Marriage Is As Protective As Chemotherapy in Cancer Care

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See accompanying article on page 3869

What is the price of a happy marriage, a secure family, and a network of well-connected friends within our communities today? Aizer et al present noteworthy findings in the article that accompanies this editorial, which suggest that being single, separated, divorced, or widowed significantly increases the risk of oncologic presentation with already metastatic cancer, reduced adherence to state-of-the-art treatment, and greater likelihood of earlier death from this cancer. On the basis of the National Cancer Institute’s SEER Medicare data from 734,889 contemporary Americans (2004 to 2008), these incontrovertible data come from the 10 leading cancers, which have been validated as a tool to identify those families with reduced cohesion, communication, or conflict resolution. The provision of family-focused therapy ought to be a mandated component of fellowship training in oncology. Through such means, the whole of the multidisciplinary treatment team can deliver optimal supportive care.

For psycho-oncology and supportive services to be able to address the needs of patients with cancer and their families, adequate staffing levels with psychiatrists, psychologists, and social workers are vital to be able to deliver group, couple, and family therapy services alongside individual care. The development of these programs is a challenge for our times. More training programs are needed, but institutions also need to open up staffing lines for services to be adequately responsive to unmet needs. Aggressive symptom management that includes treatment of depression and anxiety to optimize coping and provide support has recently been shown to extend survival further than conventional chemotherapy in patients with lung cancer.14

At the public health level, media communication about preventive screening for early detection of cancer warrants closer attention to message framing to reach the socially isolated with reduced health literacy. Community outreach through libraries, hairdressing salons,
supermarkets, and gas stations are innovative ways to promote cancer screening. Personalized tailoring of health promotion advertisements to minority communities is vital. Legislation that restricts tobacco use in public facilities, limits the sale of paan, gutka, and snus to the young, and ensures health insurance support for human papillomavirus vaccination to both adolescent boys and girls is crucial.

Our humanity is relational at its essence—we are tribal people, drawn into connection with one another to share what is most meaningful and fulfilling in life. Our medicine needs to follow a parallel paradigm: healing care that is both person- and family-centered in its expression. Several factors join together in the sociodemographic of being single—those with potentially fewer social supports, less education, membership within minorities, and limited health literacy—in short, those most in need. Aizer et al1 have reminded us of the power of human attachment in showing the contribution of marital status to survival. They stress why medicine ought not to be governed by money but by humanistic, culturally sensitive, and comprehensive care. Our response must be to develop targeted supportive programs to attend to those most in need—a paradigmatic change in the focus of healing care that truly accompanies the biologic and scientific pursuits of medicine. In the words of that 16th century axiom, “To cure sometimes, to relieve often, to comfort always (Anonymous).”

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REFERENCES

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