

Welcome to Yale Cancer Center Answers with Dr. Francine Foss and Dr. Lynn Wilson. Dr. Foss is a Professor of Medical Oncology and Dermatology, specializing in the treatment of lymphomas. Dr. Wilson is a Professor of Therapeutic Radiology and an expert in the use of radiation to treat lung cancers and cutaneous lymphomas. If you would like to join the conversation, you can contact the doctors directly. The address is [canceranswers@yale.edu](mailto:canceranswers@yale.edu) and the phone number is 1-888-234-4YCC. This week Dr. Wilson is joined by Dr. Jeffrey Orell. Dr. Orell is Assistant Clinical Professor of Medicine at the Smilow Cancer Hospital - Derby Care Center. Here is Lynn Wilson.

Wilson            Let's have you start off by telling us a little about what the care centers are?

Orell            On December 31, 2011, I was part of the biggest private medical oncology/hematology practice, I think in New England. As of January 1, we became part of the Smilow Cancer Hospital Cancer Care Centers, so for our group we had six offices and 22 doctors that delivered care in the community, that are now a part of the Smilow Cancer Hospital and we provide care locally to our patients with a very close affiliation to the mothership, Smilow Cancer Hospital.

Wilson            What does this mean for patient's today as compared to two years ago. For example, what might be different for them if anything?

Orell            First and foremost, all of us learned being in private practices that in the community our patients rely on us and look to us to give care. What I think the amalgamation with Smilow does is allow us to provide local care, but have ready access in a very positive way to the tertiary care, high powered, Cancer Center with all that they can bring to the table. It allows us to take our patients from local care and immediately get them involved in what we think is state-of-the-art 2012 care, seamlessly in a very positive way.

Wilson            Obviously your practice prior to the alignment with Smilow, I have known of your practice for many-many years, I always considered your practice completely state-of-the-art. Does the combination really enhance multidisciplinary aspects, access to perhaps clinical trials that might not have been quite as accessible before?

Orell            Thanks for the compliment that we gave state-of-the-art care. But throughout the 24 or over so years I have been affiliated with what

used to be medical oncology/hematology, we could not provide total state-of-the-art care. There were things that we knew in private practice, as private doctors that if we were going to give good care to our patients we needed to rely on our colleagues at a tertiary care center. What comes to mind is bone marrow transplantation. We did not do bone marrow transplantation, but we had our friends at Yale that we had an excellent relationship with, that when we needed to get our patients to Yale it was an easy transition. The good news is now we are all in the same division. Now simple referrals like transplantation become easier, but also as oncology is changing and new things are developing, we really can get people the care that we would not be able to get them before. One always fears town-gown issues, perhaps with a

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Wilson        Tell the listeners a little bit about yourself? What malignancies do you see most often and what is your background? How did you get involved in this field?

Orell        Back in the old days when I was a resident in internal medicine, that was the time we were deciding if we wanted to be a specialist and initially I was interested in hematology. This was in 1979-1980 and what had evolved and has continued to evolve is hematology is no longer a separate entity, hematology/medical oncology training was combined. There was the overlap of cancer with such hematologic malignancies like leukemia and lymphoma. I like intellectually hematology, but I thought there was a great challenge in oncology, and the two specialties seemed right, and that's what I became when I grew up, a hematologist/oncologist as a generalist. Typically in our group, we did not specialize in any one area. We had areas of interest but we saw generally what walked in the front door through referral and that typically was the common cancers, the lung cancer, breast cancer, colon cancer, as well as both benign and malignant hematologic problems.

Wilson        And has that remained the balance even after the combination and amalgamation with Smilow?

Orell            Certainly for most of us that are outside of the immediate New Haven area, we still are able to do general hematology/oncology. That is what our community needs, but closer to New Haven, I think people are developing areas of specialty that really work well with what existed at Yale.

Wilson            Obviously a big part of your practice has been developing close relationships with your patients, making sure they are taken care of, making sure that they are comfortable. Discuss a little bit with our listeners why this is such a critical piece of oncology care, in addition of course to the medical expertise piece?

Orell            I remember when I was a medical student, I walked into a room, and I was given the assignment to tell a patient something, a diagnosis or treatment, and I always remember I used “We.” I never came in and said “I”, I said “We” because I remember as a medical student I was not sure of myself, and I was representing an opinion that was a group opinion or the attending’s position, but I realized quite early on in practice when I was the attending, when I was the doctor that “I” is very important not in an egotistical or bad sense, but the patients look to you for direction and look for care, they look for the future, and I think it is critical to establish a relationship that you are going to go to bat for that patient and you are going to try to provide excellent care in the context of a team approach.

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Wilson            What do you think are some other concerns the patient has after receiving their diagnosis and going into the treatment program, and obviously this answer can be complicated, but how you manage that?

Orell            I think the first thing that is on everyone’s mind, whether it is spoken or not spoken, is what the future holds. You learn early on in this business that not everybody wants to ask that question initially, they may take some time, but when you are given a diagnosis like cancer, given all that surrounds the diagnosis, given all the media attention, given what people perceive to be true about cancer, they want to know what their chances are. They may not verbalize it but they want to know and I think you answer that issue in an appropriate fashion, in terms of what the patient can handle from day 1, day 2, and as you have that relationship. I think that is always on people’s mind, but on top of that I think everyone wants to know that the therapy that you are giving them is going to work, but I think more important is what am I in for in terms of side effects? I usually tell the patients that I know there are a lot of

TV shows out there about chemotherapy and rest assured when you put on a TV show about chemotherapy you are going to make it bad. So, I try very hard to give people a very balanced description of what is in store for them with the side effects because I think that is on their mind. I think patients also want to know what effect it is going to have on their immediate life. How are they are going to be getting up in the morning? Are they going to be able to work? Are they going to be able to take care of their family? What are their friends and their family going to think of them as they are going through chemotherapy? And the biggest thing I have learned is that people are afraid of the unknown, and I often tell people that in my opinion the worst day is the night before their first treatment, that is when they do not know what is coming and all the TV shows and all the radio ads, and all their friends offering advice and warnings really comes to a head. Once they get going, in general, it is a little bit better than what they perceived and people have a terrific ability to adapt, and I think they get through it, but the night before the first one is always a very difficult night.

Wilson           Have you found that over the years patients' expectations or behaviors have changed, obviously with electronic media, television, internet access, there is much easier access to information, are the kinds of questions that patients come to you with today different than perhaps twenty years ago? Or are their expectations different because of perhaps the knowledge they have gained before their office visit with you?

Orell            It is a complicated answer, I think the electronic age is very good. I always like it when patients are actively involved in their care where they want to understand what is going on. I think the internet is for all of our lives has some good qualities and some bad qualities. I think it can arm people with very good information, can prompt them to ask very good questions and likewise it depends on what you read and it depends who is writing it because it can be unfiltered data that gets to the patient, but in the end, the patients still want the same things, what do I have? What are my chances? How you are going to treat me? And what are we looking forward to? It is real

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variable as to what the patients come in with. Our job is to understand what that patient is really asking and try to give them the answers they are looking for.

Wilson           You are right, it can be very complicated and sometimes, unfortu-

nately, the patient has been reading on the internet for say a week or two before they come and see you and in many cases it enhances their anxiety, because of what they have read, because of course when you have a new diagnosis you automatically assume that you must be in the worst situation and so you gravitate toward the bad statistics, the worst prognosis, and that sort of thing. So it can be tricky and difficult sometimes.

Orell            Yeah, I would agree with that.

Wilson            Tell us a little bit about the center in Derby and what happens there from day to day. Take us through a typical day and a patient experience.

Orell            To begin with, Griffin Hospital has been around for a while and I think the strongest point is they have adopted what is called a Planetree philosophy. Simply it is a philosophy where not only are you expected to give medical and nursing care, but the environment in which you provide that care is very important to the immediate outcome of people and to their families and to the long term outcome. A lot of time was spent in building the Cancer Center at Derby, and I know that I am prejudice, but I know a lot of the other offices and it is just a magnificent facility in which to take care of patients. Along with that, when we were building this and constructing it, it was very important to create a multidisciplinary center, but not in name. There are plenty of centers out there that call themselves cancer centers and you walk in a building and to the right is medical oncology, which is what I do, and to the left is radiation therapy, which is what you do, and that is the cancer center. I think Griffin has gone out of its way not to do that. There is medical oncology on the right, there is radiation therapy on the left, but there are a tremendous number of other health care professionals, for example, the nurses, the phlebotomists, the secretaries, the people who give Reiki therapy, patient navigators, the person who gives foot massages, our pastoral care, psychology and even our financial advisors that try to deal with the entirety of the situation just not with the medical oncology and radiation aspects and I really think we do a good job with that. I think people get treated holistically in a very positive way.

Wilson            Have you found it helpful after the center was constructed and you had all of these excellent team members in one place, as opposed to having radiation oncology in one location, medical oncology at a different office, people spread all over the place, it is easier to have it all in one centrally located place?

Orell            Yeah, I mean if you walk into where I practice in the medical oncology suite, it's a busy place, it's just not my immediate staff, but all these

people that I mentioned, interacting with people and I

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Wilson Have you found that more recently Jeff, maybe because of some newer drugs, newer medicines, newer therapies and just our support systems, that the general oncology patient is spending more of their treatment time outside the hospital for example, compared to say 20 years ago?

Orell Yeah absolutely, when we were kids in this business, oncology was really an inpatient discipline, that is the majority of the care of patients was in the hospital, starting from their workup and they were kept for days in the hospital to get chemotherapy and I think all of us in the business are firm believers that it's good to see me, it's good to be in my office, but time is better spent not seeing me or my office as long as care is given and that has been a real change in what we do in the office. Medical oncology, for most diseases, is an outpatient specialty. We can give extremely sophisticated care in the office. We can support them in ways we never would have thought possible, we keep them out of the hospital for the treatment and we have ways to prevent people from coming to the hospital. We are much better at avoiding hospitalizations and I think that has really been a very big difference and very positive for the patients. Less is more. Being in a hospital if you have to be getting certain therapies that mandate you to be there is one thing, but it is better to be sleeping in your own bed than sleeping in a hospital bed.

Wilson We are going to take a break for a medical minute. Please stay tuned to learn more information about cancer care in the community with Dr. Jeffrey Orell.

#### Medical

Minute Breast cancer is the most common cancer in women. In Connecticut alone, approximately 3000 women will be diagnosed with breast cancer this year, but there is new hope. Earlier detection, noninvasive treatments and novel therapies provide more options for patients to fight breast cancer. Women should schedule a baseline mammogram beginning at age 40, or earlier if they

have risk factors associated with the disease. With screening, early detection and a healthy lifestyle, breast cancer can be defeated. Clinical trials are currently underway at federally designated comprehensive cancer centers, such as Yale Cancer Center, to make innovative new treatments available to patients. A potential breakthrough in treating chemotherapy resistant breast cancers is now being studied at Yale combining BSI-101, a PARP inhibitor with the chemotherapy drug irinotecan. This has been a medical minute brought to you as a public service by the Yale Cancer Center. More information is available at [yalecancer-center.org](http://yalecancer-center.org). You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.

Wilson Welcome back to Yale Cancer Center Answers. This is Dr. Lynn Wilson and I am joined today by my guest, Dr. Jeffrey Orell, and we are discussing cancer care in the community. Jeff, we have talked already about some changes. We have talked about the relatively newly constructed center

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Orell We talked already about the importance of keeping people out of hospitals and we are really doing very well at that. I also think that we have changed our attitude perhaps that cancer is not an immediate up or down, yes or no, but viewing cancer as a chronic disease. I personally have high blood pressure, I do not know what caused it, but as long as I take my medicines, my blood pressure is terrific. We are seeing perhaps in cancer, not the need to make it all go away, but to live with it. Take people on high blood pressure medicines, we can give them therapies that may not remove all their cancer, but allow them to have hopefully normal longevity, with no serious side effects and live with that disease rather than say, it is cured or it is not cured, I think that has crept in in a very positive way when taking care of patients. We alluded to it earlier about the multidisciplinary approach to cancer, I think that is singularly one of the most important things that we have done. It is not just the doctor and chemotherapy, but a multidisciplinary team dedicated to improving our lot with cancer, and I think that is good. As I have said to patients a lot I have never taken care of lung cancer, ever, I take care of people that have lung cancer, and that is a very different view of things, it is a different approach to people and I think we have enlisted many people that can help take care of people that happen to have cancer and that has improved outcome and it has improved quality for patients in significant ways.

Wilson            We focus a lot in discussing cancer patients on how we are doing better with cures, how we are we more successful in treating certain types of cancers that patients have, one thing we do not talk a lot about, and I be interested in your perspectives on this, is how we are doing better in terms of preventing and managing side effects from the treatments that we give. What is some of your personal perspective on that?

Orell            To take the latter part of your question first, we are certainly able to better support patients through these therapies whether it is better anti-nausea medicines, they are able to be seen in the office and prevent dehydration with fluids in a multidisciplinary approach, but I think we've made it much easier to tolerate what we do to people and that really changes the landscape on how people are going to do with their disease. I think that has been a major event that we have experienced.

Wilson            Do you think it is that we have newer treatments that are just more tolerable, or is it that we have new medicines that are better at counteracting effects? I know in my field, in radiation oncology, we are much better at targeting our targets than we were 20 years ago and so we do a better job of hitting what we are actually aiming at and do a better job of avoiding what we do not want to hit. Are there new medications to counteract effects and perhaps some of the drugs that we're using therapeutically have been better tailored?

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Orell            Everything you just said, Yes, Yes, Yes and Yes! We have better supportive drugs, we are using therapies and the word “targeted” is a very important word in oncology. We are really trying to get at what is really going on with the patient with their cancer and addressing on a genetic level, on a molecular level, what is going on. For some of the therapies there are more pills, and people always jump up and down about oral forms of medicine until they hear that the pills can have side effects as well, but I think we have approached making quality better in both directions. The medicines are more directed and our ability to support them has improved.

Wilson            In the community setting, why is it so important to have centers likes these, like where you work in the community offering this kind of care to

patients, obviously some people might say, well you know I can go to the big tertiary center, it is not that far away, but what do you feel are some of the advantages to patients being able to get this level of care very close to home?

Orell            I think there are strengths and I will also mention what the weaknesses might have been. I think the strength is that I have to earn my keep with each patient every time I walk into the room. As a private doctor, I had to reassure them I was going to work hard for them and I was going to be responsible, so the advantage to coming to someone like me is I was going to be there for them, not the big institution, I was going to take care of them. I also told them in a lot of diseases, I was every bit as good as the Memorial's, the Yale's and the Dana Farber's on most of what I did, but I had to be honest with my patients myself to know where that line had to be drawn. I cannot always deliver the best care and I would always refer that patient to someone that was providing a more novel, better approach. With our cancer centers now, I believe for a lot of diseases I can provide outstanding state-of-the-art-care, but I also know I can't do that for all instances, and now my colleagues are ready and waiting to deliver them state-of-the-art 2012 medicine that as a private local doctor I cannot deliver. I get to sleep well at night knowing that I am doing the best for my patients, whether it is in my office or referring them into the tertiary care center where things are done that I cannot provide.

Wilson            Typically, if you have a patient that you feel needs to be hospitalized for whatever reason, is that typically done also close to home in the Derby, Griffin Area?

Orell            I am going to give you the same answer, I think Griffin Hospital, like a lot of small community hospitals cannot offer tertiary level care. The example I would use is acute leukemia that is a disease requiring lengthy hospitalizations, very aggressive therapies, and a need for really specialized support, I cannot do that at Griffin, I have not been able to do that for 20 years, so I will say to my patient, we cannot do it here, the best care has to be delivered at a tertiary care center. Some things I can deliver care, as I have said to people, Griffin is a bunch of bricks, Yale is a bunch of bricks, and if I admit you at Griffin, or admit you at Yale, which I can do, I am still the one writing the orders so, if you trust me you should trust me in either place. So at a local community hospital lots of things can be taken care of, but some things can't and that has to be

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recognized and you have to get people to where they are going to get the best

care.

Wilson           Have you had patients who perhaps are concerned saying, you know Dr. Orell, I want to stay in the community, you are saying that I have to go to Yale, for example. But you still have the ability to interact with that patient here at Smilow, so I want to emphasize how it is not as if the connection to you is necessarily lost just because they may be admitted to the hospital outside of their own close community.

Orell             I hope it would not be lost, but I would also tell my patients that I am referring them to another doctor, that I have reached the limit of my expertise, my ability to care for them, whether it is the hospital or me, and that your best chance, your best care, will be delivered at Smilow by this doctor and I have full confidence, so I am not abandoning you, I am doing what is right, and most people understand and I think they appreciate it in the end.

Wilson           Folks talk about clinical trials, we talk about clinical trials a lot more and more recently than we did even 25 years ago, tell us your thoughts about clinical trials, clinical trials in the community versus at Smilow for example, and how clinical trials can be available to patients in the community? They may not necessarily have to come to a big tertiary center.

Orell             I always owe my patients options, and in my opinion what the best therapy is. I always use the analogy, if your kid has strep throat and they do not have a penicillin allergy, everyone like me knows to give him penicillin, but cancer care is a lot more complicated than that. There are some cancers where we have well worked out treatments that everyone accepts as correct, that is probably not a patient that needs a clinical trial right away, but we need to improve, we need to push the envelope of our knowledge, we need to learn what is the next best therapy and that only can be done on clinical trials. Private doctors, local practitioners, do not experiment on people, we do this through a very sophisticated and organized protocol system. So, I am the biggest believer that we have got to put patients on protocols, but people need to know the options for that and should be referred in a very appropriate way. We will be able to do some clinical trials in Derby, we are working out the kinks right now, but some trials are well designed that would do very well in our community hospital, but a lot of other trials, what we call phase I or phase II trials, need to be at an institution, need to be at Smilow, run by a few doctors. So those doctors can help me down the road, tell patients what the best therapy is and push new treatments and understand what new treatments are. I think protocols are essential to certainly cancer care and all of us in the community need to support it.

Wilson Patients should also understand that if a clinical trial is being offered in the community, it has been

vetted by other physicians, vetted by some sort of institutional review board and presumably the

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quality of care and what is going to happen in that clinical trial in the community setting should be identical to what is going to happen at say Smilow or Dana Farber, for example.

Orell It should, and those of us in the community go through rigorous training to be able to say that and we know that doing bad clinical trials is worse than doing no clinical trials. We have got to keep our standards up so when reviews of our protocols are ultimately looked at, when the FDA looks at it, that we can stand by extraordinary high level design protocols, and were administered to the letter of the law where there is no doubt about the results. That is the only acceptable letter, so any trial opened in our cancer center will have gone through that rigorous process.

Wilson What sort of changes did you perceive from some of your patients? There must have been some people that you were seeing regularly, perhaps in the midst of their treatment, when you went from your older facilities to the new facility, what sort of reactions did you see from patients?

Orell You mean in the cancer center or the amalgamation with Smilow?

Wilson Your cancer center.

Orell They were thrilled, I mean we lived in standard medicine office buildings, they were nice, they were clean, but when you walk into the Taj Mahal, certainly the biggest response was when they were on the tours just before you opened, and everyone was excited. It was terrific to be in there. It just added a level of improvement and they knew it was done for them. There was great community pride in that cancer center.

Wilson        We had mentioned a little bit before about the multidisciplinary nature, and it is not just about the physician providers, but other folks providing other kinds of services. Are the non-medical services used pretty frequently by patients?

Orell         Yes, and we encourage it, I mean other than the standard brochures all of the health care professionals are wandering in and out just waiting to help somebody and you can feel it. I think people really have gotten the sense that their doctors and nurses and all the others, are all there for one purpose, to make their life better.

Wilson        How does someone, for example, who you are seeing for the first time perhaps with a new diagnosis, how do they make arrangements for some of these other services? Is this something that you bring up with them? Do they ask about it? What sort of process do they go through if they want to experience some Reiki or speak to the dietitian, those sorts of things?

Orell         It is variable, but certainly if they do not bring it up, we offer it. People are very friendly, outgoing, and those people you mentioned, the Reiki therapist, the nutritionist, they go around and

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look for business, go around and look to support people. So by hook or by crook, whether it is word of mouth or direct contact, people really understand that we are a soup-to-nuts organization and really try to provide all of this.

Dr. Jeffery Orell is Assistant Clinical Professor of Medicine at the Smilow Cancer Hospital-Derby Care Center. If you have questions or would like add your comments, visit [YaleCancerCenter.org](http://YaleCancerCenter.org), where you can also get the podcast and find written transcripts of past programs. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.