

Overheard

John Mulder, MD



LIVE WELL. DIE WELL. GRIEVE WELL.

Overheard conversation

I felt a little voyeuristic: outside my office door at the palliative clinic, an older gentleman was having a conversation with his daughter. (I didn't know them – they were in to see the oncologist for an initial visit that day.) While it wasn't my intention to eavesdrop, I could clearly hear their discussion. "So did you hear what you expected to hear this morning?" she asked him. "Yes. He told me about the cancer, and that if runs its course, I'll live about two years. I knew that was coming." They proceeded to review the options discussed, and even how he felt about having a terminal prognosis (" . . . we all die from something, I guess this is mine . . . "), and how they ought to proceed.

It was, I suppose, a typical discourse on this topic – some evasiveness on what it might feel like to have a terminal prognosis, and more time talking about specifics and facts, all couched in the expectation that, of course, he would *have* to start chemotherapy, because that's how you treat these things.

Patient knew his priorities

I loved his response: "So in two years, how many times am I going to feel good enough to go fishing?"

It brought home again the absolute need to build value-based decision making into the central conversation about cancer care. Certainly, we need to be sensitive and appropriate about the potential of tumor directed therapies and the role they play in cancer care. But if they don't give this gentleman more time on the lake – indeed, if the interventions take away his opportunity to fish – have we ultimately accomplished what is in this patient's best interest?

Palliative care described

Later, I heard our nurse navigator join the conversation. "We're going to set up an appointment for you to meet with Dr. Mulder, our palliative doctor." She went on to describe, in delightfully accurate detail, just what might be expected from that consultation: diligent attention to any symptoms that might be problematic, and assistance with decision-making. "His job is to make sure that you

Right direction

feel as good as possibly can throughout the course of your disease. He'll be focusing on your quality of life." No apologies, no couching the reasons for referral around a bad diagnosis or poor prognosis, no connection with hospice or end of life care – just a great description of how these services will help him live better, while living with cancer.

How often have we heard reluctance on the part of other doctors to refer to palliative care, or have it presented in such a way such that our patients and families have concerns about intent and motive? This vignette this morning affirmed that though change may be slower than we'd like, we are indeed moving in the right direction. Little pockets of the health care field do understand. And the community at large is becoming more accepting.

And this summer, there's a gentleman who will be fishing his heart out. I'll personally see to that.

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