PALLIATIVE MEDICINE AND HOSPICE CARE

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Opinion

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The Role of Dose-Dense Neo Adjuvant Triple H Therapy, Hugs, Humor and Humility: Palliative Medicine, Oncology, and the Human Spirit – A Clinician's Journey

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The road to becoming a medical oncologist is a unique lattice of spiritual academic stamina. The roots of my academic and spiritual journey began well into my childhood when I was raised in a kind, warm, and genuine family. My mother and father, both immigrants who came from Israel with hardly a formal education or command of the English language came to the United States to provide a greater life for the next generation. As a child, when neither my siblings nor I could no longer receive academic help from our parents after the fourth grade, sometimes I would see other children in my class getting help from parents who were doctors, lawyers, engineers, and university professors. Despite this, however, what helped motivate my success more than anything was the loving reassurance from my parents.

MEDICAL BEGINNINGS

Originally, I started my academic career wishing to be an Academic Immunologist. During my undergraduate studies, I was given the unique opportunity to work with focused and well published investigators who fostered a genuine intellectual curiosity who wished to serve as mentors and role models. The hallways were decorated with abstracts, long elaborate gene sequences, and with pictures of western blots of gel electrophoresis slabs partially run stained with ethidium bromide. What appeared evident to me at the time was that a bridge must exist between the cluttered brilliance of the laboratory bench and that of the bedside of a fellow human being in need of answers.

During my residency in Internal Medicine, I began to notice patterns in the physiology of patients who were admitted to the ICU. A case clearly stood out of a woman with triple negative breast cancer who failed her second cycle of adriamycin/cyclophosphamide who ultimately went into respiratory failure under mechanical ventilation, and was getting to the point of requiring a tracheostomy. Well-meaning family members brought her a plethora of photographs of her 2 grandchildren, yet none of the photographs were in her field of view. In a flash of inspiration, I recall taking the photos out of the frames and taping them directly above the patient. The following week, in clinic, to my shock and astonishment, the patient appeared gleefully reading a magazine in the waiting room with her 2 young grandchildren. Immediately the woman came up to me, shed a single tear, said "Thank you Dr. For reminding me how important my love of my grand children was. It saved my life".

One cannot imagine the emotional, existential, and spiritual depth of taking a fellow human being from the abyss of uncertainty to one of self realization and fulfilment.

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PALLIATIVE MEDICINE FELLOWSHIP

At the conclusion of my residency my program director and I had a long discussion about my next career step. Too many choices had to be made in such a short period of time. I felt that I was not quite ready to begin my journey to become an oncologist as I felt an unexplained component missing that was too difficult to truly articulate. My translational curiosity was as strong as my search for the humanity of medicine. My program director made a bold and unexpected suggestion that I seek out a Palliative Medicine fellowship affiliated with a major NCI designated cancer center.

Instantly my life was transformed in a manner I never imagined possible. It was during my palliative medicine fellowship that I realized how little physicians truly knew in cancer pain management. From titrating PCA pumps, opioid drug conversions, knowing when it was appropriate to initiate neuro modulating agents, or when to initiate goals of care discussions, all have added depth and meaning required to treat our most difficult oncology patients became evident to me.

From the eyes of a palliative medicine subspecialist it amazed me to see how many patients on chemotherapy such as bortizumab had peripheral neuropathy, how many patients on irinotecan weren't warned about the diarrhea, and how so many on FOLFOX never were educated about cold sensitivity or crippling mucositis. I have also encountered community resistance to utilizing methadone to treat complicated neuropathic pain, due to its continued social stigmas and necessity for monitoring QT intervals. However, methadone is a powerful NMDA receptor antagonist, attenuates the development of morphine tolerance, and has some activity as a serotonin and norepinephrine reuptake inhibitor. Words such as Relastor, oral cryotherapy, or pallifermin began to be common daily vocabulary.

PALLIATIVE MEDICINE AND THE DEATH OF A PARENT

My father was a vibrant energetic man with a heart of gold. The son of holocaust survivors, his demeanor and attitude towards life was one of kindness and empathy. At the same time there was a strong generational stoic exterior. During my palliative fellowship my father had a cardiac event, an NSTEMI and had been given a drug eluding stent, and placed on dual anti platelet therapy. At the time I implored for my father to remain on the strict course of aspirin and plavix, only to find his compliance far less than optimal. I have vivid memories of lecturing my father near the point of verbal confrontation. As I was preparing to complete my Palliative Medicine fellowship I had received a disturbing call that my father was in the hospital after driving to his photography club meeting. Upon calling back the hospital operator I was directed to the ER and was referred to the attending physician. A short moment later he would mutter those few words that would shake me to my very core, "I'm sorry Dr. Feinsilber, but your father died."

Nothing can quite articulate the cruel irony I had felt at the time nearing the completion of my training, dealing constantly with end of life issues and the complexity of family grief, when in an instant I became the very person I was training to advocate for. It was a great and unanticipated existential challenge. The untimely passing of my father only strengthened my resolve to enhance greater advocacy among Drs. On behalf of their patients.

TRANSLATIONAL PHASE

With the difficulty in losing a parent early in life and greater understanding of clinical medicine I developed a fiery passion for patient advocacy at both the clinical and basic science levels. My intellectual curiosity began to blossom and as such I sought more mentorship and guidance. I was honored and fortunate enough to cross paths with a highly respected medical oncologist drug developer and translational researcher. From an existential, spiritual, and intellectual level I felt prepared to finally make that leap. I recall spending countless hours for nearly an entire year working in the lab and befriending the laboratory staff in what was the most unique symbiotic relationship one could imagine. I was an active attending physician with a busy clinical schedule during the day while working with laboratory technicians, research scientists, and post-doctoral fellows in the afternoon and nights attempting to get experiments to work. This was done while sharing clinical and human interest stories during the process. I recall asking the post-doctoral fellow running a western blot, "Would you ever imagine wanting to see a patient with stage 4 pancreatic adenocarcinoma with biliary obstruction going to hospice? I have a patient like that now I would love to sign you up as an observer to see this." The answer was always a nervous and hestitant yes. By the end of the year, I was able to successfully present data at the gastrointestinal symposium of the American Society for Clinical Oncology (ASCO) that dealt with the concept of synergism with statins and chemosensitization to nab-paclitaxal.

ONCOLOGY FELLOWSHIP AND INTEGRATION OF PALLIATIVE MEDICINE CORE PRINCIPLES

One could not believe the sheer feeling of euphoria and accomplishment knowing that I had obtained a fellowship position in Medical Oncology. My father up to the day of his passing knew this is what I had wished to dedicate my life to, and only now had the emotional composition to truly appreciate what it was I needed to do. My experiences in Medical Oncology as a trainee showed to me how critical it was to educate faculty and other colleagues in palliative medicine principles. This was more critical not only for pain and symptom management but for triaging treatment decisions based on functional status and the spiritual condition of the patient. Palliative medicine when initiated early not only saves money and other resources but ultimately provides better care, enhanced patient compliance, and better therapeutic relationships between physician and patient. Due to my training with a palliative care background I have been

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able to ask the hard questions and be able to comfortably communicate with a family the paradox of "More is less and less is more".

POWER AND PHYSIOLOGY OF HUMOR

The most memorable patient I have come across was a gentleman in his mid-50's who was diagnosed with Diffuse Large B-Cell Lymphoma, who had arrested weeks after having received his first course of R-EPOCH. As I approached the patient and his family shortly after being stabilized I recall the kind almost angelic face of the patient, one that was coming from a source of love and fear at the same time. Clearly the patient was in uncharted territory. I recall the patients sister and brother-in-law having been involved heavily in the patients care were equally in need of certainty, peace of mind, and clarity. I recall at that moment I felt the need to turn my pager off, hang my white coat on the hook, and sit down at eye level with the patient and his family. Having explained the intricate details of the patients lymphoma and prognosis I decided at the time to lighten the mood. I pulled out my iphone and started to play light-hearted movie clips. One such clip was of a dark disgruntled children's television star attempting to sabotage his rival in a rhino outfit. Instantly the tension in the room eased. Prior to leaving the room after laughing ourselves near the point of tears each of us gave the warmest hug. That was the start of an incredibly trusting and very special doctor-patient relationship.

I remember distinctly that when the patient required intrathecal methotrexate, here he had specifically requested I be the physician to administer the drug. It had become a tradition that I would enter the fluroscopy suite with a smile, a reassuring hug, and a 5 minute movie clip loaded on my iphone for him to watch during the procedure. By the third cycle of intrathecal methotrexate I had requested that CSF be sent for cytology, and sadly the patient had extensive CNS involvement. As the disease process continued to progress despite repeated doses of high dose IV methtotrexate, the emotional and psychological relationship was that much stronger than ever. The patient expired, and the family only recalled the attention and humor during his care. This was used strongly during the bereavement process.

The physiology of laughter and hugging another human being is complex and has positive physiological effects. Opioid receptors have an improved threshold for pain, serum cortisol levels drop, anxiety is reduced, blood pressure is lowered by decreased vasoconstriction, protection from inflammation and oxidative stress occur, and the social sense of belonging is enhanced. Endorphins increase as do serotonin levels. Oxytocin is released and mediates nitric oxide synthetase resulting in vasodilatation and lowering blood pressure.

CONCLUSIONS

My extensive life journey through different phases of my own development has allowed for me to identify the crucial role that palliative medicine plays in Oncology. I have been able to truly acknowledge the fact that mediating and harnessing the power of human physiology and spirit is pivotal in ultimate treatment outcomes. It is through the unique lattice of education and personal experiences that I have learned the role of the Oncology physician and clinical decision making should come from both an open mind and an open heart. I feel that Palliative Medicine should play a more integrative and pivotal role in the training of aspiring oncologists, and teaches the requisite skill set for the physician on their own life journeys.