

The Continuum of Communication

In the past few months I have had the privilege of traveling to Japan, the United Arab Emirates, and China with groups of physicians presenting NCCN Clinical Practice Guidelines in Oncology. One particularly rewarding aspect of these experiences has been recognizing how similar the management of cancer is in these diverse areas of the world. Physicians in all areas of the world are reviewing the same literature so that, with minor changes to account for regulatory availability of agents, access to specific technologies, and metabolic and genetic differences among populations, the treatments for common cancers are very much the same. Especially gratifying is seeing the dedication that physicians in all parts of the world show to their patients.

These travels have also illustrated a few significant differences, however, one of which is how physicians in different cultures talk about end of life issues with patients who have poor prognoses. In this area, when at its best, American medicine shines. In the United States, a continuum of care is becoming the “norm.” In this continuum, tumor-directed therapy continues throughout most of the course of the disease, even as its intent changes from potentially curative to palliative. Similarly, symptom management begins at diagnosis and becomes a greater focus when disease progresses. Patients, doctors, and nurses engage in ongoing conversations about both treatments and the changing goals of treatment.

Initially, the goal is often to cure the disease or to extend life as long as possible. During this period, fighting the cancer is both the goal of therapy and the most common topic of conversation. However, even early in treatment, managing symptoms and side effects are important. For patients with advanced disease, quality of life and symptom management eventually become primary, with anticancer therapy used to further these goals.

Clinicians recognize that a patient’s unique circumstances and life view have profound effects on his or her goals of treatment. Some patients want to be comfortable at all costs; others want the disease treated aggressively and are willing to pay almost any cost in discomfort for any chance of prolonging life. Family considerations also affect treatment choices for some patients.

One of the NCCN physicians told physicians in Japan that, in the United States, a patient should not be surprised at news that he or she is dying, because ongoing discussions about treatment and the goals of treatment give patients an awareness of the clinical situation that evolves over time. Impending death is not good news, but palliative care specialists in the United States have developed protocols for presenting bad news or difficult information in ways that allow patients to feel supported and cared for. For example, reassurance that the physician will not “abandon” the patient but will be available even after a transition to palliative care can help both patient and caregivers cope with the uncertainties of advanced disease.

Care often continues after death with sensitivity to the bereaved. It is common for U.S. physicians to either call the family or to write a condolence letter. In fact, one physician I know calls family members to thank them for taking such good care of their loved one. He recognizes that family members may feel that they have not done enough, and he tries to reassure them that they have done all they can. This is truly an example of compassionate care, which represents some of the best American medicine has to offer.



Joan S. McClure, MS

Joan S. McClure, MS, is Senior Vice President of Clinical Information and Publications for the NCCN. She is responsible for the NCCN Clinical Practice Guidelines in Oncology; associated Guidelines for Patients in both English and Spanish; the NCCN Drugs & Biologics Compendium; NCCN Information Technology; and *JNCCN*; and also serves as an Associate Editor for *JNCCN*. Ms. McClure previously managed national oncology information programs on contract with the U.S. National Cancer Institute (NCI). She directed investigator and patient recruitment efforts in oncology for a multinational contract research organization, where she also managed efforts to identify and develop standards for data for submission to regulatory authorities in the United States, Europe, and Japan.

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of the NCCN.