe founded the European Association for Palliative Care (EAPC) in 1989. The EAPC has grown in a remarkable fashion. Starting with 42 founding members in 1989 it is now a federation of national societies of palliative care, representing in excess of 50,000 members across Europe.

The European Association for Palliative Care

The EAPC with Vittorio Ventafridda as President and Derek Doyle as Vice-President elected a Board of Directors comprising remarkable individuals who had already made a mark in their own countries in pioneering hospice and palliative care. They were Michelle Salamagne from France, Charles-Henri Rapin (Switzerland), Rene Schaerer (France), Frances Sheldon (UK), Xavier Gomez Baptiste (Spain), Bernadette Wouters (Belgium) and Sonia Wallin (Sweden).

High on the list of priorities of this group emerged a plan to organize regular congresses of the EAPC to encourage scientific work and the presentation of data, to develop educational activities for healthcare professionals and most of all to give the opportunity for professionals working in this field to meet and support each other.

The first EAPC Congress: Paris 1990

The first congress was planned for 1990 in Paris. Geoffrey Hanks was appointed by the Board of the EAPC as Chairman of the Scientific Committee. Maurice Abiven and Michelle Salamagne chaired the organization committee. An ambitious programme was constructed and there was very much excitement as the congress drew nearer. However, as time passed very few delegates registered for the meeting. A considerable amount of money had been committed by the newly founded EAPC to underwrite the congress but it had been anticipated that this would be covered by registration fees. In the weeks just before the congress it became obvious that there was nowhere near the number of registrations required to cover the costs of the meeting and it looked likely that the fledgling EAPC would lose a substantial amount of money and could become bankrupt.

As it happens, on the day of the Congress a queue began to form at the registration desk and soon extended out of the conference hotel (the Meridien Montparnasse) and encircled the conference building. Within an hour hundreds of would-be delegates had joined the queue and waited patiently to gain entry. In the end, to the great relief of the organizers, more than 1500 participants attended the Congress, many more than was required to break even. The Congress was opened by President Mitterand and the Duchess of Kent (the royal patron of the EAPC), and made a great impact in Paris and France generally and wider afield.

The feedback was very positive and the Paris Congress proved to be the first of the highly successful series of biennial EAPC Congresses. These meetings provide many opportunities to meet and share experiences with colleagues not just from Europe, but from around the world. Poster presentations and poster discussion sessions are always a major part of each congress and the Scientific Committees of the Congresses
have always worked hard to incorporate information and news about the latest developments in palliative care including recent research and innovations. The Congresses have thus played a vital role in encouraging and supporting high-quality research in palliative care from the early days of the EAPC.

Peer support for researchers is essential to their continuing productivity and it is important they are able to meet each other, both in formal research-orientated meetings but also informally and socially. This gives opportunities to learn from colleagues and to keep in touch with other like-minded healthcare professionals and scientists. Such connections and meetings may not necessarily lead to new research projects or collaboration but often they do. This is one of the reasons why the EAPC Congresses have gone from strength-to-strength since 1990, attracting ever-larger audiences as palliative care continues to grow in every part of the world.

The organization of an EAPC Congress is a huge undertaking and the Board of Directors of the EAPC carefully consider all applications to ensure that the organizers have the necessary infrastructure support, sufficient money to underwrite the costs and plenty of volunteers to undertake the long list of essential activities involved in hosting an international scientific meeting with 2000 or more delegates from all over the world.

A considerable amount of time and effort is taken up by the organization of the biennial congresses, and the Board of Directors of the EAPC is always heavily involved. All of the Board members are volunteers who are committed to giving substantial time to their role in the EAPC. Without them there would be no EAPC and no EAPC congresses. The contribution of time, thought and expense is vital to the continuing activities of the EAPC including the support and facilitation of research and is something which is rarely acknowledged or written about. The Board members and particularly the office holders give freely of their time and energy and it is important to recognize the essential role they play.

The EAPC Research Network

One of the major problems facing researchers in palliative care is that it is a particularly difficult area in which to carry out randomized controlled trials (RCTs). The particular problems are in recruitment of patients, attrition and the choice of appropriate outcome measures. In palliative care clinical practice the number of patients who may be suitable for entry to a particular study will be small. A common miscalculation of those beginning clinical research (and this applies generally, not just in palliative care) is to assume that they will have many suitable subjects. In practice once the trial starts the eligible patients seem to disappear. Palliative care patients are generally elderly, are seriously ill with multisystem disease, have many symptoms and are usually receiving a large number of drugs concurrently. Thus, many patients will not meet the inclusion criteria and have to be excluded from consideration for entry to studies.

Any one palliative care centre is likely to see a very small number of patients who would be eligible to be recruited to a particular study. This means that multicentre studies will be the most efficient way of successfully completing clinical research in palliative medicine. There are problems associated with multicentre studies, but the benefits in this area of medicine outweigh them.

Recent years have seen the development of research networks bringing together researchers from a number of specialist palliative care units and centres to collaborate in clinical studies so that recruitment of sufficient numbers of patients can be achieved in a reasonable period of time. One of the first palliative care research networks to be established was the EAPC Research Network.

When we were travelling to a world cancer congress in Penang with Geoffrey Hanks, we had the idea to establish a research network within the EAPC. We felt that we had to do something about the lack of scientific evidence to underpin clinical practice in palliative care. Geoffrey Hanks had just been appointed to the first Chair in palliative medicine in Europe and this seemed to be an opportune time to establish a collaborative research base for palliative care. I proposed this to the Board of Directors of the EAPC and there was widespread support for the idea. Initially a research steering committee was appointed and had its first meeting in 1996. When we set up this committee and the research network we had in mind that it would facilitate multicentre RCTs and that was the main objective.

In 1997, I chaired a research session with Cicely Saunders in a congress in Cyprus and she publicly acknowledged the importance of the idea and the establishment of the research network, and gave great encouragement to this initiative which she felt was the only way to secure the future for palliative care. Also participating in that congress in Cyprus was Stein Kaasa, an oncologist from Norway who has subsequently become one of the most important driving forces for research in palliative care.

Other groups and collaborations started to appear. In 1998, the Palliative Care Research Society was formed in the UK. The EAPC Research Network steering committee held a number of meetings in Sicily. In order to avoid distractions and concentrate on the important discussions the meetings were held in a
convent at the top of a mountain. In spite of focusing attention on the problems of carrying out multicentre RCTs it soon became apparent that whilst some members of the group had quite extensive experience of clinical research and RCTs there were also many countries where there was no one working in palliative care who had such experience. This meant that the Research Network steering committee decided that there was no immediate prospect of setting up such studies.

There was much discussion about other activities that the Network could become involved in. Again, I made a proposal to the Board of Directors of the EAPC that the Research Network steering committee should consider organizing expert meetings to focus on particular topics which were controversial and of current interest and produce consensus statements for publication under the aegis of the EAPC. This was a new initiative which had not been attempted before by the EAPC but the proposal again met with considerable support from the Board of the EAPC. The expert meetings would take considerable organisation and also cost was a significant factor in bringing together international experts in a particular field.

The EAPC Research Network had been supported financially by the palliative care group in Sicily, particularly Georgio Trizzino and Sebastiano Mercadante and it was decided to hold the first two expert meetings in Sicily.

I proposed that the first topic to be discussed should be the question of routes of administration of morphine and other opioid analgesics. At that time in the early 1980s and early 1990s this was a topic which had been the cause of considerable controversy and argument. In particular, the role of spinal opioids was unclear with some countries using this route of administration extensively (for example, the United States) whilst in other countries the spinal route was very little used (for example, in the UK).

The Board decided that we should have two expert groups and the other topic to be discussed should be hydration and nutrition in palliative care. The two meetings were organized and expert panels were put together by the Research Network steering committee. The meetings proved highly successful and productive and both resulted in consensus papers which were published shortly afterwards.\(^{29,31}\) The paper on opioids was published in the *British Medical Journal*\(^{29}\) and has made a significant impact. It has been widely cited, translated into French, Italian, Spanish, Swedish, Thai and perhaps some other languages, and was subsequently updated by reconvening the expert group who published a revised version in 2001.\(^ {30}\)

The recommendations in these papers have come to be known as the EAPC recommendations on opioid analgesics in cancer pain and they are now being updated for a second time. As part of the European Palliative Care Research Collaboration funded by the 6th Framework Programme of the European Commission, a project that is being led by Augusto Caraceni, my successor in the National Cancer Institute in Milan. The project involves a large number of collaborating groups who have carried out systematic reviews of the evidence to support the revised guidelines on opioid use. This evidence and the results of the reviews were presented at the 5th Bristol Opioid Conference in February of this year. The presentations at this international meeting allowed considerable interaction with the audience and discussion of the new recommendations. We envisage that they will published later this year supported by publication of the individual systematic reviews in a special edition of *Palliative Medicine*.

The 2 initial expert meetings and their publications\(^ {29,31}\) have been followed by 11 other papers (Table 2).\(^ {29-41}\) So this initiative, whilst not being what we originally planned for the Research Network, did in fact prove to be highly productive. A number of the papers seem to have been influential and highly cited. One of the by-products of the exercise has been that the expert meetings and consensus documents have identified where the major gaps in evidence lie. They thus have been a means of identifying more specifically the research agenda for the topics under discussion.

### The EAPC cross-sectional survey

At every meeting of the Research Network steering group we did revisit the idea of carrying out multicentre clinical trials. In the midst of the activity relating to the expert groups and consensus documents, Nathan Cherny put forward a proposal to carry out a major survey of palliative care services across Europe. One of the objectives would be to see which services could provide basic demographic and clinical data on the patients being seen. At the same time we would collect data on particular points of interest such as the opioid analgesics being used in the centre, the doses of opioid analgesics, the other medication being used and data about the patients in terms of their diagnosis, performance status, prognosis and length of time under the care of the palliative care service. The coordinating centre for the study was set up in Trondheim in Norway in the department of Professor Kaasa.

The study was eventually completed and 143 centres in 21 countries provided data on more than 3000 patients. Clearly the study had demonstrated the huge potential for palliative care research networks to work in a coherent and collaborative fashion across many different countries and cultures. The survey has already generated three major publications,\(^ {38,39,41}\) and the
experience emphasizes that the future for palliative care research lies with networks be they local, regional, national or international.

The Research Network of the EAPC did not get involved in multicentre clinical trials as we had envisaged when we made the proposal to set it up. The palliative care community in Europe was just not ready at that time with sufficient individuals who had the expertise and experience to collaborate effectively in such studies. In spite of that the steering committee of the Research Network proved an important forum for discussing issues concerning research in palliative care and the programme of expert committee reviews and consensus papers has given rise to a number of important papers, either consensus documents or clinical guidelines, which have made a significant impact on clinical practice in palliative care.

We have in the steering committee of the Research Network some key individuals from different countries in Europe who have been instrumental individually and together in promulgating the need for research in palliative care and putting considerable efforts into undertaking and completing such research. In some ways this group has acted as a pressure group to keep research high on the agenda so that it continued to get the priority it needed if it was to become properly established with sufficient funds to provide adequate research staff, infrastructure support and all of the other activities necessary for high-quality research.

EAPC Research Forums

At the end of 2000 the Research Network organized its first Research Forum. The EAPC Board of Directors was not totally convinced that this would be a good idea. They were afraid that it would be in competition with the main biennial EAPC Congress, would decrease the number of participants at the main meeting, and hijack all of the best abstracts, leaving the less important work to be presented at the main congresses.

The idea for the Research Forum was that it should clearly have a focus on research. The main EAPC Congress was certainly an appropriate venue at which to present research findings and had served this purpose since the first congress in 1990. However, the main congress also had other functions. There was an educational teaching and learning component, opportunities for discipline-specific mini symposia and workshops,

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<td>2001</td>
<td>Morphine and alternative opioids in cancer pain: the EAPC recommendations published online in 5 Languages</td>
<td>British Journal of Cancer 84: 587–593</td>
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<td>2001</td>
<td>Clinical practice recommendations for the management of bowel obstruction in patients with end-stage cancer</td>
<td>Supportive Care of Cancer 9: 223–233</td>
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<td>2001</td>
<td>Depression in Palliative Care: A Pragmatic Report of an Expert Working Group of the European Association for Palliative Care</td>
<td>Supportive Care of Cancer 9: 477–488</td>
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<td>2002</td>
<td>Breakthrough pain – state of the art and the need for structured research</td>
<td>Cancer 94: 832–839.</td>
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<td>2005</td>
<td>Pain and pain treatments in European palliative care units</td>
<td>Palliative Medicine 19: 477–484</td>
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<td>2005</td>
<td>Prognostic Factors in Advanced Cancer Patients: Evidence-Based Clinical Recommendations—A Study by the Steering Committee of the European Association for Palliative Care</td>
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<td>Patient demographics and centre description in European palliative care units- A cross sectional survey of the European Association for Palliative Care (EAPC) Research Network</td>
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<td>Fatigue in palliative care patients – an EAPC approach</td>
<td>Palliative Medicine 22: 13–32</td>
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for national or regional meetings, for presentation of data about services and generally a much broader programme than was envisaged for the research forum. The first Research Forum in Berlin had a positive worldwide impact, sufficient to allay any anxieties the EAPC board may have had about possible conflicts with the biennial congresses. Some 342 delegates met in Berlin and the emphasis was clearly different from the main EAPC meetings. It was much smaller and the delegates were generally more experienced and professional researchers, actively involved in research on a continuing basis. This international meeting of researchers in palliative care has also now become a biennial meeting held on alternate years to the main congress. The number of participants has increased to just over 1000 in the last two meetings in Venice and in Trondheim. The number of abstracts presented has increased from just over 150 to about 575 (Table 3). I can tell you that here in Glasgow we received a total of 663 abstracts from 39 different countries, which will all be presented either as posters or as oral communications.

### The European Palliative Care Research Collaborative (EPCRC)

In 2008 I retired as Chairman of the EAPC Research Network steering committee. I handed over the reins to Professor Stein Kaasa but I was delighted and moved to be appointed Honorary Chairman of the Research Network by the EAPC Board of Directors. It is appropriate for me to end this personal reflection with a note about the European Palliative Care Research Collaborative (EPCRC) and the new European centre for palliative care research in Trondheim.

The EPCRC is a consortium of 11 centres in six countries which is being funded by the European Commission within the 6th Framework Programme. The aims of this project are *inter alia* to identify genes and genetic variation relevant for response to opioid treatment and the development of cachexia. The emphasis of this initiative is to demonstrate the relevance of translational research to palliative care. The project has already been highly productive with a large number of projects in various stages of completion. A number of papers have already been published and it is clear that this has been a highly successful and productive collaboration. The EPCRC was largely made up of members of the Steering Committee of the EAPC Research Network, aiming to build on the links already formed and it is exciting to see this group mature into a cohesive and productive international network.

The EPCRC will now put together another major application to the European Commission 7th Framework Programme. An exciting and important development in palliative care research in recent years has been the introduction of new funding streams, with substantial investment from funding bodies in different parts of the world. This has been evident in Canada and the United States, in the United Kingdom and from the European Commission. This will put palliative care research on a much more secure basis for the future and it is good to see the research community making the most of these opportunities.

### Conclusions

In many ways palliative care research is coming of age. The need is clearly recognized by the funding agencies after many years of activity from palliative care researchers. The EAPC and the EAPC Research Network have contributed in a major way to developing research in this area. Research in palliative care is going from strength-to-strength and it can only go forward. I have been privileged to have worked with Vittorio Ventafridda, one of the most inspiring pioneers in palliative care, and with many other leaders of palliative care and palliative care research across Europe and further afield. I hand over the baton to Stein Kaasa with some sadness to be stepping down at such an exciting time but also with satisfaction that we have made good progress in facilitating research which is
essential if palliative care is to grow and improve for the
good of the patients for whom we care.

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