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ONCOLOGY *Fellows*

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The *Personal* Touch: Patients Are More Than Their Charts

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The Personal Touch: Patients Are More Than Their Charts

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By Anthony Accurso, MD

As I looked at the glossy white dry-erase board and read the name of my new consult patient, written in crisp royal blue letters, I straightened my tie. I was ready to meet a new patient with a life-threatening cancer. I was ready to instill hope in someone who feared the end. Could I help cure this patient? I was confident that, at the very least, I could offer this person more time managing the disease and a better quality of life.

I placed my palm over the computer mouse located to my right. The small white arrowhead outlined in black moved across the monitor until it found the medical record number of my new patient. My right index finger pressed the left button, and I opened the patient's electronic chart. »

"Please evaluate this patient's anemia" was noted on the chart. I exhaled slowly and rolled my eyes. I reviewed the laboratory workup, which had previously been obtained by the referring physician.

- Hemoglobin is 1 point below the reference range
- Normal mean corpuscular volume
- Normal renal function
- Normal peripheral blood smear
- Normal white blood cell count
- Folate is borderline

I proceeded to review the patient's medication list.

- Primidone
- Quetiapine
- Sertraline

I paused and shook my head. "So, it takes a hematologist to know that psychiatric medications and folate deficiency can cause anemia? I chose this field to take care of people with life-threatening illness—what a waste of time!" I thought.

I locked the computer and left the workroom. I turned to my right and walked 2 steps toward the door to Exam Room 2. I looked at the stainless steel door handle. Before turning it, I tried to relax my face and the muscles in my shoulders to conceal any tension. I knocked on the door 3 times, and then pulled down on the shiny lever.

"Hello!" I introduced myself. "I'm one of the hematology/oncology fellows."

As I greeted a man sitting in the chair directly across from the door, about 3 feet away, I forced a smile.

The man was wearing an old T-shirt and faded blue jeans. He extended his right arm to shake my hand. His body leaned forward and to the left, as his free arm rested on a cane. Scattered scabs covered his forearms. Each wound was between 1 and 2 centimeters, and all seemed to be of different shapes and at different stages of healing. His eyes met mine through a pair of thick lenses.

Anthony Accurso, MD, is a hematology/oncology fellow at the University of Kansas Medical Center.

"Hello, Doctor," the man replied. His face, hidden behind an uneven white beard, moved very little. His bottom lip quivered slightly.

I asked the patient, "What do you know about why you are here in the hematology clinic?" I looked to my left. A middle-aged woman smiled at me. We gently shook hands.

The man quickly responded, "My primary doctor says my blood counts are low." His eyes remained still.

"That's right," I said, "but I don't think there is anything serious going on." I spoke more softly and slowly as I tried to reassure him. "Some of the important medications your psychiatrist is prescribing can lower the blood counts slightly."

I proceeded to obtain a full medical history and asked for his permission to examine him. He agreed and slowly walked toward the exam table. He leaned heavily on his cane and grimaced with each step. I offered my hand and helped boost him up onto the table.

"You look like you're in a lot of pain," I said.

The patient looked back at me with still eyes. His bottom lip continued to quiver slightly. "I'm always in a lot of pain," he said. "It's the arthritis."

As I examined the patient carefully, I remembered the words of my internal medicine professor during hospital rounds 5 years prior. One of my fellow medical students had grumbled about the unnecessary transfer of a surgical patient to our medicine service for comanagement.

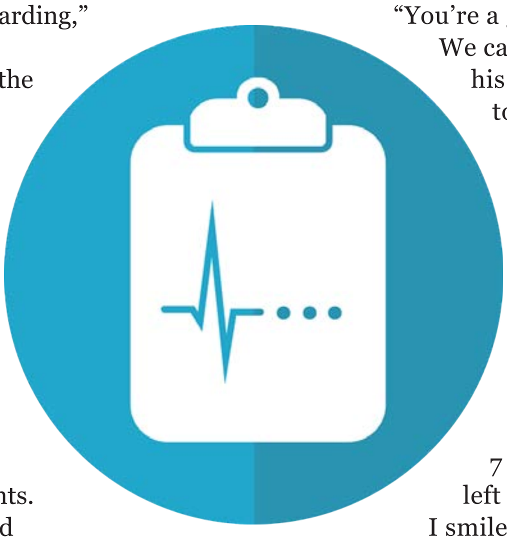
My professor had suggested that the transfer was ridiculous and surgeons could have managed the patient. Putting his arm around the student, the professor said, "Always remember this: We are internists. This is what we do. We take care of patients. Someday you will be asked to take care of a patient, and the task may not seem to be very rewarding."

The students around me nodded their heads slowly and opened their eyes a little wider.

The professor continued, "Another doctor may ask for your help in consultation. The question may seem too simple—a waste of your time. Maybe a surgeon, busy in the operating room, will ask for your help managing a patient's short list of medications. Each of you may even be asked to care for a patient without any actual medical issues."

A few students stepped forward, shrinking the semicircle surrounding our professor.

“When those situations arise, instead of complaining about the simplicity or lack of necessity of your task, ask yourself this question: ‘What can I do to help the person in front of me?’ If you keep that question in mind, I promise your career will be very rewarding,” the professor said.



I helped my new patient down off the exam table and laid my right hand across his back during the trek back to his seat.

“How are things going with your mental illness?” I asked.

“OK, I guess,” he responded.

I continued. “Are you seeing your psychiatrist regularly?”

“Yes.”

“Any thoughts of hurting yourself or others?” I waited for the same answer to the question I had asked dozens of times of other patients.

“Myself,” the man said as he looked down toward the floor. I stood up slightly, lifted my chair a few inches, and repositioned just to the patient’s left. I put my right arm around his back.

“Why would you want to hurt yourself?” I asked.

“The voices in my head are always telling me I’m worthless and that I’d be better off dead.” A tear streamed down the woman’s cheek. She moved in closer. Her right hand covered her mouth, and she took his right hand with her left.

“Honey, I had no idea,” the man’s wife said. She embraced him, and they both cried.

“You’re not worthless,” she continued.

I felt a dull ache in the center of my chest as I watched the couple endure their anguish. I rubbed the man’s back softly as he told me of his plan to wait on the train tracks near his home, until he would finally be free from the antagonistic voices. Then I stated with confidence in my voice, “We can help you. We can make this better.”

The couple gave me their permission to contact our emergency psychiatric team and arrange for admission to the hospital. As he gingerly walked out of the clinic, I attempted to reassure him one last time: “You’re a good person with a lot to offer. We can get through this.” He nodded his head slightly as his eyes looked toward the floor.

Sixty-three days passed. I sat in front of the same workroom computer, prepping to see the sixth of my 8 scheduled patients on another Tuesday afternoon schedule. I did not recognize the name of my follow-up patient. I opened the electronic medical record and the still face and white beard from 7 weeks prior appeared on the top left portion of my computer screen. I smiled and quickly walked toward his exam room. I knocked 3 times, but this time, I was too eager to enter to wait for permission. I pulled down on the shiny steel lever.

“You’re back!” I said with excitement. I walked toward the bearded man, and he briskly propped himself to his feet with his cane. “How are you?”

The man smiled. There was no quiver in his lip.

“We celebrated our 25th wedding anniversary last night,” the man said. He pointed at his wife, who was standing to my left. “We got Mongolian food at Genghis Khan. It was a wonderful night. We can’t afford to eat out often, but we celebrated. All because of you.” He paused. “I was going to kill myself. Probably that same day we met. But you helped me. Now when I hear those voices calling me names and telling me to kill myself, I take control! I say, ‘If I kill myself, that means you die, too!’” He threw his arms around me again. “Doctor, thank you. You saved my life.” ■

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Managing Up:

Fellow Relationships and Challenges

By Simon Abi aad, MD

Medicine requires by far the longest "schooling" of any career. By the time we finally become independent practice–eligible physicians, we are already in our mid-30s and have almost never had the opportunity to make an unsupervised decision on a patient's care plan. The day that comes will be scary for most of us, because we are conditioned to always double-check with the boss, to be under someone's wing. Suddenly we are the boss, with all the responsibility and liability that come with it. Until that day, we will always have several attending supervisors, some with whom we will work often and others with whom we may not even cross paths.

That's the part of training no one tells you about: "managing up." I first heard this term during my 2-year career in the pharmaceutical industry, between medical school and residency. It was a mandatory training for new hires. A whole weekend was spent teaching me how to manage the different challenges I would face with the different types of personalities that might end up being my managers. Despite all the evidence- and science-based methods out there, nothing can fully prepare you to work one-on-one with so many people of different personalities and from different cultural and personal backgrounds. »

> Sometimes a small detail of no relevance to you or your plan may be more important to your attending than the disease itself.”

At first, they don’t know you, they don’t trust you, and they almost never believe a word you say. With time, this cold start to your fellowship slowly changes—or not, depending on whom you are working with and the reputation you build. Attendings talk with each other, so expect your performance when working with one of them to be shared with the others. It’s human nature; accept it.

The following is my approach to managing up, based on nothing but my own humble experience.

1. GET YOUR INTEL RIGHT. Find out about the person with whom you are about to work. I’m not talking about what they published last month or where they worked before they started at your hospital. Ask how they like to round. What are their pet peeves? Avoid doing that “one thing” certain to anger them early on.

2. BE READY. The best thing you can do, regardless of whether you are alone or supervised, is to be on top of your game. Know everything about the patient, and I mean everything. Saying “normal” doesn’t cut it (I tried it; doesn’t work)—know the values. Sometimes a small detail of no relevance to you or your plan may be more important to your attending than the disease itself. Always have the numbers ready, regardless of whether you think they matter, and know what other services are involved in care, why they are used, and what they do for the patient. With time, as trust builds, your attending will ask for less information, so you will have more time to focus on the important stuff.

3. OBSERVE. This is one of the hardest skills to learn, and I do not believe it can ever be mastered completely. Observe your attending and try to understand their baseline personality, current mood, anxieties (let’s be honest—we all have them), cultural background, and interests. You might have a hard time with a certain type of personality and get along beautifully with another, but at least try to understand how your attending thinks and reacts to a certain situation. Figure out if you are caught in a domino effect: Your attending is under pressure and consequently puts you under pressure. This will help you navigate rough days when you are not on the same page or one of you is not in your usual mood.

4. RENDER CAESAR THE THINGS THAT ARE CAESAR’S. Most of the time you will agree with your supervisors, but sometimes you won’t. Most of the time they will be right, but sometimes they won’t. Most attendings will listen to you to see where you are going with your thinking, then nicely shut you down with data you never knew existed, because you either don’t know enough yet or didn’t attend ASH or ASCO last weekend. Inevitably, you will meet the attending who is set in the old

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ways, refusing to accept any suggestion that does not conform to their modus operandi. If it will not make much difference at the end of the day, let it go. I have yet to see any fellow win that battle (the "show me the data" approach almost never works, even if you do show the data). If you believe patient care and well-being are at stake, kindly suggest a tumor board presentation or ask an expert in the field to weigh in.

5. THRIVE FOR INDEPENDENCE. Notice I say "thrive." Independence in training, as discussed above, is not possible. The next best thing is to get as close to it as possible. How? It took me quite some time to figure this out, but what worked best for me was to study hard to be as good as my attending. I found that this gave me independence of thought and streamlined my life. My presentations became more organized, more focused, and packaged with a solid plan. The results were fascinating: no more endless questioning, triple-checking, and looking at charts together. We simply discussed fine-tuning the plan and moved on to the next patient. Pseudoindependence…close enough. With this approach, you spend time learning the things you cannot find in books instead of having your attending teach you the basics that you didn't read.

6. REMEMBER WHY WE ARE ALL HERE. One of my chief residents told me once that we, as doctors, are the most compassionate people to our patients but the cruelest people to each other. I guess any physician can understand or relate to that statement. It doesn't have to be that way; just remind yourself of why you and your attending are rounding on a sunny Sunday afternoon. Remind yourself that you are here to help patients as best you can and learn from each other. We all come from different walks of life and experiences, and it is always fascinating to discover what can be learned from an attending who has been doing this for years, before we even knew what cancer was.

At the end of the day, we need to remember that, as physicians, we all are overworked and strive every day to give our patients the best care in a new healthcare order that seems more concerned about saving money than saving lives. I was blessed to work with great attendings and not-so-great attendings. I learned from all of them, either what to do or not to do. The bottom line: Never take it personally, don't sweat the small stuff, and remember—it's temporary! ■

ABOUT THE AUTHOR

Simon Abi aad, MD, is a hematology/oncology fellow at the University of Miami Leonard M. Miller School of Medicine.

Attitude May Not Be **Everything**, But It's Definitely **Something**

By Rohit Venkatesan, MD

I remember the first time I met John.

I was on the consult service, and he was admitted to the hospital for shortness of breath. I read over his chart before I saw him and expected something grim. He had been diagnosed with an unresectable lung adenocarcinoma 3 years earlier and underwent chemoradiation with a limited, at best, response. He was offered palliative chemotherapy—this was prior to the immunotherapy boom in treating lung cancer—but instead elected to proceed to hospice.

Frankly, as I reviewed the information, I was surprised that he had even survived to this point. I prepared to see a frail, cachectic shell of a man who had wasted away over the past 3 years. When I went into his room, I had to do a double take to make sure I was in the right place. »

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There he was, out of bed, walking briskly to his window to get a view of the morning sun.

"Hey, Doc!" he exclaimed. Forget being alive—this guy had more energy than I did!

"Hey, nice to meet you," I stammered after picking my jaw up off the floor.

We then started our conversation. He told me that he enrolled himself in hospice for a few weeks after he rebuffed the plans for chemotherapy, but he couldn't take people "treating him like he was dying."

So he left and went home. And he lived. He lived in the world, where people treated him like he was living.

"I had a cancer in my chest, but in hospice I felt it going into my heart and my mind, and I couldn't take that anymore," he told me. I started to tell him how amazing it was that he had lived this long, but he was quick to stop me.

"Don't tell me I'm amazing—I'm just me. I'm just living like you. I love my family like you love yours, and I love my dog like you love yours!" he exclaimed.

I told him I didn't have a dog, to which he replied, "You should get one!"

He went on to tell me that he had lived on his own with his dog for the past 3 years, taking long walks, riding his bike around town, and still working part time as a mechanic. "I won't lie to you, sometimes the pain is bad, but it hasn't touched me up here or here," he said as he pointed to his head and heart, respectively.

He ultimately was agreeable to getting some restaging imaging, which showed that in the interim years without treatment, his tumor, although still unresectable, had become marginally smaller and had less uptake shown on a positron-emission tomography scan.

ABOUT THE AUTHOR

Rohit Venkatesan, MD, is a hematology/oncology fellow at The University of Texas Medical Branch at Galveston.

> **"I've had friends and relatives who have had cancer, and I always believed that it wasn't the cancer that got them in the end. It was the depression, the heartache, the loneliness and isolation, and the 'why me?' attitude."**

When I saw him in the clinic to go over the results, he wasn't surprised. "I've had friends and relatives who have had cancer, and I always believed that it wasn't the cancer that got them in the end. It was the depression, the heartache, the loneliness and isolation, and the 'why me?' attitude. I told myself that I was never going to let that happen to me, and as long as I did that, I could live with the results."

As I spoke to him about the next step in his treatment, his phone rang. It was his veterinarian—John's dog had been sick with some vomiting the past few days. "Doc, I'm sorry, I gotta take this," he said.

I told him that I completely understood. There I sat, watching him talk with the vet. Apparently it was just a bout of gastroenteritis that would self-resolve in the next few days. I saw the concern in his face when he started talking and the relief when he was told that everything would be fine. For John, who had unresectable lung cancer and was not on treatment, a conversation with a veterinarian about his sick dog was the most stressful part of his day.

He thanked me as he left, but I felt that I was indebted to him. Moments like that and patients like John—the kind of patient who elevates your job to something more: to a calling, a true purpose—seem few and far between. The most ironic part of all this is that a patient who "failed" treatment reminded me of why I became an oncologist. The countless advances we make in our field are remarkable, and the research and dedication to science that occur on a daily basis are nothing short of extraordinary.

But when I decided to become an oncologist, it was about more than this. It was about a belief and an unshakable optimism and idealism about the human spirit: that it would persist and could even thrive through all the darkness, despair, and, at times, the cynicism that can permeate our discipline. It was a belief about the connection and interplay between our biology, physiology, and spirit. I felt that as an oncologist, I would be able to help and know people in the most intimate ways that a doctor can, but I also felt that I would be able to feel something about these people, my patients, and ultimately about humanity. I felt that I would be able to feel a truth about the human spirit.

If someone had just told me about John's case and I'd never met him, I would have just said that he got lucky. His tumor biology was such that it happened to be slow growing and indolent, and that was it. Eventually, his luck would run out.

But after I met him, that's not what I think, and, more importantly, it's not what I believe. I think the way he looked at life and at the world contributed, in some way large or small, to his favorable outcome. I've always believed in the human spirit's ability to overcome, but I saw it and felt it up close with John, not only in what he believed, but also in what he compelled himself to believe.

It instilled a new outlook in me and strengthened my own belief in the power of will and the human spirit for all my patients. His energy has enlivened me and inspired me to nurture and lift the spirits of all my patients even in times of darkness, because you never know what effects, both tangible and intangible, a good attitude might have. ■

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Colorectal Cancer Screening Reduces Deaths, Incidence in the United States

By Ariela Katz

Colorectal cancer (CRC) screening is an important element of oncologic care, as screening can reduce death rates from the disease by enabling the detection and removal of adenomatous polyps and other precursor lesions and by detecting invasive CRC at earlier stages, which are more treatable. However, although CRC incidence has been on the decline in recent years (50,260 estimated deaths in 2016 vs 49,190 in 2017),[1-2] primarily due to an increase in screening, only 39% of cases are diagnosed before they spread from the point of origin.[3]

CRC screening is recommended for adults aged 50 years and older who are at average risk; however, earlier screening is better for those who have a higher risk due to family history or other medical conditions. Recommended methods include visual exams such as a colonoscopy, flexible sigmoidoscopy, computed tomography colonography, and double-contrast barium enema, as well as stool-based tests such as the fecal immunochemical test (FIT), the guaiac-based fecal occult blood test (FOBT), and the multi-target stool DNA (sDNA) test, which combines the FIT with an sDNA test. All of these tests have the potential to reduce mortality from CRC, but only if they are properly followedup with a complete diagnostic evaluation.

According to 2015 National Health Interview Survey data,[4] among adults 50 years and older, 62.6% reported having either a FIT or FOBT within the past year, a sigmoidoscopy within the past 5 years, or a colonoscopy within the past 10 years. Additionally, the proportion of adults who had a stool test or an endoscopy was higher among those 65 years and older (68.3%) compared with those aged 50 to 64 years (57.8%).[3]

Most notably, the biggest determinant of whether adults received the American Cancer Society guideline-recommended CRC screening was insurance status. CRC screening prevalence in adults 50 years and older in 2015 was lowest among the uninsured (25.1%) and recent immigrants (33.7%), regardless of race/ethnicity and other factors. In general, the rate of CRC screening is much lower among people without health insurance compared with those with insurance.[3] ■

Table. **CRC Screening Prevalence in Adults Aged 50 Years and Older in the United States, 2015**[3;a]

Population	Stool Test	Endoscopy	Combined Stool Test/ Endoscopy
Overall	7.2%	60.3%	62.6%
Gender			
Male	7.6%	60.9%	63.2%
Female	6.8%	59.9%	62.2%
Age (years)			
50-64	6.0%	55.3%	57.8%
65+	8.6%	66.1%	68.3%
Race/Ethnicity			
White	6.9%	63.3%	65.4%
Black	8.0%	59.3%	61.8%
Hispanic	7.3%	47.6%	49.9%
American Indian/ Alaskan Native	Not evaluable	49.6%	54.3%
Asian	9.2%	44.8%	49.4%
Insurance status (50-64 years)			
Uninsured	4.0%	24.0%	25.1%
Insured	6.2%	56.8%	59.6%
Immigration status			
Born in the United States	7.1%	62.4%	64.7%
Born in a United States territory	Not evaluable	62.5%	63.4%
In the United States fewer than 10 years	Not evaluable	25.6%	33.7%
In the United States 10 or more years	8.0%	48.8%	51.8%

[a] Age-adjusted to the 2000 US standard population

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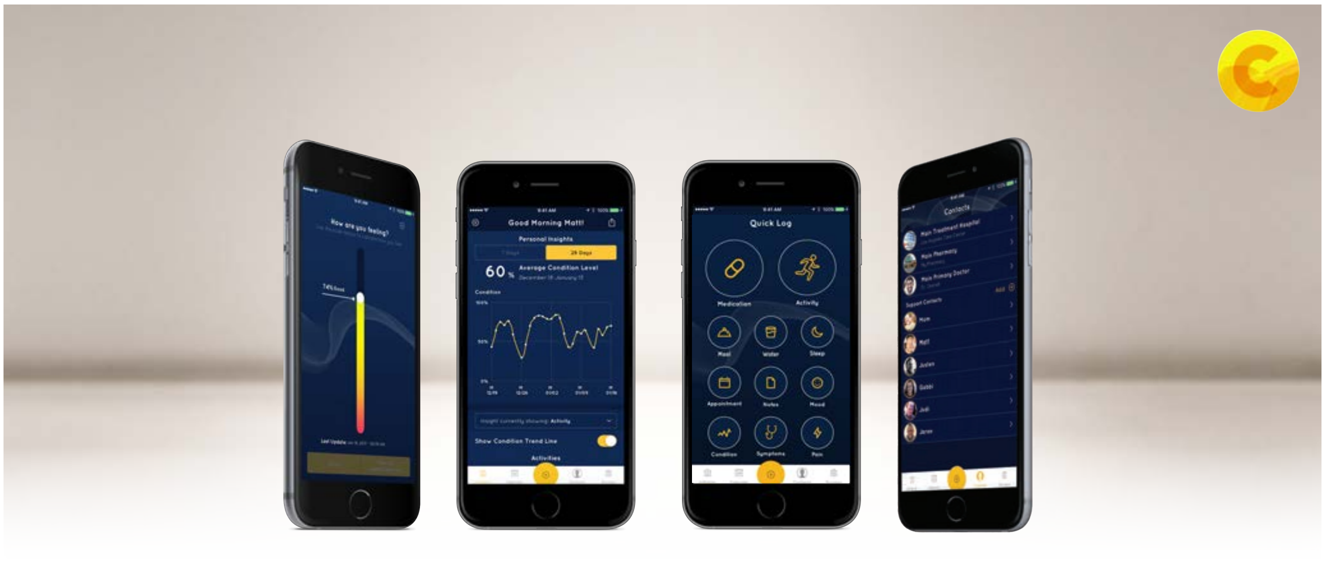
Web-Based App Tracks Patients' Chemotherapy Experiences

By Ariela Katz



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Launched in June 2017, chemoWave is a helpful tool for clinicians that enables patients with cancer to share information about their chemotherapy treatment with their physicians, family, and other supporters. The app gives patients valuable information about their treatment plans and schedule, adverse effects (AEs), and mental health, and it provides their physicians with streamlined updates of that information.

Chemotherapy treatments come with a host of adverse effects (AEs), both physical and emotional, and patients can experience changes in mood along with fatigue, nausea, loss of appetite, and other gastrointestinal symptoms. Accurately keeping track of these AEs and reporting them is an essential part of managing the treatment regimen, as it enables physicians to determine whether their patients are receiving a benefit, need to have their doses changed, or should try a different treatment method.

Not only does chemoWave record the information patients put in, but it also analyzes the data and gives individualized reports. Patients enter information about their symptoms, treatment schedule, sleep patterns, doctor visits, physical activity, meals, andmedications, which is then graphed and charted to identify trends and patterns related to the patient's treatment.

Importantly, the patient can share the information on their app with a number of others, including their physicians. This recording of data provides a much more accurate account of the patient's treatment than does reliance on memory. Patients can also set up a list of family and social contacts with whom the information can be shared.

For security, the shared information is stored and managed on a Health Insurance Portability and Accountability Act security framework certified as compliant with the Health Information Trust Alliance by the National Institute of Standards and Technology. This is so patients do not have to worry about their private medical information being shared with someone outside their approved contacts.

ChemoWave is free to download on the Apple App Store, and is currently available only for the iPhone. ■

REFERENCE

chemoWave. chemoWave website. chemowave.com/. Published 2017. Accessed October 30, 2017.

2018 Oncology & Hematology Meetings

January 17, 2018
***OncLive*® State of Science Summit on Hemotology Malignancies**
Chicago, IL
onclive.com/meetings/soss

January 24, 2018
***OncLive*® State of the Science Summit on Lung Cancer**
Fort Myers, FL
onclive.com/meetings/soss

January 25, 2018
***OncLive*® State of the Science Summit on Genitourinary Cancer**
Brooklyn, NY
onclive.com/meetings/soss

February 10, 2018
PER® *14th Annual* International Symposium on Melanoma and Other Cutaneous Malignancies®
New York, NY
gotoper.com/link/2817

February 15, 2018
***OncLive*® State of the Science Summit on Lung Cancer**
Dallas, TX
onclive.com/meetings/soss

February 15, 2018
***OncLive*® State of the Science Summit on Hematologic Malignancies**
Coral Gables, FL
onclive.com/meetings/soss

March 1, 2018
***OncLive*® State of the Science Summit on Gastrointestinal Malignancies**
San Francisco, CA
onclive.com/meetings/soss

March 1-4, 2018
PER® *22nd Annual* International Congress on Hematologic Malignancies®: Focus on Leukemias, Lymphomas, and Myeloma
Hollywood, FL
gotoper.com/link/2818

March 8-11, 2018
PER® *35th Annual* Miami Breast Cancer Conference®
Miami Beach, FL
gotoper.com/link/2819

March 10, 2018
PER® *5th Annual* Miami Lung Cancer Conference®
Hollywood, FL
gotoper.com/link/2820

March 15, 2018
***OncLive*® State of the Science Summit on Prostate Cancer**
Philadelphia, PA
onclive.com/meetings/soss

March 24, 2018
PER® New York GU™: *11th Annual* Interdisciplinary Prostate Cancer Congress® and other Genitourinary Malignancies
New York, NY
gotoper.com/link/2821

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- **A Day in the Life:** articles describing a typical workday for a fellow or an oncology professional, post training

The list above is not comprehensive; suggestions for future topics are welcome. Please note that we have the ability to edit and proofread submitted articles and that all manuscripts will be sent to the author for final approval prior to publication.

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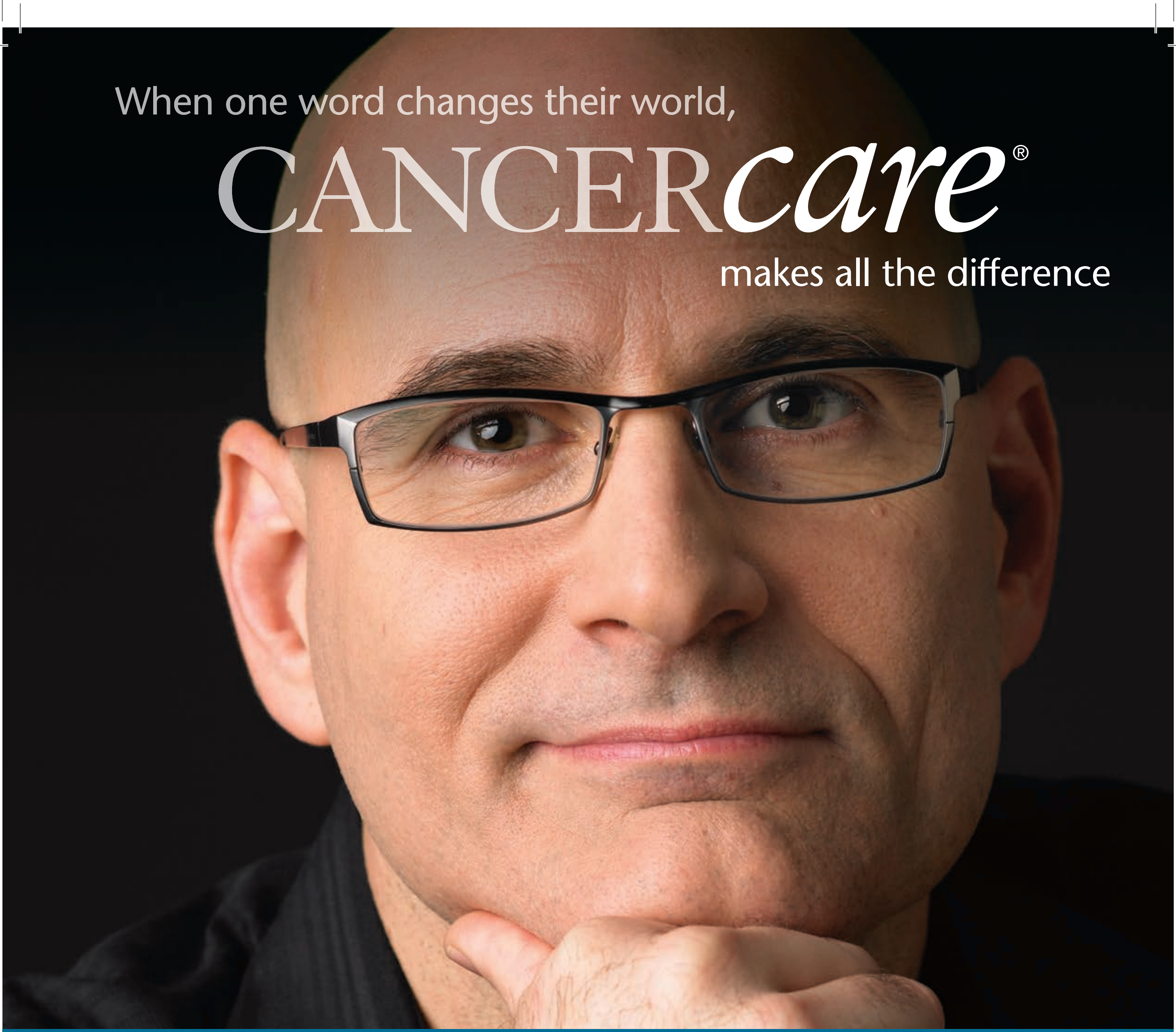
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