Dr. Peter Marks and Dr. Kenneth Miller, The Physician - Patient Relationship January 18, 2009Welcome to Yale Cancer Center Answers with Dr. Ed Chu and Dr. Ken Miller, I am Bruce Barber. Dr. Chu is Deputy Director and Chief of Medical Oncology at Yale Cancer Center and an internationally recognized expert on colorectal cancer. Dr. Miller is the Director of the Connecticut Challenge Survivorship Program and is also the author of "Choices in Breast Cancer Treatment". If you would like to join the discussion you can contact the doctors directly at canceranswers@yale.edu or 1-888-234-4YCC. This evening Ken Miller and I are pleased to be joined by Dr. Peter Marks for a conversation about the physician-patient relationship during cancer treatment. Dr. Marks is an Associate Professor of Hematology at Yale School of Medicine and an expert in the treatment and research of leukemia.Barber Peter, welcome, and Ken, great to see you as always.Marks Thank you.Miller Thank you.Barber This is a great topic to be getting into because as a lay person, I am interested to know about it. Let's start with you Dr. Marks, how long has it been since physicians/oncologists started to pay more attention to this relationship as opposed to just the science?Marks Some oncologists have been doing this from the beginning, but it has been over the past probably one or two decades that there has been real concentration on the art of talking to patients, not just giving them medical treatment per se.Barber Ken, it really is an art, isn't it?Miller I think it is. There is a lot of science in oncology, but essentially, when you first meet a patient who has just been diagnosed, there is the art of learning who they are, what their priorities are, how they see things, presenting options to them, and really coming up with a plan and moving forward in an ongoing relationship. That is one of the exciting things about what we do.Barber What we hear a lot now with physicians is they just do not get the time with patients. Dr. Marks, in your treatment of leukemia patients for example, do you feel rushed at all or do you have the time to form that bond?Marks I would say I have the pressures of getting through the day, but when it comes to breaking bad news to patients or giving a new diagnosis, that is the place where you2:31 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 cannot skimp and other things have to give way because it is a transformative moment in most patients' lives. In leukemia care particularly, we often give bad news that is very sudden and unexpected. In other types of cancer where there are solid tumors, people often have had a biopsy performed and they have had a little bit of preparation time to think that maybe they could have cancer. Often times in leukemia, it is a matter of somebody not feeling well, they come to the emergency room, they have a very high white blood cell count, and suddenly we're called on to break the bad news. It is very sudden and a shocking experience. It means that one has to take the time, and make the time as a physician to do the right thing.Barber In your career I would imagine that you have seen change occur in regards to this.Marks I have, and more and more now we understand the importance of the social aspect of this. Talking to patients, understanding their preferences, explaining the treatment options available, and understanding some of the patients' preferences as we explain those treatment options, are all things that I think are naturally part of what

we do now. There are oncologists that have always been doing this, but now it is essentially standard of care. We teach our fellows that this is something that one has to do well if one wants to be a good oncologist; it has become part of the culture more and more.Barber Let's talk to Ken about the flip side of what you just mentioned, which is, when you are dealing with a solid tumor cancer as a breast cancer specialist, and people have had a little bit of time to prepare, how is it different for you?Miller Actually I think Peter captured it very well. A lot of my patients have already been to a surgeon, a mass or lump was found on the breast exam or on a mammogram, there was a process of maybe a week going to see the surgeon and then the planning of the biopsy, then a biopsy, so several weeks have gone by. By the time that woman comes to us, she knows she has breast cancer and it is a process of really saying, here is the diagnosis and this is what we can do about it. In many ways it is actually a very empowering and exciting time to be able to say, we are going to try to get you well, we are going to work together on this. There are times, in what we call solid tumor oncology, that are more akin to what Peter was discussing where we have to share news that the cancer has come back, or the cancer has progressed, and then work towards deciding what to do about it, but there is a relationship there. You have known the person for a number of months or years, as opposed to what I think happens in leukemia where you are meeting them for the first time and giving them transformative information.5:40 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3Barber How do you train residents to deliver this news, and then how do you as a human beings working in the field of leukemia deal with delivering that news?Marks Let me start with the second question first, I think that the key thing here is to not only rely on the medicine, but also rely on your own humanity. I think back to how I would want my family members to receive the news. I think back about the importance of being one human being connecting with another. If I am going to be delivering this bad news I try to get to know the patient a little bit before I deliver it; that may mean a 10 or 15 minute conversation in the emergency room, talking about who their family members are, what kind of work they do, or what their hobbies are, just to get to know them. That is very important for me because just that little interaction lets me know many things. Even in 10 or 15 minutes, if you are really focused with someone, you can get a sense of what some of their values are, whether they are a religious person, whether that is a value to them, whether they have a family, whether they work, various aspects that are important to them, and then when you have to give the news, you can target a little bit of how you are telling them the bad news around those facts.Barber I see Ken nodding his head over there.Miller I think a lot of the audience listening has heard this over the years, but my wife had leukemia about 9 years ago so I have actually been through this with a family member. People describe it, and I would too, as cold water going through your veins. It is a moment you do not forget. I remember one of the doctors we met in the first 12 hours and I was saying to him, what caused this? I need to know what caused this, and that I think is a common question, but he did relate to us on a very personal level. He said that about 10 years ago his

son was found to be diabetic and he searched and searched and wanted all these tests to find out why he was diabetic and he said he realized at that point they were not going to get an answer, but he did have to decide what to do about it and how to get him well. That was on a very person to person level, sharing, as was appropriate, his story.Barber You are both teachers as well as clinicians, so you are charged with the next generation coming up. How do you teach them to do these things? What is it that you are thinking about when you have a group of residents or students in front of you?Marks I think that one can talk through general principles with the residents or fellows about how we need to do this. We have to have time to do it. We have to make the patient comfortable. We have to make ourselves comfortable talking to the patient. We have to have the right family members there. One of the things we teach is that when you have9:03 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 bad news, it is very important to have family members there for some support. If there is somebody who does not have anyone, I will try to find some way to connect them to somebody elsewhere, whether it be a minister or somebody that can be there for support. There are practical things we can teach them, but truthfully, what they report back that they learned the best from, is just good role modeling; seeing us do it the right way, there is just no replacement for that. When they see the connection that one can build within a half hour conversation with a patient, such that at the end of that conversation they feel a connection, it is amazing. At the end of a one hour conversation with someone I have never met before, they are hugging me and they need that connection. It is important to show students that its okay to do that if necessary, show them that you can build bridges between people very quickly by being honest, and sometimes communicating very disturbing information, yet communicating it in a way that is somewhat positive and that has hope. That is something that they have to just see it done. There is no way to put that in a textbook.Barber And once you have distributed that bad news, or had that tough conversation, then a team comes into play, is that not right?Miller I think that is an empowering thing for our patients. There is a sense of having been hit by this news that they never expected in their life. Some people face other challenges in their life that are very major and they can either bring those strings or those anxieties with them or not. People come with all kinds of experiences that preceded an illness, but there is typically a feeling at the end of the initial consultation that here is this group that is going to work with them to try to accomplish our goals, and the goals can be multiple. As always, I hope that people can get better, so that is one of the goals. I also hope that people will live longer. I hope that we will be able to help them have a good quality life.Barber Is there a point where you start to see your patients accept the bad news? That probably does not happen quickly, but once they become empowered by the fact that there are things to be done. Is there an art to that, or is it different everytime?Marks There is a certain amount of variability from patient to patient with that. Some people come around very quickly and say, "Look, I know what the diagnosis is, now I want to just get on with it; I understand the hurdles to be overcome." For other people it takes a while for them to get over that and to get to the point that

they understand what is going on and feel comfortable that they are moving towards some type of treatment that is going to hopefully get them towards cure. Judging how to work through that with patients is part of the art and knowing when not to push and when to push is an important thing. I also think it is important to understand, when we tell someone this really life-altering12:19 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 diagnosis, when to back off and come back and start the conversation again. It is not infrequent that I will start a conversation with the patient by saying, look, what I am about to tell you is quite disturbing, you may forget everything I tell you after I tell you and that is perfectly fine, you are never going to upset me by asking me something later on. And often times I will just have the conversation in its entirety again. It is very important to judge the patient, judge where they are, and even for patients' who seem to be taking it in at first, it is always very important to check in the next conversation and say, did you have questions? Did you understand or recollect everything we talked about? Even patients who seem to be taking it in, very often when I have a check in at another conversation with them, there are issues that they did not really grasp, or need to ask more about.Barber You are listening to Yale Cancer Center Answers and we are here discussing the patient- physician relationship with Dr. Peter Marks and Dr. Ken Miller from Yale Cancer Center.Barber Welcome back to Yale Cancer Center Answers, I am Bruce Barber and I am pleased to be joined by two cancer physicians, Dr. Peter Marks and Dr. Ken Miller from Yale Cancer Center. We are talking about the relationship that occurs between physicians and their patients, which is something I think that is not discussed in medicine as much as it should be. It must be both rewarding and difficult as a physician to have to break bad news, but also it must be rewarding when there are good, positive outcomes.Miller Just from my own life experiences, and I think all of ours, we all face difficult challenges during our life, whether it's personal or with our family, our children, parents, etc, and people do have resources that they call upon at different times of their life. It is an honor in every way to be able to be there for someone whom I have not met before and try to15:30 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 steer them through a crisis and try to work through with them what to do next. As I look back on my own medical career, most of us have had a role model or two, and like Peter was saying earlier, hopefully we do serve as role models now for our own fellows and the resident physicians who are training to do the same thing.Barber Peter, do you have someone that you can recall in your training who really inspired you and whose role you have followed?Peter There are several physicians with whom I was trained with at Brigham and Women's Hospital at Dana-Farber in Boston, where the way they did things was really quite impressive, just watching them. At that time I do not think anyone talked about a former curriculum, you just were there while they did it and you watched them a few times, they took the training wheels off and then you did it. There was a physician named Larry Shuman, and another physician Mark Goldberg, and they were physicians when I was in training and they just did it magnificently and were great role models.Barber I am sure you have a

great deal of respect for how important you become in someone's life, and you talked about how it can happen very quickly.Peter It is really quite amazing how quickly it can happen, and it means taking on a lot of responsibility, it means understanding how close you can be and still have the appropriate boundaries and making sure that you do what you need to, to facilitate the correct boundaries and knowing when the boundaries need to be bent a little. There are some patients, and I do not normally go up and hug my patients, it is not something I do, but there are some patients that feel they really need that and it gives them a tremendous amount to have that physical contact, that extra handshake, that extra touch of the hand when you talk to them. It is interesting, I was actually teaching a group of medical students and I had to break some bad news to a patient, and just happened to bring them along. It was interesting because what they noticed was less what I said and more some of the things I did; sitting right down next to the patient at eye level, or below eye level of the patient, and touching their leg occasionally when I could see they were disturbed. Those are some of the things where we have to understand, that yes there are boundaries, but they get blurred a little bit, and it really has to be individualized. No matter how often we do this, it is never easy, it is never just rote, it is always individualized and it is always a little bit new for me and a little bit new for the patient.Barber Is this being studied?Miller In a sense it is. This is a little bit off the track, but Yale Medical School, for example, has18:40 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 a course for medical students where they go to one of the art museums. They have an experience that they are asked to reflect on, more the feeling of what they saw versus the content, and part of it is to learn how to understand your own reaction to things and to share it. Another thing that has been taught in medical school is interviewing, talking to people, not so much focusing on medical aspects, but to talk about what a person's experience is with their own illness. I participated in a number of those teaching activities and it is very moving to see how people with illnesses are willing to share their experience, and how sensitive young physicians, young medical students, are to that experience. It is life changing; they remember that probably far more than all the lectures that they hear.Barber I find it interesting seeing classes at the medical school and I get a sense that there is a dual thing that operates in exactly what we were talking about here, which is to get into a program like Yale you have got to be incredibly brilliant. It is obvious to me that what they do try to do though is from that pool of applicants, have as diverse a group as is possible. You must see some students, and then later some residents, who it just comes to naturally, and then some that need maybe just a little more getting in touch with it because they focused so much on being brilliant in the science.Peter I think that is absolutely right. There are some medical students, residents, and fellows that it comes to naturally. It may be because of their life experience, some of it is cultural, and there are others where it does take them time to find their way with this. But in general, I think with good role modeling, you see them grow and to be able to do this. For the ones that have the most difficulty, sometimes it is just a matter of reminding them that when all else fails, you

can always rely on your own humanity, just be yourself, be honest, and just try to forget a little about being a doctor, you have news to convey, you need to do it in a way that is good for the patient, that puts it in as positive a light and as comforting a light as you can without offering false hope, without saying anything false. We need to put it in a way that conveys the information well. If they rely on that, they generally get it, and I have seen a lot of residents grow in that way and it is a beautiful thing to see that growth over the course of years.Barber We used the word art before, it is not something that you can just have a list of and here's what you do.Miller One of my mentors' years ago said, "Do you know why they call it the practice of medicine?" And I said, why, and she said, "Well we're all practicing." And it was really a great comment in the fact that we, over a career, whether it be medical school, residency, fellowship, and being an attendant or senior physician, all of us mature and grow as22:14 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 clinicians. Perhaps some of us communicate really well to begin with, and for most of us learning is an experience over a lifetime. Barber I am sure of the fact that there are physicians that listen to this show, and it must be something where you are not done learning at really any point in your career.Miller That is absolutely true and that is one of the exciting things about our work.Marks I think the reason why it is always different for me is that every time I have one of these interactions I learn something new, and it is a sense of renewal for me as a clinician. I find that one thing I do not want to leave out of this discussion is that we also work with a fantastic array of other professionals; nurse practitioners, social workers, and other support staff. I have even learned things from the nurses' aides on our floors, you see how they interact, how they do certain things, and it teaches me something. It is kind of this Faustian thing where I am going to continue learning until the day I pass from this earth because everytime I do this, I have learned something new, I find someway that perhaps I could have conveyed something better, I could have comforted someone more, so it is a constantly evolving process.Barber I am glad you brought that up because I have spoken with many people who talk about the nursing staffs they have dealt with. They are often there for long periods of time having infusions or radiation treatments, or whatever it is, and there is a strong bond that is formed there I would imagine; a bond as you as a team fight this disease.Miller A very good point. Again, from personal experience, we have had some illnesses in the family, my wife's in particular, and one of the most wonderful people was the snack lady named Philothia. She came by twice a day, she was a very funny woman and she added a lot of cheer and happiness to an otherwise really tense and difficult day. But the social workers were amazing too and they are there for both the patients and for their families. The nurses are the moment-by-moment support, so it does go far beyond just the doctor.Barber We talked before a little about the boundaries that exist there. There are boundaries that you have to have with the patients, but as physicians, what are the ways that patients respond to you that is within the boundaries that makes you feel good when you have worked with them so closely?Marks Things within the boundaries that I feel are usually the most rewarding is just to see some-

body comprehend things that they feel, to see their comfort level improve, to see25:28 into mp3 file http://www.yalecancercenter.org/podcast/Answers_Jan-18-09.mp3 them with their families, to see their ability to get back to a level of function; just seeing that is a wonderful reward in and of itself. We get thank you's and thank you notes, but a great example is seeing a grandfather with his grandson come in to the clinic and seeing them having a wonderful interaction with each other that has been facilitated with extra time that has been given to them through treatment, that to me is the reward that motivates me. To see that there is excellent quality of life with people doing what they want to be doing longer; at least for me that is my reward.Barber How about for you Ken?Miller There is a phenomenon that we call post-traumatic growth syndrome, instead of post-traumatic stress, and one of the concepts here is that after a cancer experience, or a very difficult medical experience, many people go on to say, you know, I am a different person than I was and I am a better person, or I get more out of life. I do not know necessarily if we have done that as physicians, but I think we contributed in a small way. We have tried to channel some of the trauma from it into a sense of a growth, so I really enjoy that also.Barber As we conclude this evening, Peter, is there something that comes to mind where you have seen a patient go from that horrible piece of news that you have had to deliver to an example of real personal growth?Marks I have seen many instances of it and I have seen amazing growth. I have seen patients who have come in, some of whom who have been at the margins of society. I have had more than one, but I can think specifically of a couple who have had problems with substance abuse and tremendous personal turmoil, and seeing them now several years later, they are essentially substance abuse counselors. They are cured of their disease and it's an incredibly transformative occurrence that has occurred. It brings tears to my eyes because I have been a part of that. It is one of the greatest experiences that I have had and one of the real rewards about being part of this.Barber It is nice to hear from both of you that you needn't do anything except work as a team with your physicians to get people better, and then that for you is a reward onto itself.Marks Absolutely.Barber You have been listening to Yale Cancer Center Answers. I would like to thank Drs. Ken Miller and Peter Marks for being with us. If you have questions for the doctors, we would love to hear your comments, you can go to yalecancercenter.org where you can subscribe to the podcast and get a written transcript of a past program. I am Bruce Barber and you are listening to the WNPR Health Forum from Connecticut Public Radio.