

Communication Between Doctors For Cancer Patients

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Among physicians and patients as well as among physicians ourselves communication is crucial. It is through communication with patients that we inform about risks, benefits and alternatives of medical diseases and their treatment. Risks mean what is the chance of harm associated with treatment. Benefits mean the likelihood of success and alternatives mean the medical options available including no treatment or competing modalities of therapy. We are always obliged to offer "no treatment" as a possibility. Sometimes I encourage "no treatment" as the best option. Of course, the situation is different for each. Other issues as well are discussed including treatment plan and duration as well as expected outcome.

In radiation, there are generally three types of treatment indications. One is so-called radical treatment meaning the intent is to cure the patient of the cancer. That doesn't mean cure is the uniform outcome, only that it is the uniform goal.

The second is adjuvant treatment meaning the cancer has been totally eradicated to the best of one's knowledge either by prior radiation, surgery or chemotherapy and now the intent of radiation is to increase the likelihood of the patient remaining free of cancer. This means, however, that there is a possibility of cancer recurrence and for that reason, further treatment is being considered. So really the cancer isn't all gone - it only seems to be undetectable by the best of our technology today.

The third indication is palliative. The palliative setting is when the physician believes there is essentially no likelihood of the patient being cured but the patient has symptoms, which can likely be improved to maintain a reasonable quality of life. Thus, palliative therapy. Symptoms can include pain, bleeding, shortness of breath, obstruction of a major critical site in the body, etc. Neurologic indications include brain or spinal cord metastases. These are sites where cancer impinges on crucial functioning tissues. Sometimes cancers produce hormonal agents that get into the blood and alter one's quality of life. There are numerous indications for palliation - and often other methods of palliation as well.

Frequently in these settings, radiation is started on an emergency basis to help the person with cancer to improve their desperate situation. Palliative radiation can be critical in fighting cancer. Personally, I have had patients who statistically have no chance of being cured, yet almost miraculously they remain cancer-free years later. This is the ultimate in palliation

It is estimated that about half of radiation in the United States is given for palliative reasons. A recent evaluation by Canadian doctors led by Barnes, et al and published in the Journal of Clinical Oncology evaluated the communication between the radiation oncologist in delivering palliative treatment and the primary care physician who has been involved with the patient's care over the prior years. Of course, the two health systems are vastly different.

The primary care physician is the important and central element in the medical care. The primary care physician is usually the major caregiver over years and must be in the loop of information. In Canada, where access to oncologists does not seem easy, many cancer patients continue to get their primary treatment from their primary physician rather than oncologist. Patients justifiably rely on years of association with their primary physician for advice, support and care.

In the United States, often oncologists assume much, but of course not all, of the care of the cancer patient. This paper's research found that 61% of primary care physicians play a major role in pain management and palliative care of the cancer patients always, while 33% reported sometimes playing a significant role.

Primary care physicians in Canada felt that cancer centers must be more aggressive in assisting them in the management of the cancer patient. Other issues include the timeliness of and extent of communication between the radiation oncologist and primary care physician.

A recent analysis was devised to identify the need of primary care physicians to communicate with radiation oncologists, to evaluate the information sent from radiation oncologists to primary care doctors and to access the knowledge of primary care physician about palliative radiation.

Seventy-nine percent of the time primary care physicians in Canada felt that a radiation oncologist letter was useful in managing the patient. Nearly 93% of primary care physicians felt comfortable being the primary physician after radiation was completed. Fifty percent felt that a telephone call would be useful in addition to a letter when the patient returns to them while 60% felt the radiation oncologist was easily accessible by telephone.

The primary care physician expected a letter to them from the radiation oncologist defining the goal of treatment, potential side effects, to identify the physician caring for the patient and to discuss pain medication. Technical details of radiation were only expected 18% of the time.

Yet, the radiation oncologist letter was described as containing technical details of radiation 100% of the time but only identified the goal of treatment, potential side effects in the minority of communications.

The primary care physicians were also accessed for their knowledge of the role of radiation in a variety of symptoms. Eighty-eight percent were aware of radiation's usefulness in treating bone pain when cancer has spread from the primary site to the bone. Fifty-three percent knew that radiation was useful for brain metastases and 61% for spinal cord metastases.

Brain metastases occur when the cancer travels through the blood stream to the brain producing neurologic symptoms. Radiation is generally considered the standard of care. Similarly spinal cord compression occurs when cancer nodules are pressing on the spine causing neurologic impairment. Radiation plus or minus surgery is usually considered the treatment of choice. Examples are endless. Personally, I just saw a man who was being prepared for spinal surgery as treatment for prostate cancer compressing his spinal cord. I offered emergency radiation in July 2000. To this day the treated area remains symptom-free and the mass harming the delicate spinal cord has symptomatically disappeared.

Only 32.7% of primary care physicians knew the usefulness of radiation when patients had hemoptysis or coughing up of blood. This is not an infrequent sign of lung cancer. When lung cancers obstruct the superior vena cava (the major blood vessel that carries blood from the upper half of the body to the heart) resulting in marked problems, only 45% were cognizant of radiation's role.

The authors concluded, "further work needs to be done to enhance communication between radiation oncologists and primary care physicians." Additionally, they felt that "improvement is essential, particularly considering that primary care physicians' knowledge of the role of palliative radiation has been shown to be limited, as is their knowledge of available support systems for these patients."

It is routine that all identifying physicians caring for the patient receive a letter outlining the history as well as intent of treatment. I certainly make every effort to return phone calls to patients, their families and physicians. Dozens more communicate by e-mail every day from around the world.

Our physicians meet with patients undergoing treatment on a regular basis, as do our nurses. We conduct seminars open to the public to discuss a variety of diseases and treatment indications.

Of course, there is always work to be done. The article certainly outlines the feelings of primary care physicians and suggests that more education can be done in all aspects both in keeping the medical community up to date with advances in radiation, and as well being a good communicator and listener.