Are patients receiving the right care in the right place at the right time?

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Palliative care is an approach that focuses on the relief of pain and other symptoms for patients with advanced illnesses and their families, and on maximizing the quality of the patient’s remaining life. It involves impeccable symptom assessment and diagnosis; emotional and spiritual support, as well as caregiver and bereavement support; and the provision of comfort-based care as opposed to curative treatment. Illnesses for which palliative care is typically provided include cancer, heart disease, respiratory disorders, HIV/AIDS, muscular dystrophy, multiple sclerosis, and kidney or liver failure. For patients who are terminally ill and within their last few weeks or months of life, “end-of-life care” is the term used for the specific palliative care approach.

Although most people would prefer to die at home, most actually die in hospital. In a watershed article by Dr. Lisa Barbera and colleagues in this issue of Current Oncology, death in hospital has been shown to be common in 4 provinces in Canada, replicating with the results of earlier studies in Canada and in other countries in which similar data were reported. The administrative health data care that was gathered into identically defined cohorts with commonly defined indicators was successful in demonstrating uniformity across the provinces.

The main reason considered to account for this phenomenon is that patients who need health care will usually go to a hospital when services are not available in the community (or perhaps even when services are available). The palliative care approach has not been universally adopted at this time. Physicians, nurses, and even family members may not be comfortable talking with patients about dying and may be uninformed about the definite value that a palliative care approach adds to the well-being and quality of life for patients and their families. As a result, patients might not understand their prognosis, might not have in place an end-of-life care plan that sets out their wishes, and might not be referred for palliative care until they are close to death—if at all. Patients can then suffer unnecessarily and might have to visit their local emergency department (which also increases the cost to the health system) when they could more comfortably have received care at home.

The economics have shown that 60% of deaths result from chronic illnesses, including cancer. The daily cost of providing palliative care in the last month of a patient’s life averages about $1,100 in an acute-care hospital bed, $630–$770 in a palliative care bed, $460 in a hospice bed, and less than $100 for at-home care. Admission to an acute-care hospital is also associated with admission to the intensive care unit, which also leads to increased health care system costs and often-futile treatments such as chemotherapy that might neither extend nor improve quality of life.

The current situation therefore calls for an educational public health strategy that will be collaborative and will build on partnerships, with the community as a full partner, to establish public health standards for palliative care. Work plans will include the development of a public health strategy, with public education and best-practice public health guidelines in palliative care being a standard component. Death and dying, aging, loss, and bereavement are the responsibility of everyone—not just health care providers.

An area requiring further research is the effect of, and access to, overall delivery of palliative care services to marginalized and vulnerable populations. It is no surprise that palliative care is accessed to a lesser degree by socioeconomically deprived communities than by less-deprived ones, and specific segments of the population—for example, the homeless—are often overlooked in terms of service planning and delivery, despite having a poorer health status than the general population. How people living with disabilities, in poverty and in poor conditions, are interacting with the health care system as they approach end-of-life can only be speculated about.

Collecting and reviewing performance indicators so as to monitor performance is vital to efficacy and to measurements for assessment of improvement. Consistency across provinces and, more specifically, comparability between locales is essential. Applicability by district and by available resources can complicate the recording of data if services are not equitable across the board. Now may be the ideal time to standardize the necessary metrics.

Despite the limitations mentioned by the authors with respect to methodology and missing data, as well as the limitations of the indicators themselves, this study by Barbera et al. provides invaluable insights that can be a foundation to build on.

CONFLICT OF INTEREST DISCLOSURES
We have read and understood Current Oncology’s policy on disclosing conflicts of interest, and we declare that we have none.

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