



## Framing the argument over futile care

→ Kathy Redmond ■ EDITOR

**W**e “overdiagnose, overtreat and overpromise”. This was the claim made by numerous newspaper headlines in response to the *Lancet Oncology* report last September on delivering affordable cancer care. While we do need open and frank discussions about how to curb the spiralling costs of cancer care, it was unfortunate that the media focused so heavily on the cost of futile treatment in the last weeks of life, blaming it all on a culture of excess. This sparked reports that patients would be denied potentially life-prolonging treatments purely on the basis of cost and generated fears that patients might be abandoned in their final months.

There is no doubt that we do overtreat and overpromise in the advanced cancer setting. We know, for instance, that many patients receive cancer treatments in the last weeks of their life, and that some of these treatments have no reasonable chance of helping the patient and are associated with severe side-effects that can lead to hospitalisation and even death. We also know that receiving chemotherapy is associated with a delay in referral to palliative care. But blaming this on a culture of excess is too simplistic.

Making the right decisions in later stages of advanced cancer is difficult for doctors and patients alike. It is often impossible to predict how long a patient will live, and while we have an increasing number of therapies to choose from, we don't yet know enough about who stands to benefit and by how much. There can be a huge disconnect between the expecta-

tations of patients and families and those of clinicians, adding to the difficulty of conducting honest conversations with patients about their prognosis, treatment options and end-of-life preferences.

There are no easy answers. But could we be making things harder for ourselves by posing options in terms of a choice between either fighting cancer or optimising quality of life? An emerging body of evidence shows that integrating palliative care into the mainstream care of cancer patients not only improves their quality of life, but might even help them live longer. Early involvement of palliative care specialists has also been shown to cut down on futile medical interventions and help families cope better with their loss of a loved one.

ASCO is now recommending that patients should be offered concurrent palliative care and standard cancer treatments early in the course of their advanced cancer journey. This is in line with efforts to stimulate meaningful interaction between mainstream oncology and palliative care specialists that ESMO and other European professional bodies have been pursuing for some time. However, progress so far has been infuriatingly slow.

Greater integration of palliative care requires changes in the way we organise care and train clinicians. We need to get on with this as a matter of urgency. If we fail to take a lead in addressing shortcomings in the way we care for patients with advanced cancer, the simplistic arguments about a wasteful culture of excess could win, and patients will be the losers.