

# When the patient is also a carer

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When I first went into practice, my preferred referral was a patient under age 50 with a potentially curable malignancy. For a medical oncologist, a patient like that meant that there probably wouldn't be any worries about serious comorbidities or bone marrow reserve during chemotherapy, or about prolonged loss of function afterwards. In fact, it wasn't until more than a decade later, after attending a symposium specifically devoted to the special needs of young patients, that my eyes were suddenly opened to the fact that, compared with their older counterparts, those patients experienced unique, and often more serious, medical and (especially) psychosocial morbidities from their cancer treatment—a situation that held true not only during active treatment, but well beyond<sup>1-3</sup>.

Arguably, the young patients with cancer who experience the greatest amount of psychosocial stress are mothers of young children<sup>4-7</sup>. At a practical level, those women must worry not only about childcare during appointments and treatments (babysitting, as well as tasks such as taking children to and from school), but also about caring for their children at home or outside when treatment toxicities leave them barely able to care for themselves. At the existential level, the stress is perhaps even greater, because they constantly worry about whether they will live long enough to raise their children to adulthood. The tragedy of the situation is that these young mothers might choose less toxic, but also less effective, treatment so as to cope more easily in the short term, at the expense of their long-term chance of cure (Personal observation).

Although little can be done to alleviate the existential fears, the practical challenges of childcare during active treatment are more easily addressed. In this issue of *Current Oncology*, Cohen *et al.*<sup>8</sup> report the formal evaluation of a free childcare service that has been provided since 2008 by the charitable organization Nanny Angel Network to female cancer patients in the Greater Toronto Area who have one or more children aged 12 and under. The Nanny Angels are not mere babysitters; they are highly trained, professional, and experienced childcare workers.

Of the 243 mothers alive at the time of the study, 104 completed the online questionnaire about the service. Not surprisingly, more than half the respondents ranked childcare as their most overwhelming responsibility after their cancer diagnosis. Although 90% ranked the service favourably, and 75% indicated that it allowed them to keep appointments they might otherwise have had to miss, most felt that the available Nanny Angel visits were not enough to meet their needs.

The need for childcare for young cancer patients is likely to grow in coming years. As women increasingly delay childbearing, the cohort of women with young children is aging and, compared with younger mothers, is therefore susceptible to a greater risk of most cancers. In a study of women diagnosed with breast cancer at age 40 or younger, we found that most women with young children relied on their mothers (and to a lesser extent their fathers) for help with childcare and basic household tasks<sup>9</sup>; in contrast, older patients will have older mothers who might no longer be healthy or even living. In addition, the proportion of younger Canadians who are immigrants or refugees is growing, and many of those young people have parents living overseas, making it difficult or impossible for them to come help. Finally, with the cost of one cycle of *in vitro* fertilization now covered by the Ministry of Health in Ontario, the number of single mothers without a partner to share the burden of childcare or the cost of help might be expected to grow in the future.

What can we, as health care providers, do? I believe that cancer centres have an obligation to provide in-house childcare services to cancer patients coming for appointments or treatments. I also believe that the cost would be minimal. Donations of furniture, toys, and books to a childcare room should be simple to obtain, and although volunteers might not have the same experience and training as the Nanny Angels, they could certainly be trained to provide a calm, safe, and nurturing environment.

Unfortunately, an in-house childcare room would not solve the problem of mothers with cancer needing help when they are at home. For that need, services such as the Nanny Angel Network are invaluable. Although it is noble that the Nanny Angel services are provided to families regardless of economic status, that policy is not practical for managing a very limited resource, and assuming that a deluge of new volunteer nannies is not imminent, it has to change.

The childcare needs of young patients with cancer are but one example of the primacy of the oft forgotten “social history” in oncology that lies beyond “substance use history” and “access to a private drug plan.” A proper social history might not only help the oncology team maximize patient adherence to appointment and treatment schedules, but could also flag, for close observation and early intervention, patients who are at high risk of developing psychosocial difficulties.

## CONFLICT OF INTEREST DISCLOSURES

I have read and understood *Current Oncology's* policy on disclosing conflicts of interest, and I declare that I have none.

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