

The Importance of Palliative Care in Patient Therapy

Abstract- Palliative cancer care is the integration into cancer care of therapies to address the multiple issues that cause suffering for patients and their families and have an impact on the quality of their lives. Palliative cancer care aims to give patients and their families the capacity to realize their full potential, when their cancer is curable as well as when the end of life is near. Toward the end of life, specifically in with a terminal diagnosis, when curative therapies are no longer being pursued, family and caregivers may experience tensions as the shift happens in accepting the terminality of a disease. By potentially improving the quality of life, the overall cost of care is reduced by eliminating frequent hospital and emergency room visits, and even a slight increase in survival rates of patients with metastatic cancer, palliative care has an increased relevance in the healthcare system. The introduction of community based palliative care could play a key role in providing this essential form of healthcare for the aging population, as the numbers increase of people who not only have cancer, but are also living with long term chronic illness.

I. INTRODUCTION

Shifting ones focus from finding and working towards a cure for a disease, to seeking therapies for symptom relief from the disease process itself, is not always an easy transition for patients or doctors. As patients face their own terminality, their focus shifts to a quality of life, as opposed to quantity. However, what if the mention of the word 'palliative', is the ultimate deterrent from physician making the necessary referral for patients with greater symptom management needs? Could a mere change in words used by a physician change the outlook a patient may have to becoming more agreeable to palliative care, by introducing the term, supportive care?

Palliative care should be incorporated as a routine and universal service provided by physicians; it's holistic approach to the healthcare system embodies the psychological, spiritual, and physical needs of a patient. Unlike hospice care, palliative care is shown to be appropriate early during illness. Discussions of what patients view as a quality of life should be incorporated into an initial treatment plan, with careful consideration to not pursue overaggressive treatments. If the idea of palliative care were introduced sooner to patient diagnosis, patients could potentially learn not to become attached to an expected medical outcome. Palliative and hospice providers help families reframe their curative mindset, to providing hope and supportive therapies for everyday living. Hope is an important psychological resource, that can be used as a coping mechanism and life-affirming treatment that can protect against despair in end of life situations. Toward the end of life, specifically in with a terminal diagnosis, when curative therapies are no longer being pursued, family and caregivers may experience tensions as the shift happens in accepting the terminality of a disease. Shifting ones focus from finding and working towards a cure for a disease, to seeking therapies for symptom relief from the disease process itself, is

not always an easy transition for patients or doctors. As patients face their own terminality, their focus shifts to a quality of life, as opposed to quantity.

Palliative care should be incorporated as a routine and universal service provided by physicians; it's holistic approach to the healthcare system embodies the psychological, spiritual, and physical needs of a patient. When defined this way, palliative care becomes applicable across the cancer and terminal disease spectrum. In fact, a recently updated guideline from the American Society of Clinical Oncology, strongly recommends that *all* patients with advanced cancer receive palliative care early in the disease course, concurrent with active treatment (Yael,2017).

However, palliative care referrals continue to happen too late into the treatment plan. Patients are often near the end of life when referrals are made. Patients should not have to wait until near the end of life for supportive care for symptom management. According to Bruera (2010), One of the key barriers to early referral is the misunderstanding that palliative care is only provided at the end of life once patients have exhausted all cancer treatment options. Rather, they can take advantage of the expertise of both the oncology and the palliative care teams in optimizing quantity and quality of life under a simultaneous care model (Hui, D. 2010). This is particularly important in the new era of targeted therapy, which has seen an explosion of novel therapeutic options that are less toxic than traditional chemotherapy, making it feasible for patients to receive cancer treatments closer to the end of life (Bruera, 2010).

In a survey studied by the American Cancer Society, the objective was to determine the perception of the impact of using the name *palliative* compared with *supportive* care [abstract]. The conclusion of the study shows the name *palliative* care was in fact more distressing to patients and did not invoke a sense of hope to patients and families. It was viewed as synonymous with hospice, which then leads to end of life. Patients would be more likely to respond more positive to the term *supportive* care, especially those early in their treatment plans (p.220). Some of the participants of this study viewed *palliative* care as reserved for patients with terminal cancer, that is used in the last hours or days of life. The provisions of palliative care that have been changed from focusing on end of life care, to a more comprehensive model integrated throughout a person's illness experience, would come into play at a person's initial time of diagnosis. Therefore, it is more imperative for healthcare providers to incorporate education into their practices, as well as promote changing the perception of palliative care is only for dying patients who are no longer candidates for life-prolonging therapy (Fadul, 2009).

Discussions of what patients view as a quality of life should be incorporated into an initial treatment plan, with careful consideration to not pursue overaggressive treatments. If the idea of palliative care were introduced sooner to patient diagnosis, patients could potentially learn not to become attached to an expected medical outcome and have better symptom management control. Most patients living with advanced cancer

have an average of seven or more uncontrolled symptoms (Walsh, 2000). Palliative and hospice providers help families reframe their curative mindset, to providing hope and supportive therapies for everyday living. Hope is an important psychological resource, that can be used as a coping mechanism and life-affirming treatment that can protect against despair in end of life situations.

For patients with advanced cancer, when is the appropriate time to refer to a palliative care consultation? Some of the consultation triggers for hospital-based palliative care include: frequent hospital admissions, admissions for difficult-to-control physical or psychological symptoms, complex care requirements, decline in function, or failure to thrive. In addition to these symptoms, according to Perrin and Kazanowski (2015), acknowledges the barriers late consultations can bring. An important key to overcome these barriers are critical care nurses; in hospital settings, they need to be the champions for palliative care on their prospective units. Nurses can recognize the signs of fatigue, untreated pain, which can lead to delirium, among other signs and symptoms that chronic illness brings (p.48).

Nurses can be great at facilitating communication with patients about difficult life topics; they can help bring down the barriers in difficult situations and can act as a go-between for the patient and doctor. Advocating on behalf of patients to ensure their wishes are followed needs more empathy from doctors that may help curb verbal battles at the bedside. If the idea of palliative care were introduced sooner, patients could potentially learn to not become attached to an expected medical outcome. It could take some of the heat off the doctors for potentially providing a false sense of hope and helping the family to not focus on prognosis or cure. Encouraging and supporting respect of a patient's wishes is something we can do right now to improve end of life care.

On the other hand, it is difficult to address a patient after a diagnosis of a malignancy; some doctors opt for telling the patients families over the patient themselves to avoid an emotional outburst. The question should not be "should we tell...? but doctors should switch to, "how to I tell my patient...? Open communication between a doctor and patient as well as the family is key. As discomfoting as end of life discussions are, having proper planning in place helps healthcare providers have a sort of guide in place to handle medical care and builds relationships and rapport by listening to families and patients describe what is important to them. It acknowledges and preserves the dignity of a patient and can arguably be emotionally easier on families and medical professionals alike.

The answer of when and how to introduce palliative care is not always clear and can lead to prolonged unmanaged symptoms and increased admissions in the hospital setting, which can then lead to unwanted and unneeded testing. One of the pressing realities in end of life care, is that despite more Medicare beneficiaries dying in palliative care or home settings since 2000, the frequency of hospitalizations into acute and critical care units and the frequency of transitions across multiple care sites during the end of life increased, reflecting persisting emphasis on administering aggressive, curative care, only marked by brief hospice stays immediately preceding death (Teno,2013).

When it comes to end of life care or life preserving measures, the duration of the care being received can rack up

overwhelming costs. Families will usually spend thousands of dollars with little to no insurance coverage, with a terminal illness diagnosis, which after treatments, may result in the expected terminal outcome originally given by doctors.

The skyrocketing costs of healthcare weigh heavily on these individuals who are faced with a terminal illness. In the medical industry, insurance has become a big player in how things are currently run in institutions across the county. It can be viewed that insurance, especially Medicaid and Medicare, only care about increasing revenue and decreasing patient care. For example, debt.org reports that the cost of routine end of life care for patients residing in a hospital can range from \$6,000 to over \$10,000 per day, and stay at home care for terminal patients can cost between \$150 to \$650 per day (Fay, 2016). Studies have shown that health care expenditures began to decline 24 to 48 hours after the palliative care consultation occurred, which usually has been facilitated by a palliative care team. (Greer,2013).

As the cost of healthcare rises, the number of sick people grows with it. In 2007, almost 12 million Americans with a diagnosis of cancer at some point in their history were alive. This number, which represents almost 4% of the US population, has dramatically increased from the 3 million cancer survivors alive in 1971 (Arif, 2011). Most of these people are capable of living in their normal home care setting, but require more attention to their growing healthcare needs. With chronic illness on the rise, community-based palliative care could address the multi-dimensional needs and symptoms that occur with widespread illness. Providers of community-based palliative care must be prepared to address a substantial concurrent array of symptoms using evidence-based pharmacologic and nonpharmacologic strategies.

The question then becomes how would palliative care and oncology services pair together to serve these growing community needs? To provide the best care to patients, a proper balancing system must be established for coordination of care. Community oncologists balance time within outpatient visits between the discussion of technical medical issues, such as test results and anticancer treatment options, with more broad components of health-related quality of life, such as ability to do daily activities, emotional functioning, and symptoms of pain and fatigue. Often, as disease progresses, both symptoms and family or caregiver distress increase. The goals of care usually change over time, and the issues that the patient, family, caregivers, and the oncology practice are confronted with shift as well (Muir,2010).

If palliative care services were integrated with a private based oncology practice, it could allow for the medical oncologist to focus on the evaluation of staging and treating a patient while understanding how their course of treatment is working for their disease, and the palliative care can focus on symptom management and goals of care concurrent with treatment. If these services are offered in the same setting, it could drastically improve quality patient outcomes, with the greater care given in all aspects of treatment.

Many other practical issues must be addressed to provide adequate care for the growing number of people experiencing cancer as a chronic illness in the community. For example, new reimbursement mechanisms must be effective and efficient to

ensure proper coding and billing are done correctly. The current Medicare benefit funds hospice services, but did not always include palliative care. In a recent study by the Fairfax North Virginia Hematology Oncology group along with Capital Palliative Care Consultants, together, they believed palliative care could provide a clinical benefit to patients and families, as well as changing the quality of care provided by oncologists. The economic factors had to be addressed as well as provisions to ensure each entity would not be competing for funds. Proper medical coding was established for “disease coding” for the oncologist, and “symptom management” coding when the patient was treated for such symptoms as dyspnea or pain. The study also followed the amount of time saved by the palliative care team picking up the workload the oncologist would normally have to deal with. The oncologist time is now available to see more patients, assess therapeutic regimens, determine if a patient could fit into certain disease specific studies, attend to patient specific needs regarding treatment, or take on new patients that would normally have not been able to be seen.

With chronic illness growing in numbers, and patients living through sometimes years of chemotherapy and outliving their prognosis, a change needs to happen in our current system for an increase in supportive care. Through better education early on, specialists can work together to ensure the burden of care is minimized to patients and their families.

REFERENCES

- [1] Alsbach, JG. (2016) When it's your time, will it be your way? *Critical Care Nurse*, 36. 10-13. <http://ccn.aacnjournals.org/Nurses> 10.4037/ Critical Care Nurse
- [2] Bruera, E., Hui, D. (2010 September), Integrating supportive and palliative care in the trajectory of cancer: Establishing goals and models of care. *Journal of Clinical Oncology* 28(25); p.4013-4017 DOI: 10.1200/JCO.2010.29.5618
- [3] D Hui, A Elsayem, Z Li , etal. (2010). Antineoplastic therapy uses in patients with advanced cancer admitted to an acute palliative care unit at comprehensive cancer center: A simultaneous care model *CA Cancer Journal for Clinicians*. 116, p. 2036– 2043.
- [4] Fadul,N., Elsayem, A., Palmer, J.L., Delfabbro, E., Swint, K., Li,Z., Poulter,V., Bruera, E. (2009 February 20), Supportive versus palliative care: What's in a name? *CA Cancer Journal for Clinicians* 115, p. 2013-2021 DOI: 10.1002/cncr.24206
- [5] Greer, J. A., Jackson, V.A, Meier, D.E. & Temel,J.S. (2013), Early integration of palliative care services with standard oncology care for patients with advanced cancer. *CA Cancer Journal for Clinicians*, 63(5);p349-363. Doi:10.3322/caac.21192
- [6] Perrin,KO., Kazanowski,M. (2015). Overcoming barriers to palliative care consultation. *Critical care nurse* :35[5] p.44-52). doi: 10.4037/ccn2015357
- [7] Sullivan, A. Lakoma, M. Billings, J A. Peters, A. Block, S. (2005 July). Teaching and learning end-of-life care: Evaluation of a faculty development program in palliative care. *Journal of Academic Medicine*.80 (7) p. 657-668
- [8] Yael,S., Robert, A. (2017) Toward Palliative Care for all Patients with Advanced Cancer. *Journal of the American Medical Association: Oncology*;3(11), p. 1459-1460. Doi: 10.1001/jamaoncol.2017.1059
- [9] Teno JM, Gozalo PL, Bynum, JPW, Leland NE, Miller SC, Morden NE, Scupp T, Goodman DC.(2013), Change in End-of-Life-Care for Medicare Beneficiaries Site of Death, Place of Care, and health care transitions in 2000, 2005, and 2009. *Journal of the American Medical Association* 309,(5)p.470-477. DOI:10.1001/JAMA.2012.207624
- [10] Arif,H.K .,Bull, J., Dio Kavarlieratos, P., Taylor, H.D., Downey, W., Abernethy, A., (2011 November) Palliative Care Needs of Patients with Cancer Living in the community. *Journal of Oncology Practice* 7(6). P. 382-388 DOI: 10.1200/JOP.2011.000455
- [11] Walsh, D., Donnelly, S. & Rybicki, L. (2000) The symptoms of advanced cancer: Relationship to age, gender, and performance status in 1,000 patients. *Support Care Cancer* 8,p. 175– 179 doi.org/10.1007/s00520005028
- [12] Muir, J.C., Daly, F., Davis, M., Weinberg, R., Heintz, J., Paivanas, T., & Beveridge, R. (2010 July). Integrating palliative care into the outpatient, private practice oncology Setting. *Journal of Pain and symptom Management*. 40, (1). P 126-135