Palliative Care: Staying Alive As Long As We Live

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Sometimes life's circumstances combine to simply hit you over the head. Two events occurred in the past week: I worked to complete this issue of *JOP*, and I was drawn to remember a mentor, friend and patient who completed his life's journey.

First, the completion of the issue. Over the past months, I have had the pleasure of being schooled by the guest editors of this thematic issue focusing on palliative care. Amy P. Abernathy and her coeditor David C. Currow have attracted colleagues in the field to contribute to this effort, as well as overseen a collection of manuscripts submitted in response to the *JOP* call for papers. The collected work emphasizes that palliative care is not merely a euphemism for hospice and end-of-life care. The term is broader and really speaks to many qualities we assume are inherent in being a good physician and providing good care to our patients.

Articles in this issue present aspects of recognizing patients' unmet needs, appreciating the contribution of comorbidities on patients' well-being, and working with other team members to understand how to communicate with patients in a way that leads to better understandings of their hopes and fears. These are all aspects of palliative and supportive care.

Many of us believe we do this well, although any systematic assessment of our practice reveals that we are not meeting the mark. As I read the article by Ritchie et al, I understand why. In the early paragraphs of this article, the authors capture my typical day. They recreate the clinic experience of a series of patients with unique, complicated clinical scenarios presenting rapidly during a rushed day. Each is expecting answers. Similar to our primary care colleagues, we are faced with growing lists of demands with each patient encounter, more than any superhuman physician could meet. Medication reconciliation, assessment of pain, depression, social issues, preventive care, toxicity management, and more, all in addition to assessing their oncologic disease.

Yet the patient is at the vortex of our ever more complex therapeutics and those of other disciplines who are ministering to them. We likely underestimate the impact of these multiple events on the care that we deliver. Indeed, anyone would be humbled by the list of variables that exist in caring for any one patient. How might the multiple medicines interact? What of the patient's interpretation of priorities; how might that affect what pills they take in a given day? What of the next physician they see, who may view the therapy you have prescribed with a jaundiced, eye or simply assert a different priority? These many unmeasured variables surely impact our charted courses and our outcomes. The quest to describe, measure, and understand these events is palliative and supportive care.

As I struggled to put these understandings in context, life happened. A physician who had mentored me died. His memorial service forced an assessment of how I care for patients—in many ways he was still teaching me. He lived for more than 90 years and had practiced medicine for 50 years. He was a remarkable, giant of a man who lived a full and complete life in every sense of the word. I had participated in a small way in his care for over a decade as he had two malignancies, prostate cancer and renal cell carcinoma. Neither disease contributed directly to his death. What struck me was how he managed his own course. Up until the last months of his life, he always questioned every provider's recommendation to define the necessity of each intervention. He communicated in each of his visits what he valued in life and tested each recommendation on how the intervention might impact those values. As 90-year-olds do, he accumulated multiple medical issues, yet he marshaled the several specialists who cared for him the same way.

I am not sure I understood what he was doing until I read the several manuscripts in this issue. In a wonderful way, he captured the spirit of the field of palliative care. By his actions and questions—not by ours—he guided his care to the ultimate goal of living all of his life in an optimal way. He “died in place,” as expressed by Hoverman in his article.

Unfortunately, we experience few such patients in the course of our crazy, hectic lives. Principles of patient-centered care suggest that we should have systems in place, and team members that hold us accountable to provide this kind of care to all of our patients, not simply to those that have a personal understanding of medicine. As suggested by the authors in this issue, we must gain insight to mechanisms of care and tools that help us measure, assess, and address these aspects of care in a more objective manner.

I commend this series to readers to explore, and I pray that others will also gain insight. Please note the other contributors to the issue that touch on a variety of important topics. As always, the *JOP* editors appreciate feedback at editorsdesk@jop.asco.org. Good reading.

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