

The impact of early palliative care: a medical oncologist's perspective

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Abstract: The role of early palliative care involvement for patients with cancer is being increasingly recognized for patients with incurable cancer as more studies demonstrate that it is feasible, cost-effective and efficacious. Patients benefit from improved symptom control, better supported decision making and improved quality of life. It has been shown to be effective alongside disease-modifying treatment, and evidence supports the use of multidisciplinary care in a co-management role. It is also a cost-effective way to reduce unnecessary and overly-aggressive treatment at the end of life. Efforts are needed to alleviate persistent misconceptions and support program development in areas where access is limited.

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The field of oncology has grown increasingly complex in the last two decades with patients being offered a broad array of treatment options and surviving longer (1). Given these trends, there is increased need to support patients' physical, psychological and existential needs and relieve suffering. The role of early palliative care involvement for patients with cancer is being increasingly recognized. For patients with incurable cancer, it is demonstrated to be a feasible, cost-effective and efficacious way to improve quality of life and may impact overall survival (2,3). Reflecting this growing emphasis are recent guidelines and metrics that include early palliative care involvement as a marker of high quality care (4,5).

The WHO defines palliative care as a holistic approach to care of patients and their families facing life-threatening illness and recognizes its role early in the course of disease concurrently with disease-modifying treatment (6). The practice focuses on patient wellbeing and the scope of practice is extremely broad. In addition to providing symptom-directed care, ASCO recognizes multiple other components in the palliative care of cancer patients, including rapport-building, addressing illness understanding and prognosis, assessing coping and support mechanisms, and aiding in

treatment decision making. Within this broad scope of practice usually operates a multidisciplinary team, including physicians, nursing, social work and spiritual care. The most validated successful models include a consultation service available in both the inpatient and outpatient setting (7). Different outpatient care models, exist, ranging from stand-alone clinics to fully integrated multidisciplinary clinics. This multidisciplinary model aims to facilitate communication between specialists, lessen the burden of patient visits and allow for earlier management of disease or treatment related symptoms.

Dedicated palliative care services and multidisciplinary clinics are resource-dependent; many hospitals do not have access to dedicated palliative care services in community settings (8). Yet, even in resource-rich settings, misconceptions persist that limit access. Many oncologists at comprehensive cancer centres still only involve palliative care services for patients with uncontrolled symptoms or when patients are close to the end of life (9). Furthermore, negative emotions predominate patient perceptions of palliative medicine, leading to fear and avoidance (10).

One rationale for the benefit of early involvement of palliative is the high burden of suffering that cancer patients

experience. Although the frequency and burden of physical symptoms varies between different disease sites, cancer patients report a high prevalence of symptoms of distress that impact their quality of life, including fatigue, nausea, pain, weakness, lack of appetite, and drowsiness (11). Additionally, a cancer diagnosis is associated with risk of psychological morbidity, with high incidence of anxiety and depression for patients and family members alike (12). A patient's initial visit with their oncologist is appropriately focused on establishing a correct diagnosis and treatment plan. Yet, in an environment with aging demographics, increasing cancer incidence, and increased patient complexity, the oncologist may be unable to optimally assume all aspects of patient care. The involvement of palliative medicine alongside the oncologist provides different but complimentary approaches to care and more opportunity to address suffering in an at-risk population. The benefits are clear; early palliative care involvement in patients with incurable cancer has consistently shown improvements in patient quality of life and symptom burden (3,13). In addition, one study of patients with early-stage lung cancer described a similar benefit at 12 weeks, suggesting this benefit extends to patients being treated with curative intent (14). This is unsurprising, given the substantial morbidity and treatment-related toxicity that patients experience at diagnosis, during and after active treatment.

In addition to improving quality of life and symptom control, the involvement of palliative medicine may even impact overall survival for cancer patients. While not all studies have shown such a benefit, one randomized trial of early palliative care referral for patients with metastatic non-small cell lung cancer demonstrated a 2.7-month survival benefit (2). The explanation for this outcome is unclear, but it is hypothesized that improved mood and better symptom control, establishing better support networks, and facilitating better treatment decision-making may have contributed to the effect. Interestingly, a recent trial of web-based symptom reporting system showed a 5.2-month overall survival benefit compared to the standard care and follow up, highlighting the impact of promptly recognizing symptoms of distress (15). The integration of palliative medicine to cancer care improves recognition and intervention to patient-reported outcomes.

A further and important role of the palliative care team is improving illness understanding and treatment decision-making. In order to empower patients to make treatment decision, a realistic disclosure of expectations, prognosis and goals of treatment is essential. Studies have suggested

that patients want to be informed of their prognosis, but often have poor understanding of their illness and goals of treatment (16,17). This disconnect is reflected by oncologists having a tendency to be overly optimistic in their survival estimates, and often only provide this information if it is requested (18). More so, oncologists do not often engage in discussions around end of life care and documentation of advance directives and goals of care discussion is sparse (19,20). Without these discussions, patients are at risk of receiving unwanted treatment at the end of life (21). Having a trusting, longitudinal relationship can alleviate some of the barriers associated with these difficult conversations. Palliative care providers can reinforce an oncologist assessment of prognosis and take time to explore patients' wishes and goals that help guide treatment decisions.

As the cancer treatment increasingly involves multiple agents and costly treatments, palliative care involvement may be cost effective. Cancer patients often receive chemotherapy within short weeks of the end of life and end up admitted to acute care and intensive care units (22,23). These interventions are not only costly, but associated with poor quality of life, worse caregiver satisfaction, delayed referral to hospice and lack of meaningful gains in survival (24,25). Early palliative care has been shown to reduce chemotherapy use at the end of life and facilitate advance care planning (26). Through cost-avoidance, palliative care services may reduce hospital costs without compromising quality of care (27,28). This cost-effective intervention has impact in resource-constrained settings as well; where standard disease modifying treatments may be unavailable, palliative care services through a multidisciplinary team or primary care has been recognized as a cost-effective way to improve quality of life for patients with cancer (29).

In summary, there is growing recognition that early palliative care is a valuable component in the care of patients with cancer. It has shown to be efficacious, feasible and cost effective in improving patients' quality of life. Further efforts are warranted to mitigate misconceptions and improve access.

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Footnote

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