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Title:

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Date:

2017-06-01

Citation:

Dawson, J. & Le, B. H. (2017). Palliative care and best supportive care should not be an after 'transition' missed opportunity. *Internal Medicine Journal*, 47 (6), pp.712-. <https://doi.org/10.1111/imj.13446>.

Persistent Link:

<https://hdl.handle.net/11343/292987>

TITLE PAGE

Letter to the Editor

Palliative care and best supportive care should not be an after “transition” missed opportunity.

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as doi: [10.1111/imj.13446](https://doi.org/10.1111/imj.13446)

Palliative care and best supportive care should not be an after “transition” missed opportunity.

The study by Lomax *et al.* (1) of self-funded immunotherapy in their institution reveals interesting data that adds to the developing picture of the role of immunotherapies for non-melanoma solid tumours, and provides further assistance in decision making for patients, families and clinicians. Consideration of the ethics that surrounds the usefulness of active disease management, or any other intervention, in those with advanced disease, particularly those at the end of life, is likely to require ongoing reflection.

The perception that hope equals cure is pervasive although simplistic. Many cancer patients will continue to hope for a cure or a miracle. For physicians to deny this hope has been shown to be ineffective and possibly detrimental. “Making a patient face reality” impedes quality of life, paradoxically strengthens the hope for a cure, and is likely to impair the patient physician relationship (2).

The promise held by the stunning arrival of immunotherapies in solid-organ malignancy, in the setting of an expanding but still early knowledge of the benefits and boundaries of this therapy represent a significant challenge to both oncologists and palliative medicine physicians in care of their shared patients.

Our goal must surely be to provide excellent disease management delivered concurrently with optimal symptom control.

We agree as Lomax suggests, that patients will continue to be drawn to the promise these treatments hold. However we contend that we should counsel our patients not to regard palliative care solely as end of life care, and that best supportive care is not only an option to be provided once anti-cancer therapies end. Fears of patients delaying “appropriate transition to palliative care” will only be perpetuated by continuation of the belief that involvement of palliative care is a transition in the first place.

The benefits of early palliative care have been described in different settings and in different countries in multiple studies (3, 4, 5).

Hope is the link between our present situation and our imagined futures (6). We sincerely hope that we will continue to see oncology and palliative care providing concurrent care for our shared patients to the benefit of all.

- 1 Lomax AJ, Beith J, Bhadri V, Boyer M, Grimison P, Horvath LG. *et al.* Outcomes of patients with non-melanoma solid tumours receiving self-funded pembrolizumab at Chris O'Brien Lifehouse. *Intern.Med. J.* 2016;46:1392-98
2. Nierop Van-Balen C. Hope dies last...A qualitative study into the meaning of hope for people with cancer in the palliative phase. *Eur. J. Cancer Care.* 2016;25:570-579.
- 3 Lorenz K A, Lynn J, Dy SM, Shugarman LR, Wilkinson A, Mularski RA *et al.* Evidence for Improving Palliative Care at the End of Life: A Systematic Review. *Annals Int Med.* 2008;148(2):147-59.
4. Zimmerman C, Swami N, Krzyzanowska M, Hannon B, Leighl N, Oza A. *et al.* Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial. *Lancet* 2014;383:1721-1730.
5. Temel JS, Greer JA, Muzikansky A. Gallagher ER *et al.* Early Palliative Care for Patients with Metastatic Non-Small- Cell Lung Cancer. *N Engl J Med* 2010; 363(8): 733-42.
6. Snyder CR. Hope Theory: Rainbows in the Mind. *Psych Inquiry.* 2002; 13(4): 249-75.