Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/closing-gaps-nsclc/doctor-patient-relationship-remedies-in-nsclc/10295/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Doctor-Patient Relationship Remedies in NSCLC

Announcer:
This is ReachMD, and you're listening to Closing the Gaps in NSCLC, sponsored by Lilly.

Dr. Johnson:
The clinical practice landscape for managing patients with non-small cell lung cancer has become increasingly optimistic with continuing advancements in both diagnostic and therapeutic categories, but the center of care is and will always be tied to the health of our relationships with each patient, and it's our approaches to this critical component of care that we're going to focus on improving today. This is Closing the Gaps in Non-Small Cell Lung Cancer on ReachMD. I'm Dr. Shira Johnson, and I'm joined by Dr. Ross Camidge, Director of the Thoracic Oncology Program at the University of Colorado Cancer Center. Today's topic is The Doctor-patient Relationship in Oncology Practice and Counseling Strategies to Make it Stronger. Ross, welcome to the program.

Dr. Camidge:
Thanks for having me.

Dr. Johnson:
So, let's start by setting level some of the more important aspects of counseling patients with non-small cell lung cancer. This is a unique challenge, but these patients also face special challenges compared to those with other cancer subtypes. Can you share some initial thoughts on this?

Dr. Camidge:
Well, there are different aspects when you're diagnosed with lung cancer, usually because you hit Dr. Google, and Dr. Google either tells you that you're a smoker and, therefore, you're to blame or you weren't a smoker and you're probably lying and you must have been a smoker because we don't believe you, and so people deal with this kind of burden of shame. It's astonishing. Even my own family, who I have indoctrinated over the years as to what I actually do for a living, if I were to tell them that I saw a 21-year-old woman, the first words out of their mouth were, "Was she a smoker?" And it drives me completely crazy. So this isn't about the blame game. I think that's one thing you have to tell people. "Look, it doesn't matter what caused it. There are some things we don't know what causes this, but it doesn't matter. We're dealing with you and we're dealing with what we're going to do about this." The other thing with Dr. Google is Dr. Google is always out-of-date, and the implication is if you have stage IV lung cancer, that you're probably going to be dead before you finish reading the article that you've started. And again, you have to say, "Look, these are averages. If they are talking about 5-year survival, they must by fact be more than 5 years old, and therefore, the field is moving so quickly they may not relate." And so I tend to give patients both a best case and a worst case scenario, which ranges from months to years, and then you say, "Some of this information will have to evolve. We don't know if we can find a driver abnormality. We don't know if you'll tolerate the treatment. We don't know if you'll respond to treatment." But we can keep that conversation open. And usually, the best thing to do is to sort of say, "Look, this is a serious disease. This is a life-changing diagnosis, but we're with you through the journey."

Dr. Johnson:
So, can you say a little more about the strength of your relationships with these patients, because I think that's got to be paramount—how they see you, how you relate to them? And it's ongoing. I mean, that creates a bigger picture that the treatment has to fit within; is that correct?

Dr. Camidge:
It is. I mean, it's funny, when I first started oncology, I remember somebody who had been in the medical school a few years above who had gone into oncology, and I was asking them about it, and they said, "Well, it's both terribly sad, because the patients you like don't

© 2023 ReachMD

hang around very long, but also, the patients you don't like don't hang around very long either." And I guess the good and the bad is that that's not true on either level. So you enter these long-term relationships with people, and you get to know them tremendously well, because a diagnosis of cancer really does strip away a lot of the nonsense in our lives. And what I try and do is I try and assume that this is about honesty. I don't wear a white coat. I want to minimize barriers. I make sure, in addition to the medical facts, that when I first see a patient, that social history is incredibly important, because we're treating a person and not just a patient. I work in a teaching hospital. If the fellow goes in and I say, "Well, what did the person do for a living?" and they go, "They are retired," and I say, "What are they retired from?" and if they say, "I don't know," well, they have totally failed. That patient has spent 50 years doing something. I mean, Shira, I don't know about you, but if you've ever been a patient and they don't ask you so that you don't get to tell them that you're a doctor, you know how frustrated you are?

Dr. Johnson:
Yeah, I walk out.

Dr. Camidge:
Yeah, exactly, and you go, "I can't believe it. They didn't even ask me what I did, so I couldn't show off how incredibly smart I am." And that is so vital. You have to know the person. And after a while you can say, "What's happening with you? Did you go on the vacation?" And these are important things about building that trust.

Dr. Johnson:
So you have communication barriers with your patients, and as the relationship develops, you work through them. And as you said, it's an ongoing relationship. It's not a one-time clinic visit. But when you face the patient, or rather, when you meet the patient early on, how do you overcome some of these communication barriers?—because they don't know you, and they're getting or they have just received news that they have a potentially devastating disease. How do you overcome that?

Dr. Camidge:
Well, I think one of the things is all physicians think they are good at communication, and we don't know what goes on in that person's head until they go home. One of the things that is really interesting is to be able to eavesdrop, as it were, on other patients through social media and through second opinions, so I do something called a Remote Second Opinion Program where probably several times a week I speak to patients from around the country, and indeed, around the world. Sometimes all I'm doing is taking the same information they have already got but I just don't do it in medical speak. There are no other physicians in my family, and so I'm used to trying to explain things at a normal level. And if we start to use too many medical terms, that's a barrier to communication, so you have to meet the patient halfway; you have to communicate things. My wife might disagree, but I have a passable sense of humor, and that helps to deflate some of the stress in the room.

Dr. Johnson:
For those just tuning in, this is Closing the Gaps in Non-Small Cell Lung Cancer on ReachMD. I'm Dr. Shira Johnson, and I'm joined by Dr. Ross Camidge from the University of Colorado Cancer Center to talk about ways that we can meaningfully improve our relationships with patients, and he's been doing this his entire career as an oncologist specialist. So, Ross, let me take a quick step back to refine what we mean by communication, because for many of us, that equates to verbal skills only, but communication is really more than that, and as an oncologist, it's an important moment in your relationship from the beginning and for the follow-up. So, what does communication mean to you?

Dr. Camidge:
Well, we are not veterinarians, and we're not pure scientists. This is a very applied science that we conduct. Let's imagine you knew everything there was to know about medicine but you couldn't communicate it to a patient. You would be a stunningly ineffective doctor. Equally, if you knew nothing about medicine but were a wonderful communicator, you would communicate all the wrong things. So we want to get into that sweet spot where you know the right things to say and you can communicate them in a way that that autonomous individual in front of you actually does the right thing, and that is a skill that we need to learn. As I said, I do a lot of second opinions, and sometimes people feel very guilty about coming and seeing me for a second opinion. They are sort of sneaking behind their other doctor's back almost like it's sort of an extramarital affair, and so I sometimes actually view myself almost like a kind of marriage guidance counselor where it's my job to say, "Your doc's doing everything great," and, "Sure, maybe they didn't communicate it in the way that you understood, but they are the right guy." And if I write my letter and you show it to them—so you bring that communication full circle with the original physician and the patient and the second opinion all talking to each other—then you reestablish that communication trust, and it's really satisfying when that works.

Dr. Johnson:
Can you say a few more words?—because I think our listeners would be very interested in this second physician consult field that you

© 2023 ReachMD

got into where you are either communicating or re-communicating what the original consult gave the patient. And you said you're doing this over the phone. I think that's brilliant. Can you tell us a little more about that?

Dr. Camidge:
Well, so about 6 or 7 years ago we set up something called a Remote Second Opinion Program. And a few other places have done it in a slightly clunky way. So some of big cancer centers you could send all your notes in and then you would get a letter back, but you'd never speak to the physician. Here you send all the notes in—which, I don't know, it completely fails the medical paradigm for me. We just talked about communication. There's no relationship there where all you get is a letter back which has got a whole bunch of cut and paste text in it.

Dr. Johnson:
Your slides go out to Mayo and some oncologist there sends back his opinion, and then you're right back where you started, but this sounds far more interesting.

Dr. Camidge:
I mean, some of the worst ones say things like, "Dear So-and-So, I understand you have lung cancer. Let me talk a little bit about lung cancer." And then they just plop in a bunch of text. And you go, "This is ridiculous." The people who are seeking a second opinion have something that they're missing, and mostly what they are missing is effective communication. So what we did, and it's really simple, is their visit is scheduled. The notes are all here. The scans are all here. And the only difference is, at the time when the patient is there, I'm phoning them, and I speak to them on the phone maybe for up to an hour, and we go through the whole story—I've looked at it in advance—and I write a letter, and the letter gets sent to them. And the last line of the letter always says, "Show this to your treating physician for their thoughts." And it's been incredibly effective. We've never had to market it. I've probably done over 400 of them now. We've done something like 30 different states and about 17 different countries. It's amazing to just sort of be able to look into some of these different practices around the country and around the world. And sometimes they are doing great, and like I say, it's just about improving the communication and reestablishing the trust between the original doctor and the person who's seeking a second opinion to say, "They were doing great. Don't worry. They are your guy." And just occasionally—fortunately, it's the rare thing—you have to say, "They are doing it completely wrong." But, fortunately, that's the exception rather than the rule.

Dr. Johnson:
So let's go back and talk again about the counseling strategies that you've been using in general for this patient population, do you have any evidence that these strategies improve the quality of life or their survival?

Dr. Camidge:
Well, it would be hard... I mean, we're getting into kind of the soft sciences now, so it would be very hard to do that. What I can tell you is that our patients live about 4 times longer than the national average, but that may be nothing to do with communication; although, it may be about getting them adhered to treatment and aggressive treatments within clinical trials. I can tell you that our feedback on the Remote Second Opinion Program has been universally positive. And as I said, we've never had to market it, but the patients then go on to chat rooms, and it's almost a badge of success. And some of these turn into real patients. I have this sort of slightly embarrassing bit where the patient will turn up in the clinic having had a remote second opinion, and I go, "Well, didn't we just talk about this a few months ago?" And they go, "Yeah, but I just came for a selfie with you." And it's like, "Okay, fine," And you can just see the fellow rolling their eyes as this is sort of going on. And so, presumably, that means that we've established some kind of a relationship, and, presumably, it's one that they value, and it's great. It also helps me because, usually when I've seen them, I e-mail their treating doctor because, as I said, it's about making that communication work, and that has allowed me to develop friends in community practices around the country and around the world too.

Dr. Johnson:
Those are some beautiful stories. So, Ross, before we close, any additional takeaways you want to share with our audience regarding the relationships that you have with your patients and how important they are to the whole treatment protocol?

Dr. Camidge:
Well, I want to go back to the thing we said right at the beginning. If you're a physician and you have to be a patient—we have to walk in the shoes of our patients for that period of time—it's really uncomfortable, and you suddenly realize how good or bad people are at that. And what you really want them to do is you want them to treat you as a person and not as a piece of meat and not as a medical problem. And we just have to say, "What would we want?" That's the key.

Dr. Johnson:
Very good. Well, I'd like to thank you, Dr. Camidge, for these insightful communication strategies, the approaches that you are utilizing that I know we can all adopt a little bit more purposefully with our patients. It was a great pleasure speaking with you today. Thank you

© 2023 ReachMD

for your time.

Dr. Camidge:
You're very welcome.

Dr. Johnson:
I'm Dr. Shira Johnson, and thank you for listening.

Announcer:
The preceding program was sponsored by Lilly. Content for this series is produced and controlled by ReachMD. This series is intended for healthcare professionals only. To revisit any part of this discussion and to access other episodes in this series, visit ReachMD.com/NSCLC. Thank you for listening to ReachMD. Be Part of the Knowledge.

© 2023 ReachMD