Who is the Quarterback?
Navigating the

DOUGLAS B. EVANS, MD
Chair, Department of Surgery

TB just retired from his position in retail after a very successful career. He had taken care of his body quite well; exercise, weight reduction and minimal alcohol use. He and his family were particularly surprised when he complained of fatigue, anorexia, and then his sclera were noted to be yellow. After he became jaundiced, he called his long-time internist who saw him immediately. Computed tomography (CT) imaging was followed by endoscopic retrograde cholangiopancreatography (ERCP) and a plastic stent was placed in the bile duct. The gastroenterologist who performed the ERCP suggested that he then reconnect with his internist to discuss overall management; was he operable, what is his stage of disease—all questions that the gastroenterologist was not equipped to answer at the time of the procedure. The patient and his family were somewhere between horrified and confused; should he go directly to surgery? Is there a clinical trial that may offer a better chance for cure? He and his family had read on the internet of the poor prognosis (no one had said the words pancreatic cancer, but the diagnosis had been implied by the doctors and nurses they had seen). There were simply too many options and they needed a quarterback. Someone who they could trust to provide them accurate medical advice, inform them of possible regional experts in the field, and provide access to potential new and emerging treatments which may offer a better chance of survival. The literature was simply too overwhelming for them to navigate even though TB's three children were all on the case and included one pharmacist and one nurse practitioner.

TB's internist, Dr. C, was the consummate physician and he had cared for TB and his family for many years. Dr. C was part of a large physician group that recently had been acquired by one of the health systems in the area. The health system had good outcomes, was highly regarded in the community, and staffed two or three of the hospitals closest to where TB lived. When TB had an episode of chest pain three years ago, he was cared for at one of these hospitals; after placement of a coronary stent and started on aspirin and Plavix, he was well and has remained asymptomatic. After obtaining the results of the abdominal CT and having a stent placed in the bile duct, Dr. C met with TB, his wife, and three children. At this time, the bilirubin was coming down, TB was feeling better, and they all assumed the diagnosis was pancreatic cancer even though a biopsy had not been performed. The family had done as much research as possible and although not physicians, they had created a list of questions, some of which included:

- Should a biopsy be done?
- What is the best treatment: surgery, chemotherapy, a combination of both, should radiation be included? If so, in what order?
- Will the treatment be more effective if it is part of a clinical trial? Do you have access to any new and innovative clinical trials?
- What is the importance of the so called "volume-outcome" relationship? Do we need to be treated at a "high volume" center?
- Do we need a high volume surgeon? If so, is your health system high volume? If not, who would you recommend that we see?

Dr. C was ill-equipped to provide accurate and adequate answers to these questions as after all, he was an internist and spent most of his time staying up-to-date on the literature involving cardiovascular disease, hypertension and diabetes. He suggested a referral to one of their surgeons and medical oncologists as the next best step. TB's daughter (call her daughter #1) was a nurse practitioner and asked if these physicians, who were the suggested next referral, specialized in the management of pancreatic cancer or were more general in scope. She was familiar with PubMed and could not find either of the physicians to have a track record of publications in the field. The family was (rightly or wrongly) associating such intellectual commitment to the disease with perhaps the ability to access newer and innovative therapies. For patients and their families, innovation, clinical trials, and related emerging

Dr. Tina Yen

Tina Yen, MD, MS, receives Society of Surgical Oncology Award

Tina Yen, MD, MS, Associate Professor, Division of Surgical Oncology, is one of two recipients of the Society of Surgical Oncology's James Ewing Foundation 2013–2015 Clinical Investigator Award for her proposal titled: "A population-based study of sentinel lymph node biopsy adoption among breast cancer patients: Does efficacy translate into effectiveness?" This two-year, $100,000 award is intended to promote patient-oriented research conducted by surgical oncologists in clinical and translational science. Congratulations Dr. Yen!

Complex Healthcare Environment

technology often provide hope. Daughter #1 went on to ask Dr. C about referral to a high volume provider; clearly complicated questions for the dedicated family internist who was now an employed physician. Hospital systems have employed physicians for good (business) reasons—it provides them the freedom to require that employed physicians refer patients to the practitioners within their own service lines. Such referral can preserve market share, ensure that their facilities are used, and capture valuable downstream revenue.[1] To what degree did Dr. C feel pressure to maintain TB within his health system? The discussion became more difficult when TB's wife, who had been largely silent throughout the discussion, asked about the experience of the recommended surgeon. Although the association between volume of the surgeon (and institution) and outcome of the patient remains controversial for some medical conditions, there is little debate in two surgical procedures: esophagectomy and pancreatectomy.[2,3] The demonstrated improvement in mortality and long-term survival with increasing volume is likely multifactorial and includes the management of complications when they occur. The failure to manage such complications, referred to as "failure to rescue" can occur at low volume institutions even when the surgeon may be experienced.[4] Indeed, at many high volume (pancreatic) institutions, the nurses caring for postoperative surgical patients have a knowledge of pancreatic surgery which far exceeds that of many physicians. This can provide a level of patient safety that often cannot be compensated for by even the most dedicated physician if working at a low volume hospital.

The result of the meeting with Dr. C proved unsatisfactory; Dr. C was conflicted and uncomfortable recommending a physician outside of his hospital system, at least at this visit, and TB's family was not satisfied; some were disappointed. They felt that Dr. C had an allegiance to his employer that superseded his commitment to their father/husband. They left the office without a clear plan and were not sure that Dr. C was the right physician to manage this life changing event despite the long duration of their relationship. At this time, there was no quarterback of the team and there was no plan of care.

There is no stress greater than that faced by patients and their loved ones who are given a cancer diagnosis, and then asked to make life-altering decisions under enormous stress and time-pressure. TB's family felt this stress and began the process of investigation and research, something few can accomplish successfully in the absence of a sophisticated medical background. While on the one hand, patients should be applauded for their heroic efforts in taking on such a challenge, on the other, these patients often end up being shortchanged. Instead of concentrating on fighting their disease, the patient and their families spend valuable time and energy combing through every resource available, often largely from the internet, in an effort to quickly become experts in cancer diagnosis, staging, and treatment, in addition to the complexities of insurance/Medicare. If there is a gap in the coordination of care, patients can fall through the cracks in communication and crucial interventions can be delayed.

The absence of a quarterback in this case may have been related to the employment status of the physician, who worked at a low-volume institution (for pancreatic cancer management) but there are other potential reasons for the loss of a quarterback: the failure of (some) physicians to assume this responsibility, the decreasing availability of doctors, and the apparent increasing barriers to direct physician-patient communication. The result is that patients and their families feel compelled to investigate their disease themselves, to the best of their ability, and seek out the expertise of those who they feel are most likely to help them. A physician quarterback, when committed, not conflicted, and free to advocate for the patient in whatever way necessary, can help put the diagnosis and at least some of the treatment options in perspective and seek the advice of the best available expert consultants appropriate for the diagnosis. Importantly, the physician quarterback can usually interact in an efficient manner with the specialists, streamlining the referral process, limiting duplication of testing, and preventing misinformation. Most patients with a new diagnosis (cancer being just one example) want two things: hope and a plan. Unfortunately, it has become increasing complicated to develop the plan which has limited our ability to maintain the hope and confidence that should be in the eyes of our patients and their families. •

FOR ADDITIONAL INFORMATION on this topic, see references, visit mcw.edu/surgery, or contact Dr. Evans at 414-805-5706; devans@mcw.edu.

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