Palliative care addresses the symptoms of cancer throughout the course of the disease. Moreover, rather than just improving end-of-life care, palliative care also improves survival. It has long been established that a patient's survival is dependent on the palliation of symptoms caused by cancer therapy, such as neutropenia and chemotherapy-induced nausea. However, the relief of other symptoms, such as pain, has also been shown to increase survival.[1,2]

Symptoms both influence and prognosticate survival, acting as a surrogate for the extent and complications of cancer. Shorter survival in non–small-cell lung cancer is associated with moderate to severe coughing at baseline, poor appetite, or increased fatigue or shortness of breath during the first cycle of chemotherapy.[3] Symptoms such as fatigue and dyspnea were associated with lower survival rates among the 75% of cancer patients who were unexpectedly discovered to have pulmonary emboli on routine computed tomography (CT).[4] Although no difference in survival was identified in another study, 77% of patients with unsuspected pulmonary emboli detected on routine CT also had symptoms of dyspnea.[5] These studies demonstrate that pulmonary emboli can be diagnostically evident with symptoms far less severe than those classically associated with pulmonary emboli, such as pleuritic chest pain and tachycardia. It is unknown how many patients develop complications, such as pulmonary emboli, from reduced mobility due to unrelieved pain and other symptoms of cancer and its treatment. Symptoms that occur after the diagnosis of cancer are a sensitive measure of disease and its morbidity. Once the etiology of a symptom is diagnosed, treatment of the symptom's cause can influence overall survival.

Beyond the statistics on survival are the ethics of palliative care. Compassionate care is defined by the four characteristics of understanding and relief of distress and suffering, empathy, emotional support, and effective communication. A survey of 800 hospitalized patients and 510 physicians showed broad agreement that compassionate care is very important. Despite this, only 53% of the patients and 58% of the physicians indicated that compassionate care is delivered—because of the increasing pressures within the healthcare system.[6]

The most pressured environment in the healthcare system is the emergency room, where physicians who do not have a relationship with the patient must quickly evaluate and relieve significant symptoms. Of 228 emergency medicine (EM) residents, 159 (70%) completed a survey on palliative care. Of those surveyed, 50% had completed some palliative care training before residency, and 54% were interested in receiving future training in palliative care. While 71.1% agreed or strongly agreed that palliative care was an important competence for an EM physician, only 24.3% had a "clear idea of the role of palliative care in EM." The highest self-reported level of formal training was in the area of advanced directives or legal issues at the end of life; the lowest levels were in areas of patient management at the end of life.[7]

While palliative care is an ethical responsibility for all healthcare providers, it is also instrumental to reducing the human and economic costs of cancer. Improved palliative care among nearly 500 Medicaid patients in four New York State hospitals reduced inpatient costs by about $6,900 per admission. These savings could reduce healthcare costs by up to $250 million annually in New York State alone.[8] Recent US Food and Drug Administration decisions have focused on the endpoints of the prevention/delay/relief of symptoms and disease progression, which are of unequivocal and meaningful benefit to a patient's quality of life.[9] Meaningful benefit, as a measure of the quality of oncology care, is defined as quantifiable factors that influence the decision making of patients, caregivers, providers, payers, and policymakers.[10]

Palliative care should be at the forefront of discussions about healthcare. This is because medical decisions that incorporate palliative care can have a direct impact on both survival and quality of life. While a survival benefit of a few weeks during a clinical trial is considered significant, improved survival resulting from better pain management has, disappointingly, not changed the paradigms of...
clinical practice or clinical trials. Symptoms that arise during the course of cancer have been shown to be significant measures of disease and morbidity. Improved palliative care has reduced healthcare costs by preventing morbidity and obviating futile care. Physicians are often not adequately trained in the principles of palliative care, even though patients and physicians both wish for more compassionate care in which symptoms are relieved and clinical status is better communicated. Every stakeholder in the process of healthcare delivery is looking for meaningful benefit, in which the patient's quality of life is improved. Palliative care, by definition, provides meaningful benefit in the treatment of every phase of cancer. The articles in this special issue of ONCOLOGY provide a wealth of evidence and persuasive arguments for the benefits that flow from integrating palliative care more fully into the care we give our patients.

References:

REFERENCES


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