

memo (2019) 12:91–92
<https://doi.org/10.1007/s12254-018-0465-2>



memo
 magazine of european medical oncology

Demystification of palliative care. In regard to Masel and Kreye

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Received: 18 November 2018 / Accepted: 27 November 2018 / Published online: 5 December 2018
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We read with interest the article by Masel and Kreye [1]. We celebrate their well explained ideas concerning palliative care (PC) myths and we would like to comment some about the topic.

The authors argued that PC aims to prolong life with an improvement in quality of life. We do not completely agree with this affirmation.

More research is needed before solid conclusions regarding survival benefits of early PC in advanced cancer can be advocated. The results of the meta-analysis by Haun et al. do not support that early PC leads to prolonged survival in general [2].

Prolonging survival should not be the primary objective of PC, this idea may be misunderstood for patients and relatives, and it could determine unrealistic treatment goals and support futile treatments. In a study by Weeks et al. patients who thought they were going to live for at least 6 months preferred life-extending therapy over comfort care and they were more likely to undergo aggressive treatment, although their 6-month survival was not better [3].

PC more often deals with physical deterioration, functional impairment and dying; objectives other than curation or prolongation of survival could be identified and assessed case by case. PC not only deals with survival.

We share the conviction that palliation is an active form of therapy. Targeting improvement of symptoms, promoting wellbeing throughout the course of the illness and providing advance care planning are certainly a major focus of PC teams. Nevertheless, some studies show that an important number of patients who suffer from fatigue and those who want to

receive information on the expected course of their illness did not receive this or only do so sometimes [4]. Moreover, despite the goal that PC should provide advance care planning, there are many practical difficulties in achieving this ambitious goal and some studies show that advance care planning was not a completely accurate representation of patient wishes [5]. PC also deals with talking.

In the integrated care model, oncologists routinely refer patients to specialist PC teams earlier in the disease trajectory—this is within eight weeks from diagnosis of advanced cancer. However, an obvious question about this model is: who does what? Certainly, many elements of palliative care can be provided by a specialist or generalist clinician regardless of discipline. But, if all PC tasks are taken on by PC specialists, then primary care clinicians and other specialists may begin to believe that basic symptom management and psychosocial support are not their responsibility, then care is not integrated at all [6]. Even, in busy clinical environments “shared responsibility” could be interpreted as “others’ responsibility” [7].

Integrated oncology seems a wide concept and its definition can vary in the practice. Perhaps, a more accurate definition of different roles is necessary and a realistic adaptation to each health system, centers and population could be desirable.

Finally, PC needs to be demystified through realistic information about the disease and its course for improving care, avoiding demoralization and also futile treatments.

Conflict of interest A. Vargas declares that he has no competing interests.

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