Stanford’s Palliative Care Program Enhances Cancer Patients’ Quality of Life

Living Well Through Cancer

SCI News readers have seen many stories on the complexity of cancer biology, with its myriad causes, mechanisms and adaptations. And—as on Pages 6 & 7 of this issue—there are numerous descriptions of the sophisticated technologies and techniques SCI members use to understand and eradicate cancer.

But as any patient knows, modern cancer treatment can also be overwhelmingly complex. To help ease the burden on patients and their loved ones, the Palliative Medicine Clinic at Stanford Cancer Center has developed an innovative program to provide an array of patient-support services in an integrated, holistic way.

The outpatient oncology palliative care program employs a complementary and skilled group of doctors, nurses, social workers and other professionals who deliver individualized support throughout, and beyond, the course of cancer treatment.

“Our palliative care team is an integrated group of specialists that works with patients to define goals and priorities,” said Kavitha Ramchandran, MD, a medical oncologist and palliative medicine physician, and director of the Palliative Medicine Clinic. “We then work with the care team to deliver the best possible care based on the patient’s priorities.”

See LIVING, page 4
Message from the Director

Addressing the Continuum of Cancer Challenges

This issue of SCI News illustrates the broad spectrum of cancer-related activities supported and coordinated by the Stanford Cancer Institute. What is also unmistakable is how the individual cancer patient and their loved ones remain the focus of everything we do.

Our featured story is on the oncology palliative care program, directed by the talented and committed Kavitha Ramchandran, MD. It highlights our effort to bring structure and thoughtfulness to every stage of the cancer care process—to help manage its complexity and improve the quality of life for patients. We will continue to extend this coordinated care to more cancer patients and plan to initiate discussions of goals of care closer to the time of diagnosis for each patient. Palliative care is also the subject of a compelling conversation with Paul Kalanithi, MD, a young Stanford neurosurgeon who is making the most of his life with advanced lung cancer.

We also introduce you to the first of what will be many Multidisciplinary Care Coordinators (MCCs), the specially trained nurses who function as cancer patients’ partners and advocates throughout their course of treatment. The MCCs are one of the many tangible ways we are transforming the cancer patient experience through the Stanford Cancer Initiative.

Another important aspect of the Initiative is our investment in the innovative research projects and skilled investigators who are advancing our understanding and treatment of cancer. This edition’s In Research section contains just a few recent examples of the outstanding science that is being conducted by SCI members. Research will also provide solutions to the problem of the complexity of cancer cell types within individual tumors, one of the major challenges to be overcome in devising truly effective tailored therapies for cancer patients. Our recent conference on this topic, also reviewed in this issue, highlights the nature of this problem as well as the promise of harnessing the immune system as a general approach to its solution.

Finally, we note the recent fundraising dinner for Camp Kesem Stanford, the student-run organization that provides a summer camp and year-round programs for the children of cancer patients. These dedicated students provide emotional support for kids and families coping with a devastating diagnosis or loss. It is yet another way that the Stanford community delivers critical services and compassion to reduce the burden that cancer poses to individuals and their families.

Beverly S. Mitchell, MD
Director

The Stanford Cancer Institute provides support and coordination for the range of cancer-related activities occurring at Stanford University, Stanford Hospital and Clinics, and the Lucille Packard Children’s Hospital. Our 300-plus faculty members belong to more than 30 academic departments, and represent the array of disciplines involved with comprehensive cancer research and treatment.

The Institute is a National Cancer Institute-designated Cancer Center, with a scientific agenda combining laboratory research, clinical study and population science. The Institute also engages in patient care, community education, clinical trials, as well as support and training for the next generation of cancer physicians and researchers.

Simply put, all of our members and resources are focused on one goal: to reduce the occurrence and impact of cancer.

Stanford Cancer Institute News is a quarterly update for members, supporters and friends. On behalf of our members and staff, we thank you for your ongoing support and welcome your feedback and inquiries.

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SCI Holds Symposium on Tumor Heterogeneity

Most cancer tumors are a chaotic mix of various cell types, some more aggressive—and dangerous—than others. A new class of drugs, called “targeted therapies,” works by acting on a specific characteristic of a cancer cell, such as a genetic mutation or surface marker. In a complex and evolving tumor, though, not all cells exhibit that characteristic, or may do so at different times, thereby making targeting more difficult. It is also possible for cancer cells to develop resistance to individual treatments.

In October, SCI sponsored a scientific conference to explore the major issues in understanding and treating cancer’s diversity. Titled Tumor Heterogeneity: Implications for Targeted Therapy, the two-day symposium addressed topics from current limits on our ability to accurately measure cell types and characteristics, to the clinical impacts on patients.

Of course, a single symposium cannot solve all the questions surrounding heterogeneity, and the answers can vary depending on the type of tumor under consideration. Single targeted therapies have proved successful in managing certain forms of leukemia and breast cancer, as well as gastric stromal tumors. It is also possible that some tumors might succumb to combinations of treatments. Still, new measurements illuminating the extensive heterogeneity that can occur in a patient’s primary tumor and/or metastases, and the toxicity associated with targeted therapies, suggests important limitations on the potential of these treatments.

What is certain is that the SCI-sponsored symposium sparked new hypotheses to be investigated, forged new research collaborations and advanced the collective thinking of the participants. SCI program leaders are pursuing new questions raised during the discussion and generating potential topics for future conferences.

‘Magical’ Dinner Supports Children of Cancer Patients

Camp Kesem Stanford recently held the third annual “Make the Magic” dinner to support its summer camp and year-round programming for children of cancer patients. The student-run program offers a free one-week, sleepover camp for kids—ages 6 to 16—whose parents have, or have had, cancer. In June, more than 80 undergraduate counselors made magic for nearly 130 campers, many returning over multiple years.

Founded at Stanford 14 years ago, Camp Kesem has provided invaluable support for hundreds of children and families, given more than a thousand Stanford students unique leadership experience and inspired a national program with over 60 chapters at colleges throughout the country.

This year’s event was the most successful yet—requiring a move to a larger venue—but what did not change was the heart of the evening’s program: personal and powerful speeches from those who know Camp best.

“The students who volunteer at Camp Kesem have brilliant minds, incredible drive and determination, but they also possess the hearts of servants,” said a parent of two campers. “There is not a thing that could stop my children from going to Camp. It is a sacred week for them; a week that stays in their consciousness throughout the year.”

“When my mom went through chemo, radiation and surgery, there were numerous friends, neighbors and family members that helped by bringing casseroles or bringing my sister and I to outings. I am grateful to all of them, but nobody understood what I was going through and how to help me like Camp Kesem did,” said a multi-year camper. “I am worried about kids who have been affected by cancer but do not have the magic of Kesem, who have to face cancer without this week of hugs and love and support.”

Throughout the evening’s celebration, the Camp Kesem community pulsed on. As reunited friends hugged and laughed, they also exchanged updates on individual camper’s situations. Plans were made for bereavement notes, care packages and group visits to families in need of support. Camp Kesem Stanford is a not just a week of camp, it is a year-round, and life-long, community.

For more information, or to enable more magic for kids and families in need, go to campkesem.org/stanford.
Palliative medicine providers assist in areas outside the domains of oncologists, radiologists and surgeons. They address a range of concerns—financial, social and spiritual—that often accompany complicated cancer treatment. The team also helps manage unpleasant side effects, like uncontrolled pain, nausea, constipation and sleep disruption.

Unlike the traditional patient experience, palliative care outpatients choose how and how often they interact with their team—sometimes even the appointment location—which is both comforting and empowering for individuals to whom so much can seem out of their control. Joint appointments with oncologists and palliative care specialists are available, as are periodic telephone check-ins, for additional convenience.

Palliative specialists are advocates for their patients, helping them navigate additional care and service options, even those not related to their cancer.

“For it is the right thing to do for people.”
— Kavitha Ramchandran, MD

For example, Ramchandran recalled a seriously ill patient—a woman in her 80’s with advanced lung cancer and end-stage kidney disease—who nonetheless maintained an enjoyable quality of life. A suspicious mass was found near the woman’s tonsil and, as is routine, preparations were made for surgery and/or chemotherapy, as necessary. However, for this individual with a prior liver transplant and metastatic lung cancer, treatment of the new cancer in her neck was a very low priority.

Just as the intensive therapy was about to commence, Ramchandran was able to intervene and prevent much needless discomfort (and expense). The other doctors were doing their jobs, but they didn’t have Ramchandran’s more complete understanding of the patient’s overall condition, prognosis and stated desires for her remaining life.

“In those types of situations it often takes someone who can step back and assess what is really most important for this person at this point in their life,” said Ramchandran.

Experience indicates that health care delivered in line with people’s specified quality of life goals reduces procedures, improves efficiencies and saves costs. Some studies have shown increased longevity in patients for whom palliative care was initiated early in the disease process.

“For it is the right thing to do for people,” said Ramchandran.

Learning and Unlearning
Ramchandran earned her medical degree and clinical residency at the University of California, San Francisco, then pursued an integrated palliative care oncology fellowship at Northwestern University—one of the few programs in the country combining palliative care principles and clinical oncology. She spent a year treating seriously ill cancer patients, learning techniques for complex symptom management as well as communications skills to help deliver complex and difficult information with clarity and compassion.

“We actually had to unlearn habits from our medical training, because we had started speaking like clinicians instead of like people,” she said. “When someone is ill, they want their doctor to speak to them the way a good friend would.”
Stanford’s palliative care efforts began as an inpatient program in 2007, under the leadership of Stephanie Harman, MD, clinical assistant professor of medicine, and a general palliative care practitioner. In 2012 Ramchandran started the outpatient program, initially as a pilot housed in the Stanford Women’s Cancer Center. It has since grown into larger space in the Stanford Clinical Cancer Center, where it is staffed five days a week and supports more than 100 patients a month, with capacity to expand.

“Inpatient palliative care is a big deal, so it’s important to have a big population to treat,” said Ramchandran. “Our goal is to provide compassionate, individualized care to our patients, and to provide ongoing support in her survivorship.

“Palliative care is crucial to our efforts to provide compassionate, individualized therapy,” said George Sledge, MD, professor, and chief, Division of Oncology. “Most of our work focuses on treating the cancer; palliative care focuses on treating the patient. It is how we would want to be taken care of: as unique individuals with special needs.”

In an effort to extend their services to more patients earlier in the disease process, the palliative team is working with the new Multidisciplinary Care Coordinators (MCC) being deployed as part of the Stanford Cancer Initiative (see story on Page 10).

“We are partnering very closely with the new MCC’s and instructing them in what I call ‘primary palliative care,’ which is essentially screening their patients to see if they are in need of the types of services we offer,” said Ramchandran.

Extending Services
In collaboration with Jonathan Berek, MD, director of the Stanford Woman’s Cancer Center and chair of obstetrics and gynecology, and David Speigel, MD, the Jack, Lulu, and Sam Willson Professor in Medicine and professor and associate chair of psychiatry and behavioral sciences, Ramchandran is organizing interactive training sessions and online education programs to help oncologists improve their communications skills. In 2015 she and others are launching a quarterly palliative care training program that they hope will become required coursework for all Stanford oncology trainees.

In addition to serving more cancer patients, the Palliative Care Clinic is coordinating with other groups throughout Stanford Health Care that provide some elements of palliative care—including the Stanford Integrative Medicine Center and Stanford Pain Center—to build a cross-disciplinary leadership team to assess a wide variety of complex disease and treatment scenarios.

“It empowers individuals and families to make important care decisions, and helps restore dignity and humanity to an increasingly complex and technological disease-fighting system.”

Seshadri, PhD, Vice President, Cancer Services Line. “In addition to providing compassionate care to our patients, Dr. Ramchandran and her team are also redefining the role of palliative care for our nation.”

What motivates and unites all of these activities is the knowledge that integrated palliative care demonstrably improves patients’ wellbeing and quality of life.

What Others Say About the Palliative Care Program

“The beauty and genius of Dr. Ramchandran’s approach is that she makes it clear that she and her team also learn from me. In so doing, she lifts me out of just being a patient, to someone who offers value as a human being.”

— Victoria Ferra

“We cried a bit as we talked about the end, and they had tissues and warm hands to hold ours. Their compassion was palpable, and as her primary caregiver, I felt heard. They honored our relationship.”

— Barbara L. Wrigley, spouse

“Kavitha has been remarkable and inspirational. With her leadership as both a cancer clinician and palliative care specialist, we are creating a model of palliative care that will be unique to Stanford, formed by the needs and wishes of patients and their families.”

— Meryl Selig, philanthropic investor with her husband Bob
In Research

Important Recent Advances by SCI Researchers

Bilateral Mastectomy Doesn’t Improve Breast Cancer Survival

Breast cancer patients who had a lumpectomy followed by radiation therapy survived as long as patients who had a bilateral mastectomy, according to a large study conducted by researchers at Stanford and the Cancer Prevention Institute of California (CPIC).

The analysis of nearly 190,000 California women with breast cancer is the first to directly compare survival rates following the three most common surgical interventions: bilateral mastectomy (the removal of both breasts), unilateral mastectomy (the removal of the affected breast), and lumpectomy (the selective removal of cancerous tissue within the breast) plus radiation.

The researchers sought to understand why increasing numbers of women are choosing bilateral mastectomies after a diagnosis of cancer in just one breast. The study found that, in 2011, as many as 12 percent of newly diagnosed breast cancer patients opted for a bilateral mastectomy, despite uncertainty as to whether this approach was better than the alternatives. This study dispels much of that uncertainty.

“We can now say that the average breast cancer patient who has bilateral mastectomy will have no better survival than the average patient who has lumpectomy plus radiation,” said the study’s lead author, Allison Kurian, MD, an assistant professor of medicine and of health research and policy.

“We’re hopeful that this study will open a dialogue between a patient and her physician to discuss these kinds of questions,” said Scarlett Gomez, PhD, a research scientist at CPIC, and the senior author on the study, which was published in the Journal of the American Medical Association.

New Imaging Strategy May Improve Bladder Cancer Detection

Researchers have developed a new imaging technique that they say could detect bladder cancer with more accuracy and sensitivity than standard methods.

Bladder cancer, the fifth most common cancer in the US, is generally identified in the clinic by a procedure called cystoscopy, an endoscopy in the bladder. But by themselves these imaging techniques are insufficient to diagnose cancer, particularly flat-appearing tumors that blend in with the bladder tissue, so painful biopsies are required.

“Our motivation is to improve optical diagnosis of bladder cancer,” said Joseph Liao, MD, an associate professor of urology. “Molecular imaging offers the possibility of real-time cancer detection at the molecular level during diagnostic cystoscopy and tumor resection.”

Molecular imaging needs a target. Liao and his colleagues found one in a protein called CD47, which resides on the surface of cells and signals the immune system not to attack the cell. Most cells produce CD47, but cancer cells make much more than normal.

“We hypothesized if it’s a good therapeutic target and it’s also expressed on the surface of the cancer cells, it may be a good imaging target,” said Liao.

The work was published in the journal Science Translational Medicine. In the future, this technique could improve bladder cancer detection, guide more precise cancer surgery and reduce biopsies, thereby increasing cancer patients’ quality of life.

Researchers Engineer ‘Decoy’ Protein to Stop Cancer from Spreading

A team of researchers has developed a protein therapy that in mice was able to disrupt the process that causes cancer cells to break away from original tumor sites, travel through the bloodstream and start aggressive, new growths elsewhere in the body. This process, known as
metastasis, can cause cancer to spread with deadly effect.

“The majority of patients who succumb to cancer fall prey to metastatic forms of the disease,” said Jennifer Cochran, PhD, an associate professor of bioengineering.

Today, doctors try to slow or stop metastasis with chemotherapy, but unfortunately it is not very effective and has severe side effects.

The Stanford team seeks to stop metastasis, without side effects, by preventing two proteins—called Axl and Gas6—from interacting to initiate the spread of cancer. Cochran engineered a harmless version of Axl that acts like a decoy and latches onto Gas6 proteins in the bloodstream, thereby preventing them from linking with and activating the ‘real’ Axl on cancer cells.

In collaboration with Amato Giaccia, PhD, professor of radiation oncology, and co-director of SCI’s Radiation Biology Program, the researchers gave intravenous treatments of this engineered decoy protein to mice with aggressive ovarian and breast cancers. The results, published in the journal *Nature Chemical Biology*, found that mice in the ovarian cancer treatment group had 90 percent fewer metastatic nodules, while mice with breast cancer had a 78 percent reduction, versus the control groups.

**UV Light Can Turn Gene into Source of Skin Cancers**

New research shows that a genetic mutation caused by ultraviolet light is likely the driving force behind millions of human skin cancers. The mutation occurs in a gene called KNSTRN, which is involved in helping cells split their DNA equally during cell division. Although KNSTRN hasn’t been previously implicated as a gene causing human cancers (also called an “oncogene”), the research suggests it may be one of the most commonly mutated oncogenes in the world.

“This previously unknown oncogene is activated by sunlight and drives the development of cutaneous squamous cell carcinomas,” said Paul Khavari, MD, PhD, the Carl J. Herzog Professor in Dermatology and chair of the Department of Dermatology. “Our research shows that skin cancers arise differently from other cancers, and that a single mutation can cause genomic catastrophe.”

The mutation in the KNSTRN gene was caused by the replacement of a single nucleotide, called a cytosine, with another, called a thymine, within a specific, short stretch of DNA. The swap is indicative of a cell’s attempt to repair damage from high-energy ultraviolet rays, such as those found in sunlight.

Cutaneous squamous cell carcinoma is the second most common cancer in humans. More than 1 million new cases are diagnosed globally each year. The research, published in the journal *Nature Genetics*, found that a particular region of KNSTRN is mutated in about 20 percent of cutaneous squamous cell carcinomas and in about five percent of melanomas.

**Drug May Prevent Invasive Bladder Cancer**

A recent study showed that a drug approved for use in humans for another purpose may prevent against invasive bladder cancer. The drug, called FK506 or tacrolimus, is commonly used to suppress the immune system of organ transplant recipients to combat rejection.

The researchers found that low doses of FK506 prevented the development of invasive bladder cancer in 10 out of 10 laboratory mice that were given a carcinogen over five months. In contrast, seven of nine control mice developed invasive cancers during the same time period.

The study, published in the journal *Cancer Cell*, showed that FK506 works by activating a molecular pathway that signals potential cancer cells to become specialized, non-dividing tissue. This keeps them from engaging in the uncontrolled growth that can lead to the invasion of surrounding tissue.

“The effective prevention of progression to invasive carcinoma would be a major advance in the treatment of this disease,” said Philip Beachy, PhD, professor of biochemistry and of developmental biology.

About 70 percent of all bladder cancer cases are noninvasive, meaning they remain confined to the bladder lining, and are usually treatable. Some cases become invasive, however, and spread to the muscle around the bladder and to other organs. Such cases are largely incurable and often deadly.
The doctor and patient sat in comfortable leather armchairs, facing each other onstage in the School of Medicine’s Berg Hall. Timothy Quill, MD, a palliative care specialist, leaned forward, hands clasped on his knees, head tilted to one side. For about an hour, he asked short, pointed questions of Paul Kalanithi, MD, a 37-year-old Stanford neurosurgeon with advanced-stage lung cancer, encouraging him to talk about his illness.

But mostly, Quill did what he trains other physicians to do. He listened.

“Are there things in particular that you worry about now?” said Quill, professor of psychiatry and medical humanities at the University of Rochester School of Medicine. He is an expert on end-of-life decision-making and how to preserve quality of care for seriously ill patients.

Kalanithi — a husband, new father and writer who recently completed Stanford’s neurosurgery residency program — paused for several seconds before responding.

“Not really,” he said. “I am sad at not seeing my daughter grow up, at probably not being here long enough for her to have a memory of me.

“I try to worry about things that are actually changeable. I worry about getting my book finished. I’d like to have that done for my daughter to know me.”

— Paul Kalanithi, MD

Taking on the Roles
“We thought we’d have a conversation to see how we might do it,” explained Quill, who has written several books on end-of-life care and how doctors should address the emotional ramifications of illness, as well as the medical treatment plan, with their patients. For an hour, he played the role of Kalanithi’s physician. And Kalanithi played the role of patient.

“How are you now?” Quill asked, to open the conversation.

“I’ll give you the medical history in five sentences, if I can,” Kalanithi said. “I was diagnosed in May 2013, my sixth year of residency. At the time, I was having a lot of back pain, night sweats, fever. I was diagnosed with lung cancer. I responded well to Tarceva [a chemotherapy drug] for about a year.

Then I had a relapse—last spring, a course of chemotherapy, which was extremely difficult with a number of complications. I was able to finish residency. Right now, I’m still kind of recovering from that cycle of chemotherapy.

“My last hospital visit was around July 1 or 2. My first child was born July 4.”

At this the audience applauded. Kalanithi introduced his wife, and pointed to her in the audience.

“Do you remember when you first got the news of your diagnosis?” Quill said.

“Yeah, I was able to look at the CT scan. It was very dramatic. My lungs were filled with nodules. … Seeing that confirmed my suspicions. Seeing how widespread it was, I figured my life expectancy couldn’t be more than a few months.”

Confronting the Challenges
Throughout the presentation, the audience, which filled the auditorium and included an overflow of young physicians and medical students in scrubs seated on the carpet, sat in rapt attention. The crowd listened to Kalanithi tell the story of his diagnosis and how his life changed after that day in May of 2013.

“My first thought was my wife should remarry as soon as possible, and we should redo the mortgage on the house,” he said. He said he assumed there was “no way” he’d be returning to his residency. The next day, he met with his Stanford oncologist, Heather Wakelee, MD, who he complimented as being “superb” at supporting him both medically and emotionally throughout the next year and a half.

“She said, ‘Because you’re a surgeon, we want to protect the nerves in your hands in case you want to go back to work,’ ” he said. “The day before I had thought I was
dead. Now, I thought, here’s this crazy lady discussing going back to work.”

But Kalanithi did go back to work, completing his residency while at the same time focusing, together with his wife, on getting their finances in order. He also made a conscious decision to kick-start a career in writing, 20 years earlier than he had originally planned. He wrote an opinion piece, which was published January 24 in The New York Times, titled, “How Long Have I Got Left?” And now he’s working on a book proposal.

What surprised him most about his life after being diagnosed with lung cancer was just how hard it was dealing with existential types of questions, about what he valued most in life, he told Quill.

“Having to deal with questions like, ‘What am I going to do with my life?’ was exceedingly difficult. After realizing I wasn’t going to die in weeks or months, figuring out what I was going to do with that time was a struggle.”

Quill nodded. Then he asked the patient to continue with the rest of his story.

Grieving Period

“You went through what sounds like a grieving period, then threw yourself back into your life. What do you remember about getting hit [with bad news] a second time?” Quill said.

During the presentation, Kalanithi spoke to the physicians in the audience, urging them to prepare patients as much as possible for the “experiential landscape” of living with a serious illness. As patient, he found solace in poetry, in his writing, in his family and friends. Talk to your patients, he said. Listen to them.

“Seeing a big tumor when there wasn’t one on the prior scan was sort of expected at some point,” Kalanithi said. “Well, [I thought,] it’s now. The idea that my life span was still going to be curtailed was always present in my mind. The hardest part is still thinking about how my wife and parents and siblings will react. I will have the easy part. I’ll just be dead.”

“Is a cure still on your radar screen?” Quill said.

“A cure was never really on my radar screen. There’s a 1 percent complete remission rate. It’s really now about the length of life left, the quality of life. How many good years do I get to have?” Kalanithi said.

“Do you ask ‘Why me?’”

“Not really. I know bad stuff happens, and it seems to happen more or less randomly. I don’t bother too much with, Why me? Why not me? The statistic is something like 0.0122 percent of 36-year-old nonsmokers will get metastatic lung cancer. Our careers are built on treating people who have had similarly bad luck.”

The next step in his treatment plan is his first visit with a palliative care expert next week, Kalanithi told Quill. Until now, he said, he had only had the kind of discussion he was having onstage with Quill with his oncologist because he was still highly functional. He’s entered a new stage in his care, he said.

During the presentation, Kalanithi spoke to the physicians in the audience, urging them to prepare patients as much as possible for the “experiential landscape” of living with a serious illness. As patient, he found solace in poetry, in his writing, in his family and friends. Talk to your patients, he said. Listen to them.

Responding to a final question from a medical student in the audience who asked for advice on how to train to be effective at palliative care, he said, “Focus on your patients. On who they are, what they care about. It’s really why you went into medicine.”

The audience broke its silence and rose in a standing ovation.

This story was written by Tracie White, science writer, Stanford Medicine. It first appeared in Inside Stanford Medicine.
Streamlining Cancer Care
Expert Coordinators Provide New Level of Patient Support

Sharron Brockman had become all too familiar with cancer. Diagnosed two years ago with Stage 3 ovarian cancer, Brockman underwent two rounds of chemotherapy and then had to drop out of a clinical trial because of a reaction to one of the medications. When she decided to continue her treatment last spring at the Stanford Cancer Center, the Sacramento resident came across something new: her own Multidisciplinary Care Coordinator (MCC).

“Before I even showed up for my first appointment, we spent more than 40 minutes on the phone going over everything from my medical history to my personal background,” Brockman said. “And once I showed up for my first appointment, she made it a point to come by to see me. I was flabbergasted. I never had anyone spend that level of dedicated time with me before.”

Brockman was an early beneficiary of the new MCC program—a central component of the multi-faceted Stanford Cancer Initiative to transform the cancer patient experience—that assigns specially trained nurses to serve as one-on-one advocates and liaisons for cancer patients new to Stanford Health Care. MCC’s follow their patients from the first point of contact through the entire span of care. They assess patients’ needs, triage symptoms and questions, make referrals, coordinate logistics and explain terminology, putting a friendly face on the often confusing process of cancer diagnosis and treatment.

“Our role is to act as an agent of change in terms of the patient experience,” said Laura Birmingham, RN, the coordinator working with Brockman and 17 other new patients in gynecologic oncology.

“We’re here to help improve outcomes and reduce stress on patients and families. But mostly we’re here to create a relationship that says, ‘We are here with you. We can help you with whatever you need.’”

Pioneer Program
Birmingham handles all patient questions and concerns, from possible side effects of treatment to what a hospital resident does. She keeps in contact with patients through calls, texts or emails, and follow up after clinic visits and before and after any transitions in care. She serves as the single point of contact for resources and support, tailoring information to suit patients’ needs and explaining it in a way that they understand.

“Cancer care has become so complex because it involves so many subspecialties,” said Julie Kuznetsov, director of the Cancer Patient Experience, who oversees the new program. “The field continues to evolve with new technologies and specialized expertise. While that means more options and better outcomes, for patients it has...”
become more difficult to put the pieces together to coordinate their care.”

The logic behind the MCC program is to take that complexity away from the patient. The coordinators are familiar with the Stanford Clinical Cancer Center’s medical and supportive care programs, and work directly with the patient’s physicians to organize treatment and follow-up services. They stay with the same patient throughout that person’s care, even when multiple specialists and subspecialists are involved.

“Cancer patients are already dealing with all kinds of stress, and coordinating visits can be overwhelming. The MCC’s make it their personal responsibility to manage the moving pieces so the focus for patients and families can be on quality of life and healing,” said Kuznetsov.

**Setting the Groundwork**

Birmingham will be joined in January by a new MCC supporting the hematology program. These first coordinators are laying the foundation for a program that eventually will serve all new cancer patients. Breast oncology is the next program to have MCC support in early 2015.

Part of their role is to help refine the process based on evidence-based practice—tracking what works to identify the most effective processes while keeping each patient’s individual concerns the priority.

“Most patients are in shock when they are first diagnosed, so that initial call we make starts a relationship before they have their first clinic appointment. We are constantly evaluating and assessing different approaches as their needs change,” Birmingham said. “There’s a lot of triage involved—even over the phone. We’re creating guidelines based on patient-centric care. We’re building a whole new system.”

**Team Effort**

By helping patients prepare for their clinic, diagnostic and treatment visits in advance, MCC’s help reassure patients and families and provide much-needed support to the clinical team. By fully assessing the patient’s physical health, psychosocial wellbeing and personal needs from the start, they allow clinicians to focus their time on disease management and treatment. The cancer physicians also include the coordinators in their discussion of care.

“The concept works especially well in gynecologic oncology because there are so many different aspects of care involved,” said Oliver Dorigo, MD, PhD, director of the gynecologic oncology clinical care program and associate professor of obstetrics and gynecology (oncology) at Stanford School of Medicine. “It’s a fully comprehensive approach, and it helps to better integrate the full spectrum of ancillary services, such as palliative care, genetic counseling and clinical trials. I trust the coordinator’s judgment as an integral, knowledgeable member of the team.”

For Brockman, having a MCC has made it easier to cope with a difficult situation.

“It is an incredible program, and I hope that other treatment centers will follow Stanford’s lead. It’s a pleasure to be part of it.”

*This article is adapted from a story by Ruthann Richter, director of media relations for Stanford Medicine, which originally appeared in the Fall 2014 edition of the Stanford Medicine Newsletter (stanfordmedicine.org/communitynews/2014fall/).*

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**Your Part in the Stanford Cancer Initiative**

As highlighted throughout this edition of *SCI News*, the Stanford Cancer Institute is leading an ambitious effort to truly transform the diagnosis, treatment and outcome of cancer. Through the Stanford Cancer Initiative we are investing in the people, technology and systems to spur innovative research and speed discoveries to patients, while delivering integrated treatment and support to individuals and families living with cancer.

While broad in its scope, the Initiative focuses resources in four priority areas:

- Creating a new standard of cancer care
- Targeting the toughest cancers
- Capturing the power of Stanford science
- Seizing the innovations of our age

Of course, driving and unifying all these efforts is our unwavering commitment to deliver superior and individualized care for every cancer patient who enters the Stanford system. To do so we rely on the contributions of our research and clinical collaborators throughout Stanford Health Care... and you, our indispensable community partners.

Your investment enables us to continue to provide comprehensive and compassionate care to the cancer patients of today, and to discover, develop and deliver the improved treatments of tomorrow. Thank you for being a valued part of the Stanford cancer community.

More information can be found and contributions can be made online at cancer.stanford.edu/help/gift.html.
SCI Director Featured in New Video Series

SCI Director Beverly S. Mitchell, MD, is one of the Stanford physicians who share their motivation to become a doctor in a new Stanford Health Care video series entitled, “Why I Went Into Medicine.” Stanford physicians from a variety of disciplines discuss why they chose their specialties and what they love about the field.

“My father is a physician, so I had a role model of somebody who was compassionate and took care of people really well,” said Mitchell.

See her entire video, and all the other segments, by searching “Why I Went Into Medicine” on YouTube (youtube.com). ■

Follow SCI on Twitter!

SCI recently launched a Twitter feed (@stanfordcancer) and you can join its nearly 6000 followers!

The new feed promotes cancer-relevant news, events and the activities of SCI members. Retweeting SCI tweets is a great way to gain new followers and raise awareness of Stanford’s leading role in the effort to better understand, treat and prevent cancer.

Questions or feedback can be directed to Michael Claeys at 650.736.7862 or mclaey@stanford.edu. ■