There’s two certainties in life – death and taxes. Somehow discussions about death are considered taboo and people have a tough time with this topic. In cancer care we praise patients and doctors for not giving up and we use terms like “fighter” and “survivor,” as if those who did not survive didn’t fight hard enough or they somehow gave up. Nothing could be further from the truth. The reality is that, in cancer care, though mortality rates have significantly declined and survivability is going up, there are those patients in whom treatment options hit a road block and there is simply nothing further that can be done – enter palliative care.

Palliative care is a collaborative form of care that includes doctors, nurses and social workers. Their aim is to provide relief from symptoms of all terminal illnesses, not just cancer. The symptoms they seek to alleviate are depression, pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, trouble sleeping and more. It does not mean hanging up your coat and calling it a day. It does not mean no treatment. It means getting the most out of the time you have left. Hospice care, is similar to palliative care but without curative intent.

At the recent American Society of Clinical Oncology (ASCO) meeting in Chicago, preliminary findings of a study conducted by the University of North Carolina were presented. Researchers analyzed data provided for 28,731 patients from HealthCore Integrated Research Database who were younger than 65 years of age who had incurable cancers. They determined that about three-quarters of patients with metastatic cancers (lung, colorectal, breast, pancreatic or prostate) received aggressive or invasive procedures or were admitted to tertiary care facilities within the last 30 days of life.

“Overuse of aggressive care at the very end of life for a cancer patient can translate to increased burden on patients and their families,” according to Aaron Falchook, MD, a co-author of the study and a resident at the UNC School of Medicine Department of Radiation Oncology. “In essence what we’re doing is we’re giving patients side effects without giving them the benefits of the treatment, and that’s really the fundamental problem with aggressive care at the very end of life.”

It is exceedingly hard to navigate through such an emotionally charged situation, especially if the patient is younger. And one way to circumvent this problem is ensuring that palliative care is part
of the dialogue early on after diagnosis. In a study [4] published in the New England Journal of Medicine, it was found that in patients with metastatic non-small-cell lung cancer, an earlier introduction to palliative care resulted in significant improvements in both quality of life and mood in comparison to patients who did not receive such care. Additionally, earlier introduction to palliative care led to less aggressive treatment at the end of life as well as longer survival.

There are also those patients in whom the treatment well has dried up and the only alternative is to have a frank discussion with the patient and the patient’s family. According to one young couple [5], the husband, 31 years of age was dying of colon cancer. “It was a whole new way of thinking to wrap our minds around,” stated his widow. Without this ‘fight mode’ she felt, “We finally felt like we were allowed to live.”

On the other end of that spectrum are patients who consider discontinuing treatment as giving up. According to Dr. Neil Wenger [6], director of Healthcare Ethics Center at UCLA’s David Geffen School of Medicine, “It’s very common for us to receive consults with clinicians who are being pushed to provide treatment that won’t do any good.”

But the reality of the situation is, even for specialists in the field of cancer, dying remains an uncomfortable topic, despite its reality. And that makes frank discussions about expectations [7] early after diagnosis so imperative. It not only helps the patient, but it inevitably translates into more efficient allocation of valuable medical resources. Pointless aggressive interventions in dying patients, especially anticancer treatments, are intensive and costly.

One of the ways that palliative care discussions can become standard of care in cancer treatment is ensuring that physicians are educated to make appropriate and timely referrals [8] for palliative care services. Again, palliative care should not be equated to dying or be viewed as a last resort. There is a need to overcome physician and patient barriers for referral.

“In late-stage cancer, higher levels of medical treatment usually mean more suffering, with little or no extension of life. So why push for more?” asks Dr. Ira Byock [6], the director of palliative medicine at Dartmouth-Hitchcock Medical Center and author of The Best Care Possible: A Physician’s Quest to Transform Care Through the End of Life.

“The bottom line is people don’t want to be dead. We doctors don’t want them to die. The problem is, we have yet to make one person immortal.”

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