• The entire family enjoyed many memorable moments together at the beach, and the patient’s pain was controlled sufficiently that he was able to sit outside on the beach with all his children every morning and again in the early evening.

• His health decline was rapid when they returned home. The palliative care physician made a home visit to assess his pain and overall condition, to talk about his and his family’s preferences for staying at home, and to discuss adding the help of a hospice nurse to remain on call and help them with his care.

• A few weeks after a family celebration at home for his younger daughter’s 21st birthday, the patient died at home with the support of hospice on hand to manage his pain and breathlessness and with his entire family present. Before the memorial service, his children each received a letter that he had written for them as part of his personal legacy.

• The family received bereavement counseling to help the children cope with their loss and to ease their transition into living life without their father and returning to school. They reported high satisfaction with the care they received throughout and were particularly grateful to have enjoyed the beach and the birthday together and fondly recall taking their father to see his colleagues at the conference.

When It’s the Right Care, More Is Better

The front page of the Wall Street Journal reports that, according to a randomized clinical trial, a new drug, palliatosin, when given to patients with metastatic non–small cell lung cancer, like the patient described by Kirch,1 reduces depression, improves quality of life, and, as embazoned in the headline, lengthens life by 2½ months. Based on the results of this trial, the stock price for the maker of palliatosin rises sharply. Word spreads like wildfire among patients, driving intense demand for palliatosin. The manufacturer struggles to maintain adequate supplies. Palliatosin is hailed as a major breakthrough in cancer care. Although it costs $2000 a month and was tested only in patients with incurable lung cancer, physicians prescribe palliatosin to patients with all types of cancer at all stages based on its impressive impact and complete lack of adverse effects.

Unfortunately, the above description is fiction and palliatosin does not exist. If it did, all patients with cancer would ask for it, and most would get it. While palliatosin is not real, the outcomes are fact and, rather than resulting from a made up chemical compound, they derive from a real intervention consisting of experts in palliative care. This team achieved dramatic results and profoundly changed the course of care and quality of life for the patients described by Kirch and Meier2 in this issue of the Archives. As would be expected for rigorously designed research, the results of the randomized trial described above were reported first in the New England Journal of Medicine3 before being picked up by the Wall Street Journal and the New York Times.

With the addition of palliative care, Kirch’s patient experienced better pain control with fewer adverse effects, achieved a better quality of life, and, despite receiving less chemotherapy, lived longer. In fact, with the help of palliative care, he enjoyed a beach vacation with his family and lived long enough to celebrate his daughter’s 21st birthday. Meier’s patient experienced similar benefits. After 63 days in the hospital, withdrawn and combative, and enduring painful dressing changes, she found comfort, pain relief, and meaningful interactions with her family and was able to return to her original nursing home. Her nurses experienced relief from the distress of feeling like they were hurting her with every dressing change.

The addition of palliative care to the care of these patients had an impressive positive impact. However, it is equally impressive that an intervention focused on the patients also had such a positive effect on their loved ones. The children of Kirch’s patient received bereavement care after he died to help them adjust to their new life and return to school. They reported high satisfaction with the care that he received and gratitude for the time that they enjoyed with him in the last months of his life. Meier’s patient’s son experienced the warm glow that arose when his mother was able to recognize him and smile. Studies show that communication to understand and ensure that care aligns with patient preferences reduces depression and complicated grief in loved ones after the patient dies.4 Also, Meier’s patient’s nurses were no longer distressed, and the chief executive officer of her hospital had the pleasure of reading a letter from her family expressing gratitude for the palliative care that she received.

Palliative care also benefits our health care system and society. Each year, 27% of Medicare expenditures are used for the 5% of people who die.5 While we should expect to use...
the most health care resources in the last 12 months of life, when we are likely the sickest, the sad fact is that for all the money spent, the quality of care is poor. As in Kirch’s case, patients often receive care that they do not want and from which they do not benefit, and like Meier’s patient, they often fail to receive treatments from which they would benefit. More care, through the addition of palliative care for these patients, costs money, but the savings that can result from a patient choosing less chemotherapy and from shorter hospitalization, which can be achieved through good pain control managed by the palliative care team, will more than pay for the cost.4 In an era of budget deficits, rising health care costs, and health care reform, expanded access and availability of palliative care promises to deliver the holy grail of value—better quality at lower costs—to patients, families, health care providers, and society.

We may never see a drug called paliatoin, but, fortunately, we do not have to wait for one. Palliative care, provided by trained teams of experts, including physicians, nurses, social workers, and chaplains, is already available. Interestingly, the results of the randomized trial of palliative care for patients with metastatic non–small cell lung cancer generated the headlines but not the demand that such a drug might have. And if it had, it is not clear that the health care system could have responded. The supply of palliative care–trained clinicians falls short of the need. In hospitals where palliative care is available, most teams struggle to keep up with demand.7

While more studies will be helpful in understanding the full impact of palliative care, the evidence is sufficiently strong for the American Society of Clinical Oncology to have published a consensus statement recommending consideration of palliative care alongside standard oncology care for patients with metastatic cancer.8 The question is no longer whether palliative care can improve care, but how to ensure that patients receive it. Challenges remain in supply and demand for palliative care, but the following 5 initiatives could dramatically increase availability and access:

1. Having hospital palliative care teams be a condition of participation in Medicare and Medicaid could increase the number of US hospitals that offer palliative care from the current 60% to 100%.

2. Allowing open-access hospice, in which patients with serious illness could receive palliative care services from hospices alongside curative intent treatment, would greatly increase access and lower barriers to enrollment.

3. Expanding the supply of palliative care experts by increasing palliative care training positions for physicians, nurses, and nurse practitioners would help meet the growing demand for specialists.

4. Educating all clinicians in basic palliative care would ensure that all patients have access and that clinicians know when to refer to expert palliative care. The 5 mg of oral morphine that so dramatically helped Meier’s patient is a treatment that any physician should be comfortable prescribing. Furthermore, the unfortunate question, “Would you like us to do everything?” failed to elicit true preferences or to establish real goals and could have been replaced with the better phrase, “How were you hoping we could help?”9

5. Educating the public through a marketing campaign about the potential benefits of palliative care would drive demand. Currently, Americans are unfamiliar with palliative care but when informed about it, they overwhelmingly want it.10 Public demand for birthing suites and a more holistic approach to pregnancy and the beginning of life transformed how we are born.

For the patients described by Kirch and Meier, adding palliative care dramatically changed the course of care, improved quality of life, improved symptom control, relieved the stress of serious illness, and helped Kirch’s patient live longer. At the same time, their families received care and were supported by the palliative care team. Costs of care were reduced, while quality improved. Palliative care is good for patients, good for families, good for clinicians, good for hospitals, and good for society. When it’s the right care, more care is better.

Steven Z. Pantilat, MD, FAAAAHPM, SFHM

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Author Affiliation: Palliative Care Program, Division of Hospital Medicine, Department of Medicine, University of California, San Francisco.

Correspondence: Dr Pantilat, Palliative Care Program, Division of Hospital Medicine, Department of Medicine, University of California, San Francisco, 521 Parnassus Ave, Ste C-126, PO Box 0903, San Francisco, CA 94143 (stevep@medicine.ucsf.edu).

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