Ageing and cancer: psychosocial burdens

Cancer Council Australia Essay Competition

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Introduction

The ageing of the Australian population means that the issues related to cancer care in the older patient will become more prominent, especially with the potential for increasing numbers of cancer diagnoses and elderly cancer survivors. People diagnosed with cancer and their loved ones can take some comfort from the knowledge that remarkable advances in cancer treatment have dramatically increased the rates of survival from cancer. However, these advances in biomedical care have not always been matched with progress in the development of high-quality care to address the social and psychological consequences of a cancer diagnosis, which can especially burden older patient groups.

This essay will examine the psychosocial effects of cancer and its treatment on older adults, and the supportive care needs of the older patient. The ways in which practitioners can meet those needs will be explored, as well as the importance of the medical school curriculum in producing practitioners who are well-equipped with the skill set to do so.
The older patient with cancer seen through a psychosocial lens

‘It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.”

- Sir William Osler, Canadian physician.

In 2011-2012, approximately 1.5% of the Australian population had cancer, with the prevalence of cancer increasing with age [1]. The highest rate of cancer was found to be for the 75 years and over age group, and one in approximately 14 people in that age group had cancer [1]. Prostate and breast cancer remain the most common cancers diagnosed in men and women respectively [2].

The impact of cancer and its treatment is influenced by the patient’s age. However, the elderly are not a homogenous population with respect to health, ability to cope with the psychosocial and physical impacts of cancer and views about management [3]. The clinician therefore must avoid making presumptions about the patient’s needs and attitudes stemming from age-based stereotypes. The need to be mindful of this is illustrated by the fact that health care providers have been found to generally underestimate the quality of life of older patients with chronic disease [4].

Cancer can bring significant emotional upheaval, and people with cancer may experience a range of social and emotional difficulties, including potent feelings of distress, fear and anger. An individual’s level of psychological distress may vary depending on the extent to which a person which cancer feels supported by family and friends [5]. Financial stress from the cost of health care and reduced income and employment may also contribute to the stress experienced by people living with cancer. Although the resolution of such financial and social problems is beyond the capability of medical practitioners, an understanding of how these problems can affect the psychosocial state of the patient with cancer is a vital part of good-quality health care as it facilitates the addressing of these issues within the constraints of clinical practice [6].
Older people often have medical conditions in addition to cancer that are likely to affect function, and the number of comorbid conditions increases with age. Cancer-induced physical stressors include fatigue, pain and various disabilities which may create limitations in the ability of patients with cancer to perform activities of daily living [6]. Older patients with cancer are more likely to require functional assistance than those without cancer [7]. The physical sequelae of cancer and cancer treatment can exacerbate emotional and mental health problems.

Older people with cancer frequently have a slightly different set of concerns than other adults with cancer, which can affect how they cope with their diagnosis and treatment. One of the key concerns for many older adults with cancer is whether they will be able to maintain independence and remain in control of their health and health-related decision-making [8]. For example, cancer treatment may limit the ability of people to perform independently activities of daily living such as cooking, washing and accessing transportation [8].

Furthermore, older cancer patients are less likely to have social support systems in place, especially as they may not live close to family or may have experienced the loss of family members and friends [9]. Isolation increases the risk of depression and anxiety, the development of which increases the difficulty of older adults to cope with cancer treatment [10].

Older people have typically retired from paid employment and they may have reduced opportunities to be involved in their local community. Older people may have a reduction in the scope of their social lives especially if they are gradually spending more time at home alone, which slowly narrows of their life-space [11]. For elderly patients with cancer, the death of the primary wage earner, retirement and existing financial issues can be important factors contributing to limitations on financial resources, especially to pay for costs associated with cancer treatment [11]. Such concerns can contribute to feelings of anxiety and depression in patients. Thus, a multitude of factors unique to the older patient demographic result in cancer typically having psychosocial impacts significantly disparate to the impacts of cancer on younger people.
Psychosocial support needs

‘Mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say “My tooth is aching” than to say “My heart is broken”.’

- C.S. Lewis, English novelist and scholar.

There has been an increasing interest in formal needs assessments in Australia and abroad. The first known study to explicitly examine the supportive care needs of people with cancer was conducted over 30 years ago by the American Cancer Society [12]. Needs not addressed and where additional support is required were classified as “unmet needs”. Growing evidence points to the detrimental effects on patient wellbeing from unmet needs [6]. These unmet needs include the domains of psychological and other forms of patient support, access to health information and the ability to undertake activities of daily living.

A systematic review demonstrated that the level of unmet needs in older adults newly diagnosed with cancer and undergoing active cancer treatment is high, with a wide-ranging prevalence of between 40 and 90% because of the vast range of tools and definitions used to assess unmet needs in various studies [13]. This systematic review found that the most common unmet needs include psychological needs (typically fear of the spread or return of cancer), information needs (most frequently regarding the likelihood of cure and the adverse effects associated with treatment) and physical needs (most commonly with complaints of tiredness and lack of energy) [13]. Older patient groups are more likely to be vulnerable to unmet needs and treatment toxicities due to their comorbidities and decreased physiological reserve capacity [13].

Failures to address psychosocial problems can result in suffering for both the patient and their family, and potentially affect the course of the disease. Stress, social isolation and untreated mental health problems can contribute to emotional distress and interfere with the ability to perform social roles and adhere to treatment regimens [14]. These problems may cause changes in the functioning of the endocrine, immune and other organ systems in the body, which could then have implications for the course of the disease [14].
One out of two cancer patients report psychiatric disorders, especially depression, and elderly patients with cancer are at a particularly increased risk of depression [15]. Depression can be difficult to identify in elderly patients because they may not manifest prominent anhedonia or sad mood which are the main symptoms of unipolar mood disorders [16]. Unrecognised and untreated mood disorders in aging people with cancer is a key cause of disability and suffering for patients and their caregivers [17].
Caring for the older patient with cancer

‘The physician should not treat the disease but the patient who is suffering from it.’

- Maimonides, 12th century scholar and physician.

Cancer and its treatment can lead to psychological distress, physical disabilities and increased healthcare needs [13]. Supportive care is defined as care that helps people with cancer and their families to cope with cancer and its treatment, beginning at diagnosis and continuing throughout treatment to cure, continuing illness, or death and bereavement [18].

It is particularly important for medical practitioners to address practical issues of coping and the limitations on home activities created by cancer diagnosis and treatment in older patient groups [19]. This may not always be a straightforward process, as the psychosocial needs of older patients can be hidden beneath a façade of stoicism and a wish to be compliant. Thus clinicians may need to question older patients sensitively in order to fully understand their patients’ psychosocial needs [19]. Specific concerns which may need to be explored include body image concerns, interpersonal problems, existential concerns, anxiety and depression [19].

Supportive care needs can be diverse. They may relate to coping with the physical impacts of cancer and its treatment, or with its psychosocial and psychological effects in the form of depression, anxiety and feeling isolated [20]. Practical measures such as assistance with transportation and daily activities and the provision of prostheses and wigs are considered important elements of supportive care and they can reduce the psychological distress experienced by people with cancer [20]. Access to evidence-based information throughout the cancer journey is also viewed as an essential aspect of supportive care [20]. It is important to note that the goals of treatment for the older patient with cancer often differs from those for younger patients. This is because the focus of treatment can shift from prolonging survival to quality of life endpoints, and especially aiming to prolong the period during which the person is independent (‘active life expectancy’) [21].
The ageing of the Australian population has particularly driven the need for geriatric oncology in order to identify and manage psychosocial and other health needs of older patients with cancer. Over the last 10-15 years, oncologists and geriatricians have begun to have a greater collaboration in order to integrate geriatric principles into oncology care [22]. Use of a comprehensive geriatric assessment (CGA) for assessment of older patients with cancer is an example of such efforts in Australia. A CGA involves an evaluation of an older person’s functional status, cognition, nutritional status, comorbidities, psychological state, social support and a review of their medications [23]. The International Society of Geriatric Oncology has arrived at recommendations regarding the use of CGA in older cancer patients [23]. There is growing evidence that the variables examined in a CGA can predict mortality and morbidity in older patients with cancer and expose problems relevant to cancer care that would otherwise go unrecognised [22].

Although the CGA is a useful tool, it can be unsuitable for daily clinical practice because it is time-consuming, as it can take between 45 minutes and 2 hours to complete a CGA for a single patient [24]. There are a wide variety of other instruments that can be used to assess the needs of cancer patients and their families in place of the CGA, of which two were developed in Australia, namely the Cancer Patient Need Questionnaire and the Supportive Care Needs Survey [25] [26].

Regardless of the specific tools used to do so, it is essential that a plan be developed by the treating health care team to assist the person with cancer to manage their illness and maintain the highest possible level of wellbeing and functioning [6]. The ‘Care Coordination for Older Australians with Cancer’ project which is an initiative of Cancer Australia and funded by the Australian government is an example of the type of initiatives which can assist Australian medical practitioners to coordinate supportive care for older cancer patients [27].

It remains vital for medical practitioners to re-assess older people with cancer frequently in order to ensure that their psychosocial needs are being addressed. This is especially important given that there are a number of supportive care interventions available. Such interventions include peer support programs, counselling and psychotherapy, family and caregiver education and provision of comprehensive illness self-management and self-care programs.
[6]. As such, medical practitioners are well-placed to significantly assist elderly patients with cancer to cope with their disease.
Preparing the future medical workforce

‘There are two objects of medical education: to heal the sick and to advance the science.’

- Charles Mayo, American medical practitioner and co-founder of the Mayo Clinic.

The Cancer Council Australia’s Oncology Education Committee has stated the “psychosocial and cultural significance of cancer” as a learning objective in its *Ideal Oncology Curriculum for Medical Schools* [28]. Medical students who meet this objective are able to demonstrate an ability to assess the psychosocial state of patients, the cultural and psychosocial factors mediating the effect of cancer on the patient and can demonstrate an understanding of sources of reliable patient support information [28]. The importance of this learning objective becomes clear when we consider that the number of cases of cancer diagnosed in Australia each year is projected to rise over the next decade for both men and women and it is anticipated to reach about 150,000 cases in 2020 [2]. The medical practitioners of the future therefore need to be equipped with the skills to manage the growing number of patients, and particularly those from older age groups, who will present with the psychosocial issues associated with cancer.

Health professionals may avoid discussion of emotional concerns with patients due to a fear of causing unnecessary worry or distress, feeling out of their depth or assuming that the spiritual elements of the cancer trajectory are not the domain of the medical practitioner [19]. A concerted effort by medical schools and those involved in developing medical curricula to foster an improved understanding in medical students of the psychosocial needs of people with cancer and particularly those of older patients will go some way towards removing these barriers to high-quality psychosocial support for people with cancer.
Conclusion

The older cancer patient has a set of psychosocial needs that can differ greatly from that of the younger patient. A recognition of this fact is vital for the provision of individualised, patient-centred care to elderly patients in order to assist those patients to maximise their quality of life. The provision of adequate training to medical students in managing both the biomedical and psychosocial aspects of care for elderly cancer patients is important especially in the context of the ageing Australian population.
References


