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Integrating Holistic Care into Breast Oncology

Dr. Birnholz:
Coming to you from the Lynn Sage Breast Cancer Symposium in Chicago, Illinois, this is ReachMD. I'm Dr. Matt Birnholz.

Joining me today is Kelly Scheu, a nurse practitioner specializing in breast oncology at the University of Michigan. Kelly is also a candidate for the diaconate of the Episcopal Church, and the ways in which her spirituality and medical expertise of 27 years in the oncology field blend to enhance breast cancer care will become the focus of our conversation today.

So, Kelly, welcome to the program.

Ms. Scheu:
Thank you. Thanks for inviting me to speak.

Dr. Birnholz:
Thanks for joining us. So, from your vantage point, just to get a basic-level grounding, what is the state of breast cancer care in daily practice today? Are we as a field in the breast oncology space firing on all cylinders, or is there some rust still in the gears that need to be addressed?

Ms. Scheu:
Well, there's always rust in the gear when you have a certain amount of time to see so many patients, and I think the more therapies that we are coming up with, as we have been presented at this conference, the more complex these patients get and the sicker they set. And so there are multifactorial things that affect their quality of life but we are limited in how much time we have to spend with patients, and so, as the institution as a whole is pushing to go faster and see more revenue-driving, it's really making it challenging for us clinicians to provide, what I feel, the care that these patients need, and that's a holistic approach to care, meaning that it does take a lot of time to address the physical issues that patients go through with treatment as well as how it affects them psychologically, spiritually, and also the social aspect of it—how is it affecting their family, their jobs and everything else—so there's like almost a fourth aspect that I think of as a holistic part of care, so that's the challenges that I feel that I'm being faced with right now as a clinician in breast cancer. There's so much to someone but limited time to address it all, so how do I prioritize what I need to address in a given appointment? And I find that sometimes that the major need could be a spiritual need, and then that takes a lot of the time, and then I still have to address all the other side effect things that they are experiencing with their treatment, so it's that balance.

Dr. Birnholz:
Right. And on that idea of time-balance prioritization, what does a typical day look like for you in your practice? And is that even a misnomer of a term to have a "typical day"?

Ms. Scheu:
There's never a typical day. As I try to drive in and center myself an expectation of what my day is going to look like, it will take 1 patient complication or mental health issue or spiritual health that will derail what I want to keep going as a normal day. And when you are an independent clinician, I do not see patients with a physician. I have my own independent clinics. We are like tandem... He has his own and I have my own. You get 1 derailment and then I am derailed for the rest of the morning or afternoon and how to make that time up and how to give each patient to me equal time, because everybody needs time with you, and so how do you not short-change somebody who might be doing better than someone else? I don't know if that answered your question or not. There is no typical day.

Dr. Birnholz:
There is no typical day.

Ms. Scheu:
And I have to remind myself that when I'm preparing mentally for my day that something is going to come up and you're going to be okay. You'll adjust. And I'm really honest with my patients about, "I just had a very difficult conversation with a patient before, and I'm sorry to make you wait," you know, trying to give them clear understanding that they are important too and here I am to be present for them.

Dr. Birnholz:
That's interesting and very much shared by many of your colleagues that I speak to. Another question that comes up then is: Given your independence in the clinical practice but also a very tight partnership with other clinicians, including the doctor you spoke of, what is it like working on a multidisciplinary team with a fair amount of independence but also trying to work together with different areas of expertise or different levels of specialization in order to deliver the best care for your patients? What's that like?

Ms. Scheu:
It can be challenging at times. There are times that I get caught up and should I get some patient care stuff done or do I need to go to these multidisciplinary meetings. At the University of Michigan, we do meet every Monday and go over all clinical trials and accrue*5:28 and how they are doing on them and what new patients have we identified could be candidates for, so it helps me remember all the different options that patients have in treatment options. It's really hard to stay up on all the different options, but that's a great way to do that and have discussion about difficult clinical cases with our specific breast oncologist. We also have a multidisciplinary tumor board when we're talking, when we're meeting with surgeons and radiation oncology and everybody else to hear what's going on and what's the best treatment for a patient. It really takes a lot of time and energy, and I think that the key is that we get comfortable sometimes with what we know, but there are times that we don't know things, and I think when you have colleagues to be able to run things by… and I will do that with my nurse practitioner colleagues or other physicians if my doctor is not around to say, "Hey, what do you think about... I'm sensing something is changing. How would you handle this? And how do you handle this?"—because it's hard to keep up on everything. Everything is changing so quickly, so we do need each other, I think, to provide the most optimal care.

Dr. Birnholz:
Well, certainly as evidenced by this conference where even those with 30-plus years of experience are probably looking at the slides with their eyes wide open, mouths open and agape wondering, "Where did that come from?" "I wasn't completely up–to-date on that." "That's pretty amazing." But let me turn over to the idea of working with administrations too, because you mentioned there's always going to be a drive for revenue, there's going to be a drive for cost monitoring, there's going to be a drive for trying to standardize practices with algorithms that are coming maybe from elsewherebut need to cascade down to the practice level. What are those interactions like for you as an advanced practice clinician?

Ms. Scheu:
You know, I have been pushing at the institution, University of Michigan, to... There always seems to be a disconnect between the advanced practice providers and the physicians, and we never meet together, and so, when you're hearing changes coming down the pipe of RVUs—that's a numbers type of calculation for what they give us for benchmarks and how many… I don't know exactly what RVU stands for. It's revenue something unit. But we don't hear the same things the physicians are, and so we are being asked to practice kind of like independent clinicians. I'm not saying we are physicians, but we have our own independent clinics and billing independently, but we're not hearing the same information from administration, so I have been pushing to have joint meetings with all us clinicians who are asked to see patients and generate revenue and bill together so we're hearing the same things. I'm someone who pushes back, and I always want to tell administration, "Just come walk in my shoes. Feel free to come shadow me on a given day and you might understand a little bit more of why I'm pushing back of numbers are not the end-all be-all of patient care," and I think outcomes will be affected if that's what we're pushing, because not every patient is—the acuity is not the name, so if I have a stage IV breast cancer patient, they're much more complicated than someone who's on tamoxifen for 2 or 3 years in a curative setting, so there are days I'll have 13 stage IV patients and it's intense. It's a lot of work. But you're asking me to see 16 in a day? That's the benchmark. That's a lot.

Dr. Birnholz:
And certainly, coming back to the holistic lens on your practice, every patient has a very different set of needs from a holistic care standpoint, so maybe we can dive right into that and talk about some of your views as somebody who is working towards becoming ordained, blending these 2 elements of your practice. What is that like for you? Are there any pain points in trying to bring your spiritual views into your clinical ones?

Ms. Scheu:
You know, it's always that fine line. I don't ever want the institution I work for to think I'm proselytizing, and I think that's the key of any

clinician. I've done talks with the clinicians, including nurses to advanced practice providers to doctors on spirituality, and you don't have to be religious or overly spiritual to address it and assess it and get the support that a patient needs, and so my main goal is to educate clinicians to at least assess it, at least... As a new patient, the social history is a great place to do it. "Are you spiritual?" And the first things patients say to me is, "No, I'm not religious," or, "I don't go to church," and I then have further conversation. "It's not about being religious. It's about what connects you to your meaning and purpose." And once I get that baseline assessment in my note, I know in the back of my head that this is important or not important or what's important to them spiritually.

A lot of people in the Midwest are religious; they are. In Michigan, in the area of Ann Arbor, a lot of them are Catholic. A lot of hurt has happened in the church, so a lot of people have lots of negative feelings, but teasing that out about how they're now looking at their own spirituality in a setting of a cancer diagnosis is huge. No matter what stage of cancer you have, you think about dying. You think about what that's going to—how that's going to impact your whole life. And there are some patients that say, "Kelly, I'm not going to leave this appointment until you pray with me before I go down to chemotherapy." I've sang with patients. I have prayed with my non-Christian patients. It doesn't matter. It's what's important to them and how can I connect that with them. And a part of the assessment is, "Are you spiritual and/or religious?" "How does that affect your decision-making?" "Do you have a community that supports you?" And then, "How can I be a part of that?"

Dr. Birnholz:
How do you try to be a part of that in general to affect that community sense for a patient when they are isolated?

Ms. Scheu:
Yeah, getting a sense of who do they interact with. Is it their synagogue or their parish or whatever term, or quilting club or whoever, whoever that community is, making sure that they are still interacting with them, because when you do get diagnosed, you're just on survival mode. "Is your church or synagogue—are they reaching out to you?" "Are you still going to church?" "Are you having some theological struggles?" Because there are so many times that we don't use a chaplain. A chaplain is not Christian-based. They can deal with all the theological distressors that patients... "Why am I going through this?" "Where is God?" "I'm angry." There's lots of questions. There's lots of red flags that we just gloss over. And what we do in medicine is we always address these—what we think are lesser than important things at the end of the visit when sometimes that's the main thing on a patient's mind, so the first thing I do when I see a patient is just check in with them. "How are you doing?" "How is life?" And the cancer is the last thing that I address. I mean, their cancer treatment, it's one of those things I just... "How is your son?" or, "How is your dog?" Whatever is important to them, I remember that and just check in.

Dr. Birnholz:
And check-in is such a great operative word because that can be applied towards the idea of checking a review of systems at the very end or in the middle embedded into your history.

Ms. Scheu:
Right, right. I don't even look at those.

Dr. Birnholz:
Or it can be center.

Ms. Scheu:
I mean, I know that patients are like, "Well, I wrote it down." I'm like I'm just here... I want you to tell me what you're experiencing, because so many times they put nothing on the review of systems when there's so much going on, and now we have these spiritual distress things that we're using or spiritual psychological distressors that we're having. Who doesn't have that with a cancer diagnosis? And there's so much more than what people put down or what they don't put down, so I'm more about talking. I'm more about relationship, trying to understand where they are at. There's so much to talk about in these visits, but I think it's getting a sense of... And someone reminded me. The best way to approach patients is, "I can't cover all the things that you may need today. What are the top 2 or 3 that are important to you?" And that's a good way, and I've got to remember that myself. That's important to them.

Dr. Birnholz:
Yeah. And in a system that requires that based on the patient demand, the volume, how do you try to find peace with that?

Ms. Scheu:
It's hard, and that's probably one of the biggest challenges of my job and the biggest, I call it, empathic fatigue. I don't call it compassion fatigue. I mean, I think I walk in the shoes with people, and I really get into what they are feeling, and it's hard. I think self-care is the challenge for any healthcare provider. Sometimes I'll walk away, okay, I think some differences were made in someone's journey of cancer, and there's other times I feel I failed, and it's hard. It's a really good question, and it's something that—and the system does not

build any time for me as a clinician to breathe during a day. There's no lunchtime. There's always things coming in. It's not just about the direct patient care. I have all the indirect patient care I'm responsible for now as we have gone into the electronic medical record and patients can portal in with their concerns, and you can imagine what the portal messages' lengths are like at times, and there's so much to address beyond non-patient care. And that's another pushback with administration that I'm like, "You want me to see 16 patients almost most of the days, but how about the other stuff coming in?" like lab results, like scan results, like all the other stuff.

Dr. Birnholz:
And that is shared among every practice level that we speak to.

Ms. Scheu:
That's right.

Dr. Birnholz:
And even making time for education, which I have to applaud you, you're here; you are making time to advance your practice in the best possible way. But you also alluded to the fact that in conferences such as these, as dedicated as they are to breast cancer, as dedicated as they are to finding what's new, trending and needed for optimizing patient care, there are gaps, especially at the advanced practice level. As an advanced practice clinician, what are some of those gaps, and what would you love to see in continuing education going forward?

Ms. Scheu:
Where do we have a conference that's simply breast cancer focused, because we have one of the largest numbers of cancers, breast cancer, and what about focusing on these are the approved treatments and these are the side effects, the management of all them. There are so many different ways to manage nausea, vomiting, diarrhea. How can we learn from each other? Example is that I just really realize that after you've been on an oral chemotherapy that you don't have to keep checking labs every month. You actually can go to every three. That's a lot less for a patient to have to do, going every month versus every... So sharing information on how we treat patients I think is very helpful. Just like you said, use your colleagues to figure out other ways to better manage patients. But these conferences just throw out all the trials and all those plots, and I understand physicians like that data and that's what they need, but I think for us who are coming to learn more about breast cancer, how do we better manage these patients with these toxic drugs that are coming out? We are keeping you alive a lot longer, but with what quality of life.

We don't do certain treatments because it's not going to improve their overall survival, but how about their survival when they're alive? Is that going to improve their lives if they had their mass removed? For some of my younger patients, that's what drives them, absolutely, to anxiety levels that are so high because they know that this cancer is sitting in their breast. That's hard to live with every day. I might not be able to provide you any change in your overall... But how about what quality I can provide you while you're still here? So that just came to my mind sitting in that last talk about the stage IV and when do we use aggressive therapy. Who are we to decide. It's their journey.

Dr. Birnholz:
You have places to be and many things to do. But any other thoughts for our healthcare professionals of all practice levels who are in the thick of it just like you are treating patients with breast cancer? Anything that you'd want to impart to them that you find is imperative for making your practice work?

Ms. Scheu:
I think the number one thing is remembering self-care, and it's really hard in a system that drives us with revenue. We're all in this because we care deeply about human beings. We all have different approaches. Physicians have their own role, and I have no idea what it's like to be a physician when someone's looking at you like, "Are you giving me no more treatment options?" That's hard. We have raised physicians up to this level in this society of cure, and that's the oath that they take, and it's hard. Looking at and understanding each and everyone's role in the patient's experience from physician down to whatever, everybody cares about people. They wouldn't be there. And self-care, talking to each other, appreciating each other… We're all so quick to criticize, but how about appreciating each and everybody's role and what they bring. Just because you have lots of letters after your name doesn't mean that you're actually an expert in how to take care of someone, and we have to remember that and be humble. Be humble. Know what you don't know, because that gets you in trouble when you think you know it all, so we have to remember what we don't know. And ask. That's why we have colleagues. But unfortunately, what I'm sensing is we're becoming more silos and we're just all in survival mode, and that really concerns me that we're really going to burn out. I personally thought about leaving myself. I don't know what more I can continue to do at the level that I'm doing, and so how do I find that balance and not leave the field that I do love so much. Thank you for the time today.

Dr. Birnholz:

Of course. I have to say, from one colleague to another, I am humbled by your wisdom on these matters. You have a wonderful perspective. I'm pulling for you to find that balance, as we all are looking for, and to continue striving to bring that holistic care to your practice because clearly your patients are benefitting from it. I very much want to thank you for your time.

Ms. Scheu:
Thank you.

Dr. Birnholz:
I've been speaking with Kelly Scheu from the University of Michigan about holistic practice in the care of patients with breast cancer. For more access to this and other episodes specializing in breast cancer care, visit ReachMD.com where you can join the conversation and Be Part of the Knowledge. I'm Dr. Matt Birnholz, and thanks for listening.