Curative to Palliative Care-Transition and Communication Issues: Surgeons Perspective

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ABSTRACT

Transition of a cancer patient from curative to palliative stage is one of the most difficult and challenging phases of cancer care both from patient and physician point of view. Most of the time the treating surgeons are expected to facilitate this transition but due to a number of reasons surgeons often fail to fulfill this crucial responsibility. This article highlights the various issues involved in the transition phase from a surgeons perspective.

Key words: Communication skills, Palliative care, Surgeon, Surgical curriculum, Transition zone

Complete and comprehensive management of a cancer patient throughout the process of disease spectrum is a challenge often faced by the oncology community. A patient suffering from any malignancy in the course of his/her clinical care may be placed in one of the three zones [Figure 1]. At one extreme is the zone where the patients with early stage cancers can be potentially cured off their disease and at the other extreme is the zone of terminal cancer requiring palliative care. Most often cancer patients with bad prognostic factors transit from curative zone to palliative zone during the course of the treatment and follow-up. Most of the cancer surgeons feel comfortable in the curative zone. The mental agony and despair of patients belonging to the transition zone is imaginable and yet this is the zone which the surgeons are most uncomfortable in handling. This transition demands for utmost skills in communication and delicacy from the treating physicians, usually the surgeon in case of most solid tumors. Considering the difficulty faced by the physicians and patients alike in handling this transition, there are some pertinent questions that need to be addressed. Have these transition-related issues being adequately addressed in the form of guidelines or protocol? Do surgeons receive adequate training and feel confident in dealing with patients at this stage of the disease? What are the patients/their family members' impressions about the communication between them and the doctors? These are some of the questions that have hitherto not received adequate attention in the medical domain with the importance that it deserves.

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INFLUENCE OF SURGICAL PHILOSOPHY AND TRAINING ON SURGEONS ATTITUDE AND BEHAVIOUR

Traditionally, the focus of surgical education and training is centered on mechanistic aspects of disease management. A surgeon's approach is usually disease centric instead of patient centric and death is still viewed as defeat and a crushing blow to the "surgeon's ego". The surgeon should be able to step away from the bright operating room lights where the sterile environment and modern machinery have removed any visible evidence of the humanity, and later sit at the patient's bedside and involve in the empathetic exchange of dialog.[1] By focusing entirely on the disease, they sometimes fail to see the larger picture, e.g., patients' expectations and desire, effect of the disease on the socio economic aspects

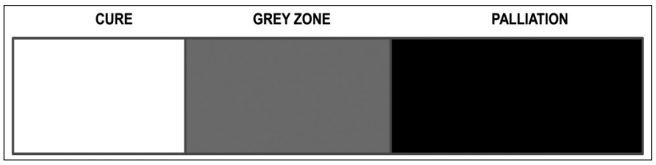

Figure 1: Three zones of cancer patient care

of the patient's life and patient's family. This problem is especially true with regards to cancer surgeons who often approach a patient with the sole motive of removing the tumor. Relapse of cancer with no option for curative resection is taken as an indicator of failure which often leads to dumping of the patient abruptly to allied oncology specialties.

Proper counseling of the patients and the relatives while handling the transition from curative to palliative zone is often lacking. Mere focus on the mechanical repair of the body in a hospital setting, as evident from the rounds aimed at specific post operative goals, fragments care, and provides scant opportunity for the surgeon to become intimately acquainted with his or her patients.[2] Surgeons obsession with curing and the inability to accept the value of caring over the value of curing often turns them away from playing a crucial role in the final chapter of the cancer patient's life.

ROLE OF SURGEON IN PALLIATIVE CARE

The palliative care as a field was alien to surgical field till the end of the 20th century and even now is unfortunately perceived as a defeat zone by the surgeons. Communication regarding unavailability of curative treatment options and referral to palliative care is the most difficult task of a treating surgeon. It is high time the surgeons realize that the defeat is not this transition of a patient but inability to facilitate this transition as smoothly as possible through proper support and counseling. Palliative care involves interaction between three major stakeholders: Patients, physicians, and patients' family.[3-5] Palliative surgical oncology is a relatively new concept and still evolving.[6-8] With respect to the role of surgeons in palliative care, it is important to know the distinction between the following two terms:

- Surgical palliative care: The treatment of suffering and the promotion of quality of life of patients who are seriously or terminally ill under surgical care
- Palliative surgery: A surgical procedure used with the primary intention of improving quality of life or relieving symptoms caused by advanced disease. Its effectiveness is judged by the patient acknowledged symptom resolution.[9]

TRANSITION AND COMMUNICATION ISSUES

In specific reference to cancer care, counseling by a surgeon of a patient for this transition involves several components like breaking the news to the family/patient in an appropriate manner in an ideal setting, confirming the relapse and explaining the basics of relapse, explaining futility of surgery in such situations and briefly explaining available non surgical options. Following this conversation, surgeon should facilitate a smooth transfer of the patient to oncology or Palliative care service after reassuring the patient and relatives about his continued availability for any questions or concerns. Unfortunately, there is a lack of adequate training of surgeons in the communication and counseling related to this transition.

It would be pertinent for a surgeon involved in surgical palliative care to keep in mind following five areas that were identified by family members to be significantly associated with distress and needed improvement:

- Physicians' responsibility and saying nothing can be done
- Providing information with careful consideration of the family's preparation and preferences
- Emotional support for families
- Physicians' knowledge about advanced treatment options
- General communication methods in breaking bad news.

Although, the goals of the treatment have changed from cure or the temporal extension of life to symptom control and the enhancement of quality of life, reassuring the patient that he or she will still be cared for can alleviate fears of abandonment. Published guidelines recommend that physicians should restrain from saying that they have nothing to provide for patients.[10] It has also been shown that prognostic disclosure of definite survival periods without probability and ranges caused high emotional distress. Moreover, in a large survey from Japan, the percentages of respondents who wanted to know the estimated prognosis was not very high (63%) and it was recommended that estimated prognosis be conveyed within the context of statistical uncertainty for each patient.[10]

BARRIERS FACED BY SURGEONS IN TRANSITION AND COMMUNICATION ISSUES

The responsibility to initiate the transition from curative to palliative care often falls on the shoulders of the surgical oncologist in the setting of unresectable cancer, disease progression that precludes further surgical therapy and or

life threatening perioperative complications. This transition is riddled with many barriers including,

- Surgeons' inability to evaluate the futility of aggressive therapy
- Patient or relative's reluctance to stop anti-cancer treatment
- Reluctance to communicate the real situation of incurable stage
- Unavailability of palliative care facility and/or appropriate drugs
- Cultural, linguistic and religious differences.

A surgeon is also reported to exhibit "situational unawareness"-failure to see the actual person behind the drapes and dressings. Usually, surgeons deal with their patients from a physiologic point of view. This entails attention to fluid and electrolyte status, wound care, intake and output, etc., Under such circumstances, the surgeon can overlook the emotional state of the patient.[1]

The problems that surgeons face during the implementation of palliative care can also be attributed to the short comings of the surgical training programs. There is a serious lack of palliative care-related education and training in the undergraduate and post graduate surgical curriculum. The traditional system of medical education doesn't involve a formal training in developing communication skills, leave aside palliative care counseling. Surgeons in general have been acknowledged to be good in first order communication involving interviewing and methodically eliciting history. However, they fail in second order communication skills involving empathy and understanding. There is a need to introduce chapters related to these issues in surgical textbooks.[11] Recommendations for surgical competencies in specific areas, such as interpersonal and communication skills, have also been published.[12,13] In view of these shortcomings, many surgeons adopt "hit and run" method of delivering bad news - insensitive and abrupt dumping of bad news on the patient.

METHODS OF ACQUIRING OPTIMAL COMMUNICATION AND TRANSITION SKILLS

Surgeons often learn these issues by personel experience or by watching more competent people handling such situations. The information should be passed slowly to the patient and family on an incremental basis without destroying hope.[14] The surgeon's should formulate the counseling session with the following levels of possible interaction in mind.[15]

- Cognitive involvement (assessment of the diagnosis and patient's treatment options)
- Emotional involvement (acknowledging the patient's fear, anxiety, etc)
- Values (understands what the physician and patient believe may differ)
- Relationships (Patients and families ability to accept the bad news and decision making capabilities).

Communication is often the most important component of palliative care, and effective symptom control is virtually impossible without effective communication.[16] Compared with other palliative therapies, communication skills have clear palliative efficacy (reduces patient anxiety and distress), and a wide therapeutic index (no treatment-related morbidity and mortality).[8]

CLASS protocol is one of the most widely accepted techniques for successful medical communication. It includes Context, Listening, Acknowledgment, Strategy and Summary. SPIKES protocol, a variant of CLASS protocol has been designed specifically for the purpose of successfully communicating bad news with patients and families.[16] The aspects covered in SPIKES protocol are; S: Setting up the interview, P: Assessing the Patients Perception, I: Obtaining Patients Invitation, K: Giving Knowledge and Information, E: Address Emotional responses with Empathy, S: Strategy and Summary for next steps for treatment.

In addition, two important qualities that every surgeon practicing oncology should inculcate are introspection and empathy.

Introspection

Historically, surgical impulse for action described as "Sometimes wrong, but never in doubt", can only be overcome with honest self-introspection. Without this quality, surgeons are unlikely to overcome their penchant for control and domination of patients. An introspective surgeon will share his or her carefully thoughtout concerns and acknowledges and reflects the emotions of the patients. By opening up the conversation and allowing the patient to indulge in his narrative, surgeons may discover ways around what seemed like insurmountable barriers in planning the next step in the patient's care.[1]

Empathy

Empathy depends not only on one's ability to identify someone else's emotions but also on one's capacity to put oneself in the other person's place and to experience an appropriate emotional response (Charles G. Morris).

CONCLUSION

Transition from cure to palliation is one of the most difficult and challenging phase of cancer care both for the patient and physician community. The job of facilitating this transition often falls into the hands of cancer surgeons. However, most of the cancer surgeons are ill-equipped and uncomfortable in handling these crucial issues due to the inherent nature of surgical training, prevailing surgical philosophy and lacunae in surgical curriculum. There is a dire need for the surgeons to change their attitude while caring for cancer patients and efforts should be made to incorporate palliative care and communication skills in the surgical curriculum. Acquiring these skills requires commitment and a desire from the onco-surgeons to improve the holistic care given to cancer patients with the same commitment that is routinely given to a new technological advances and achievements like lasers, robotics, and minimally invasive surgery.

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