

# LOVE AND RESPECT

THE HAPPY MARRIAGE BETWEEN ONCOLOGY AND PALLIATIVE MEDICINE  
...WITH APOLOGIES TO EMERSON EGGERICHS

- Introduction
- The Battleground
- Crazy Cycles
- Resolution
- Conclusion

## INTRODUCTION

- 1.4 million cases of cancer per year in the United States
- Nearly 60% of all patients diagnosed will be cured of their disease
- 70% of all patients will survive at least two years
- Many patients die *with* cancer rather than *from* it

## INTRODUCTION

- The problem...
  - Many patients with advanced cancer will die within 6 months of diagnosis
  - Many cancers are terminal at time of diagnosis:
    - Stage IV NSCLC
    - Stage IV Pancreatic carcinoma

## INTRODUCTION

- The problem...
  - Medical advancements coming at a rapid rate
  - Patients and doctors alike may be led to overestimate the value of available treatments
  - Unrealistic expectations lead to frustration and grief
  - Differing perspectives are likely to develop between patients and families and physicians

## THE BATTLEGROUND

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• The Oncologist...<ul style="list-style-type: none"><li>• Compassionate</li><li>• Caring</li><li>• Data-driven (what's the best treatment for a cancer?)</li><li>• Focused on results</li></ul></li></ul> | <ul style="list-style-type: none"><li>• The Hospice/Palliative Care Doc...<ul style="list-style-type: none"><li>• Compassionate</li><li>• Caring</li><li>• Data-driven (what's the best fix for a problem?)</li><li>• Focused on needs</li></ul></li></ul> |
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## THE ONCOLOGIST

Curative / life-prolonging therapy

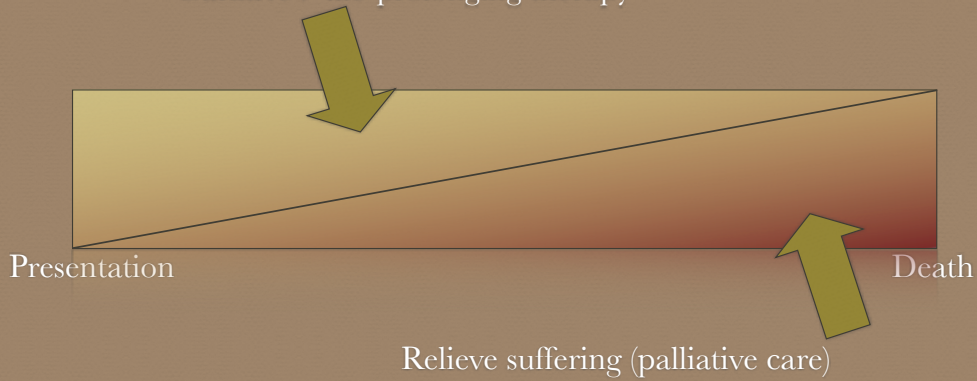
Presentation

Death

Relieve suffering (hospice)

# THE PALLIATIVE CARE DOC

Curative / life-prolonging therapy



## THE BATTLEGROUND

- As applied to a patient...
- Different perspectives on management often lead to different recommendations to a patient/family
- Patient/family perspectives on physician recommendations leads to confusion and frustration
- The crazy cycle begins...

## CRAZY CYCLES

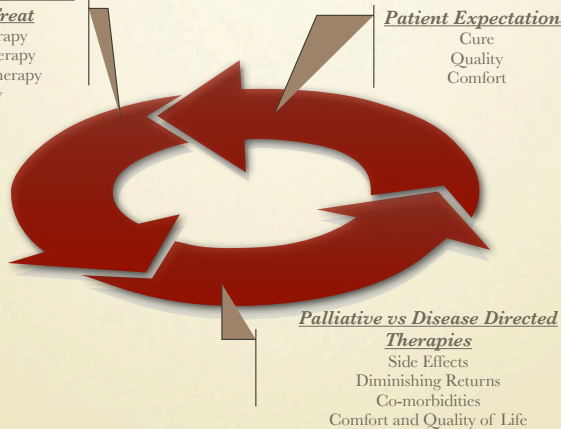
### Oncologist's Perceived

#### Need to Treat

Chemotherapy  
Biologic Therapy  
Radiation Therapy  
Surgery

### Patient Expectations

Cure  
Quality  
Comfort



## WHAT DOES THE PATIENT HEAR?

- “I’ve got a secret”-classic children’s game where information becomes altered as it is conveyed one to another
- “Selective hearing loss”-patients hear what they select and complete ideas on their own
- Defense mechanism or human nature?

## WHAT DOES THE PATIENT HEAR?

- “I’ve got a secret”-classic children’s game where information becomes altered as it is conveyed one to another
- “Selective hearing loss”-patients hear what they select and complete ideas on their own
- Defense mechanism or human nature?
- When a patient receives devastating news and asks, “What are the chances?” what do they hear when we reply?
- “The chances that your cancer will respond to the treatment are very minimal” may be interpreted “So you’re telling me there’s a chance!”

## THE DISCONNECT

- What Do Oncologists Say about Chemotherapy at the Very End of Life? Results from a Semiquantitative Survey (Behl D, Jatoi A; *Jour. Pall. Med.* 2010; 13(7): 831-835)
  - 61 (422 mailed) oncologists in midwest surveyed on attitudes around chemotherapy near the end of life
  - In response to *JCO* article noting that 20% of oncology patients received chemotherapy in the last two weeks of life (Earle CC, Neville BA, Landrum MB, et al.: Trends in the aggressiveness of cancer care near the end of life. *J Clin Oncol* 2004;22:315-321)

## THE DISCONNECT

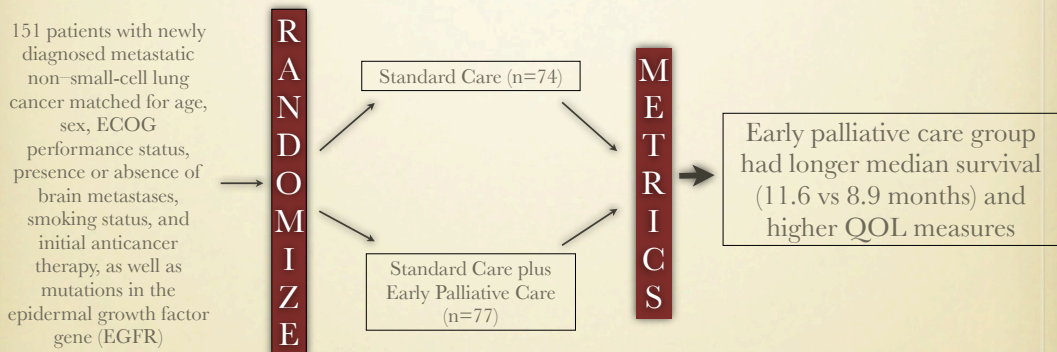
- What Do Oncologists Say about Chemotherapy at the Very End of Life—Nine Major Themes Emerged
  1. These decisions are strongly patient-driven
  2. Newer agents are driving the decision to continue with cancer treatment
  3. Financial incentives on the part of the medical community explain these high rates
  4. Healthcare reform is necessary
  5. Even a small chance of patient benefit justifies this practice

## THE DISCONNECT

- What Do Oncologists Say about Chemotherapy at the Very End of Life—Nine Major Themes Emerged
  6. This practice is detrimental to patients because it precludes the initiation of hospice services
  7. Others may be prescribing in this manner, but “not us”
  8. These issues are complicated, revolve around society values, and the oncologist alone cannot claim responsibility for such high rates of chemotherapy administration
  9. There exist barriers to end-of-life discussions

## EARLY PALLIATIVE CARE FOR PATIENTS WITH METASTATIC NON-SMALL-CELL LUNG CANCER

Temel, JS, et. al; *N Engl J Med* 2010;363:733-42



## THE DISCONNECT

- Now what?
  - Oncologist feels...“I’m doing this because the family and patient are pushing me to do it, and because I’m trying to help the patient live longer and because I have bills to pay”
  - Palliative Care doc feels...“This treatment is futile and the patient and family will suffer needlessly.”

## THE DISCONNECT

- Then...
  - Oncologist feels...“I’m being judged unfairly by the palliative care doc. I don’t feel loved or respected for what I’m doing or by what I’m trying to bring to the situation”
  - Palliative Care doc feels...“I’m being judged unfairly by the oncologist. My skills are not appreciated. I don’t feel loved or respected for what I’m trying to bring to the situation.”

***The battle ensues...***

## RESOLUTION

- How do we resolve this?
  1. Recognize the crazy cycle
  2. Understand the timeline and where the patient is on it

## RESOLUTION

- How do we resolve this?
  3. Physicians need to work toward more effective communication with each other...
    - a. Try “When you say (or do) \_\_\_\_\_ I feel \_\_\_\_\_.”
      - a. “When you say the patient should try the experimental treatment, I feel that you’re not acknowledging to them that the chance for response is small.”
      - b. Can follow up with “Is that the message you wanted to send?”

## RESOLUTION

- How do we resolve this?
  3. Physicians need to work toward more effective communication with each other...
    - b. Use “and” reasoning rather than “but” reasoning (can launch into a “so” phrase)
      - a. “I want to address the patient’s pain, but you’re too focused on the benefit of the chemotherapy.”
      - b. “I want to address the patient’s pain, and you’re focused on the benefit of the chemotherapy. So why don’t I work on the pain issue until the chemotherapy has time to work?”

## RESOLUTION

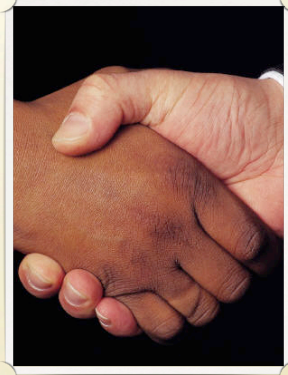
- How do we resolve this?
  3. Physicians need to work toward more effective communication with each other...
    - c. Avoid categorical infinitives like the plague!
      - a. “You never listen to the recommendations from our service!”
      - b. “You always find ways to work around our team!”
      - c. Go back to “When you say (or do) \_\_\_\_\_ I feel \_\_\_\_\_.”

## RESOLUTION

- How do we resolve this?

### 4. Remember your oath...

- a. Osteopathic: "...I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices."
- b. Hippocratic: "...To hold him who has taught me this art as equal to my parents and to live my life in partnership with him."
- c. This leads to reconciliation and then collaborative care of the patient and family



## RESOLUTION

- Address patient issues...
  - Where is the patient in the timeline?
  - What are the goals of treatment? Malignancy AND palliation issues!
  - Be sure the patient/family are on the same page and on board with plans

## CONCLUSION

- The relationship between the palliative care doc and the oncologist can be a mutually beneficial one
- Recognize the crazy cycle
- Reconcile the rift between the physicians, then negotiate the plan of care with the patient/family and involve the team
- A happy marriage can be a wonderful and lasting thing...