Rehabilitation and Continuing Care of Cancer Patients

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Abstract

Health professionals are responsible for helping cancer patients and their families readapt to society. Frequently, coping with alcoholism is an integral facet of the rehabilitative process, and in this respect a patient’s family often presents more of a problem than does the patient himself. Physicians have shown a lack of knowledge in detecting and dealing with the alcohol problems of their patients. Health professionals involved in the management of patients with cancer must learn to recognize alcoholism to ensure that the problem is referred to an organization or individual who will cope with it adequately. Volunteer groups such as Alcoholics Anonymous, as well as the clergy, some psychiatrists, psychologists, and sociologists, have demonstrated expertise in dealing with alcoholism.

Structured programs to readapt to society patients who have had cancer were practically nonexistent until the early 1970’s. A few health professionals, with the backing of the Division of Cancer Control and Rehabilitation of the National Cancer Institute and the American Cancer Society, developed plans to provide the optimal quality of life for cancer patients and their families. The plans are now implemented throughout the United States. Cancer centers, community hospitals, community cancer centers, industry, labor unions, and schools of medicine, nursing, social work, and allied health professions are involved. The rehabilitation process is frequently impeded by the injurious use of alcohol by patients and their families, which makes it obligatory for those involved with their physical, emotional, and economic problems to understand and detect the problem and provide assistance which may alleviate such situations.

Alcoholism at Memorial Sloan-Kettering Cancer Center

Health professionals and administrators at Memorial Sloan-Kettering Cancer Center are quite familiar with problems related to alcoholism among our patients and their families. Patients with cancer of the head, neck, and esophagus are most likely to fall into this category. Patients from all strata of society are involved. Frequently, they are very secretive, thus making detection of their problem most difficult. We have observed that families and friends support the patients’ habit by sneaking them liquor while they are hospitalized. Often a patient’s wife or husband is an alcoholic. They not only create chaos in the hospital, but they upset the fragile equilibrium of their loved one. Parents of our pediatric cancer patients frequently develop guilt complexes regarding their children’s problems. Unfortunately, alcohol is used as a defense mechanism against these feelings. The patient and the hospital staff are subjected to difficult situations unless the resulting problems are quickly detected and solved.

Objectives of Program

The objective of a rehabilitation program may be restorative, supportive, or palliative, depending upon the individual situation. Achievement of the objectives requires that the problem be defined, the individual involved be analyzed as a person, and the rehabilitative process proceed in a manner that will achieve the maximal impact on solving the pertinent problems. A patient subjected to a laryngectomy undoubtedly will be offered speech rehabilitation. Let us assume that he has been a heavy drinker and smoker and was a salesman. The surgery was considered to have eradicated his cancer, but what about the possibility of his developing other cancers of his oral cavity or pharynx as a result of continued use of tobacco and alcohol, which probably had something to do with his incurring the laryngeal cancer? In addition, he has little hope of continuing as a salesman. Having recognized these problems, then what? Our distraught patient may be one of those rare individuals whose life-style is such that he will need very little help in readapting to society. Let us assume that he will stop drinking and smoking and find another job. Perhaps he may need job retraining, but will he find and utilize it? It is quite possible that our patient may be one of those people who can solve most of life’s problems provided that others turn to him and help him. This type of person will readapt if assistance is made available to him. A third type of patient might be portrayed as one who looks at life’s gloomy side. Everyone has been against him, and he is just about ready to give up. To make some progress in readapting this defeated to society, the rehabilitation team will require input from all of its members. The family must be motivated strongly to participate in this effort. In addition, the acceptance of job retraining will be most difficult. As a clinician at Memorial Hospital for nearly 40 years, I have worked with a fourth type of patient as well, the ne’er-do-well whose intellect and/or life-style prior to his encounter with cancer relegated him to that category in society labeled ‘chronic loser.’ Self-pity and defeatism are reflected by increased consumption of alcohol and the acceptance of a worthless existence. Tremendous effort on the part of the rehabilitation team and family members may possibly have some impact toward solving his problems.

There are many similar problems encountered when dealing with patients who have restorative and supportive objectives. However, those individuals whose prognosis for cure is poor frequently have the chance of leading a normal life for months or even years before residual disease causes their demise. Support for these patients may be made more difficult by the defeatist attitudes of the rehabilitation team and the patients’ families. We must strive to provide the optimal quality of life for these unfortunates.

When dealing with those patients whose life expectancy is
relatively short (the preterminal patient), we must attempt pal-
liation to make the quality of life as good as possible. I am not
sure that recommending to them that they stop drinking and
smoking makes any sense. I do know that taking cognizance
of diet requirements, relieving pain, counseling families, and
providing those involved with considerate attention are valuable
ingredients in our armamentarium.

Road Blocks to Achieving Objectives

The only real deterrent to rehabilitating cancer patients with
alcohol problems is people. There are several classes of de-
terrent people: physicians, because of their lack of knowledge
concerning the problem; patients, because they usually refuse
to admit that alcohol is one of their problems; patients’ families,
since they are protective toward the "poor patient"; those
taking care of the patients, who are frequently inept at recog-
nizing the problem; and others who ignore the problem, not
believing it to be a problem.

We health professionals have the responsibility of structuring
programs that will provide our associates with available infor-
mation related to the detection and treatment of alcoholism.
Physicians have a poor record for coping with their patients’
alcohol problems.

Some of us have accepted the help of members of Alcoholics
Anonymous and other similar organizations: the clergy, psy-
chiatrists, and others. However, we and other health profes-
sionals have the responsibility of ascertaining if an alcohol
problem exists. It is imperative that those involved in the man-
agement of cancer patients know enough about alcoholism to
recognize and do something about it or, at least, to see that
adequate help is provided to the patient or family member
afflicted with this illness. Health professionals must provide
more than just cancer care for the disease. They must detect
their patients’ illnesses. At times, it is more difficult to cope with
the serious illness of alcoholism.
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