



Newsletter

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EDITORIAL

BUILDING TRUST IN DOCTOR - PATIENT RELATIONSHIP

Trust is one of the central feature of doctor patient relationship. Only 23% Americans have confidence in health care system but more than 69 % trust their doctor's honesty and integrity according to paper in NEJM (2014). Majority of patients in India continue to trust their doctors to act in their best interest. Concern is growing with the rapid and far reaching changes in the health care system which have placed great pressure on this trust.

Patient trust is quite complicated and multidimensional. It may be defined as a set of beliefs or expectations that a doctor will behave in certain way. Among the most commonly described dimensions of doctor's behavior on which patients are believed to base their trust are competence, compassion, privacy, confidentiality, reliability, dependability and communication. These are important components of interpersonal trust between doctors and patients. This is different from social trust which means trust in collective institutions, influenced broadly by the media and by general social confidence in particular institution. Comments by politicians and media on health care systems in recent past have led to breach in social trust. Recent gag rules (controlling cost of stents etc) have only confirmed the fears in the minds of public which is now seeking regulation through political process. It is the social trust which weaves the framework of traditional interpersonal trust between doctor and patient. Media and public at large have also shown their concern about doctor's conflict of interest in the setting of strong financial incentives. This occurs when the patient is referred to a particular centre for imaging or lab test. Doctors should explain the need of doing the intervention or test which could be carried out at any reliable diagnostic centre. It is important to mention that the patients have the autonomy to get the tests from any NABL approved centre.

Now our medical culture seems to rely on technology to answer questions with a greater certainty than the technology can deliver. Doctors themselves have contributed to a culture of medical practice in which lab/imaging tests are given more credence than subjective assessment by doctor. In truth more than 80 % diagnosis can be made by history and Hand Scans (clinical examination). Doctors need to control their own reliance on non contributory tests. By fostering a system of care in which concern of cost is acceptable and unnecessary services are not provided, doctors can be perceived as being socially responsible and perhaps restore some credibility in this area of profession.

Trust is also important at an institutional level. Now the patient is dubbed as "king" and "consumer" and expert patient plays an active part in decision making regarding his treatment. Macro (system) trust concerns social institutions and healthcare newer technology, systems or media. Macro trust promotes structural bonding of the doctor-patient relationships.

A. What the doctors can do to build trust ?

1. Communicate:(Two-way street) The greatest frustration of a patient is feeling that he is not being heard. Doctor should be attentive, polite and patient in his communication. If doctor does not take time to listen to a patient, not only will his ability to care for the patient, be compromised, but also a great opportunity for developing the trusting and meaningful relationship will be lost. So communicate, communicate and communicate meaningfully and honestly.

2. Doctor's Empathy Empathy is the ability to share someone's perspective, to stand in their shoes and see the world from their point of view. Simply listening is not enough; a doctor who fully understands where a patient is coming from is better able to build trust and advice treatment that aligns with the patient's needs. Empathy is the most effective way to gain the trust of a patient.

3. Ethical Guidance: As part of the trust worthy relationship doctors need to present before patients and family members with an honest assessment of the risks and realistic success rates with the recommended treatment. Doctors should also trust the patient that he/she will follow his advice, take the prescribed medicines and follow up as needed.

4. Professional Boundaries: As doctor you must walk a fine line always keeping within professional boundaries. Maintain distance, maintain dignity.

B. What the Institution / Hospitals can do ?

Trust building behaviors include comforting and caring, demonstrating competence, encouraging, asking questions and explaining at all levels. Staff courtesy acts in cementing trust between doctors and patients. Creating professional working environment fosters trust between patient and the institution. Delivery of quality care in cost effective manner helps in strengthening this relationship. Relationship building with local community (Public lectures, health camps) is another important trust building mechanism.

C. What the health care authorities do ?

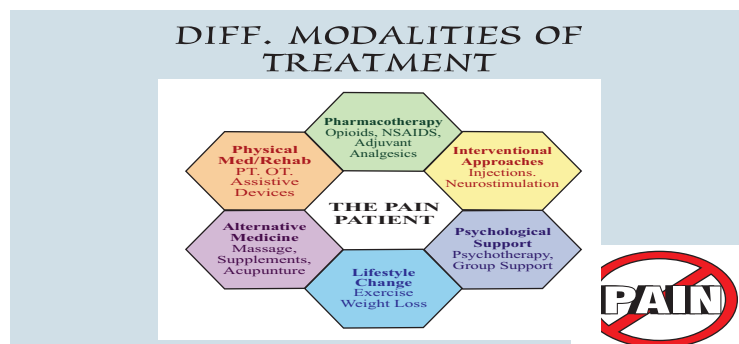
It is suggested that doctors follow the ethical principles in medicine, based on updated scientific protocols. In this respect, the health institutions like IMA, DMA, MCI may monitor the applications of these principles respecting the dignity of medical community. In addition, these institutions may attempt to make appropriate policies to eliminate economic concerns during treatment procedures. Health care authorities/insurance agencies could draft guidelines and protocols for different symptoms and diseases. The policies can be said to be self imposed by various institutions or doctors who also audit and police their employees. The openness and honesty of a system or organization can contribute to a climate of trustworthiness.

There is no quick fix in building trust in Doctor- Patient relationship but a **social and cultural change is required.**



Dr. A. K. Dewan
Director - Surgical Oncology

PAIN KILLERS - WHAT IS THE LATEST ?



For millions of patients with chronic pain, paracetamol and NSAIDs, including aspirin, ibuprofen and diclofenac, are often prescribed but for many, these painkillers can actually make the patient's pain worse and side-effects, including indigestion, cramps, nausea and diarrhoea, as well as erosive ulcers leading to gut bleed and anemia can occur.

Other common issues with pain killers such as opioids include sedation, dizziness, nausea, vomiting, constipation, tolerance, respiratory depression, physical dependence and addiction detract them from regular prescription. These are clinical and ethical concerns that lead to inadequate pain management.

Consultant in pain medicine at Royal Liverpool University Hospital and a council member of the British Pain Society, Dr Austin Leach remarks—"Opiates are still very useful drugs – it's their extended use for long-term pain that is being increasingly questioned. Currently we accept that opioids are not without their problems, but with careful management they remain extremely valuable drugs and they cannot be completely discarded, as thousands of people do benefit from taking them."

Leading neuroscientist Professor Stephen McMahon is Sherrington professor of physiology at King's College London and director of the London Pain Consortium. He is very optimistic about the appearance of new classes of analgesic drugs in the future. "It's all very good news, something I could never have said 10 years ago, as there has been a dearth of new products,".

"The best new classes of drugs on the horizon are monoclonal antibodies that work by targeting nerve growth factor (NGF), a peptide involved in the growth and survival of sensory neurones that regulates how the body processes pain. There are three drugs of this class that are now in advanced clinical trials: tanezumab, fasinumab and fulranumab."

Prof McMahon also predicts that these new drugs could be "game changers" in the future because they have shown good efficacy in treating the chronic pain of osteoarthritis and also may have some efficacy in very difficult to treat conditions like low back pain and bladder pain syndrome. "NGF inhibitors work in the clinic; the only issues are the side-effects and bringing them to market. They are monoclonal antibodies so they won't be cheap – there are several practical problems, but this is likely to be a completely new class of drug in the armory of physicians."

One downside is that the therapy will need to be injected, but antibodies persist in the body for many weeks. "Tanezumab is usually dosed every eight weeks, and experience with other monoclonal antibody treatments suggests that nurse- or self-administration is well tolerated," adds Professor McMahon. He continues: "Another class of compounds, which are orally available small molecules that block P2X3 receptors, a type of purinoceptor found on nociceptors (pain-sensing neurons), have now been tested in a few phase 2 and phase 3 trials."

Another hope on the horizon is a new class of angiotensin II-receptor antagonists that targets type 2 receptors (the current angiotensin II-receptor antagonists licensed for the treatment of hypertension and heart failure target type 1 receptors) for the treatment of neuropathic

pain.

Nonpharmacological Treatments: Electroceuticals are not drugs but devices that deliver electrical stimulation, often at very high frequencies, to different parts of the body as a therapy. Techniques such as epidural stimulation and vagal nerve stimulation, which can be quite invasive and expensive, are being developed for chronic pain.

Professor McMahon has "mixed feelings" about this development because he believes the evidence base is much weaker than for drug trials. "You often can't do a proper randomised control trial with such devices because people know they are being stimulated and the placebo effect may contaminate the findings," he explains.

More Distant Therapies: Epigenetics, the study of the way our genes can be switched on and off, and neuroplasticity – the process that allows the neurones in the brain and spinal cord to compensate for injury and disease, and to adjust their activities in response to new situations or to changes in their environment. "Epigenetics is having a huge impact on breast cancer treatments – making it much easier to target treatment individually by looking at which genes are active and which genes are dormant in any particular patient. "We are hopeful that this approach can be replicated in other body systems. In the future, we will be able to target drugs or drug combinations that are more effective – because if a person has x gene then drug A will be better than drug B for their pain. It could be years before we can achieve this level of sophistication but we are inching towards a target and as we do so, the treatments are getting better."

A Combined Approach to Pain Management: A combination of approaches that may incorporate the use of drugs is a much more effective way of managing longterm pain. This includes psychological treatments, relaxation and realism – accepting you have a medical problem and looking at ways to manage your life better around it, rather than hoping for an impossible cure. Healthcare professionals can provide much of this support through the pain clinic."

Consultant in pain medicine at Southmead Hospital, Bristol, Dr Cathy Stannard comments: "I don't think we'll get more effective drugs for treating pain but I do think we are getting wiser about where medicine fits in pain management. "Drugs can sometimes make a patient's quality of life worse because of side-effects and what people often need to do with long-term pain is learn how to manage it. There are patients that need to be taken off medication that is not managing their symptoms effectively. "There is no painkiller that has no side-effects, even paracetamol has more side-effects than we first thought," Dr Stannard adds. "For long-term pain, anxiety and distress make a large contribution to how you feel your pain. Molecules that block pain signaling from the periphery are never really going to cut it because the process is much more complicated and we need to recognize that. "A very central message that people find quite difficult is that actually being off drugs that are not working is a better health state than being on drugs. Careful assessment is key and we should all be able to achieve that."

Complete pain relief is not a realistic goal – the idea behind any medicine should be to reduce the intrusiveness the pain enough so that you can get on and do things."

Dr Stannard suggests that doctors can empower their patients to manage chronic pain by highlighting the importance of maintaining mobility, exercise, general fitness and general health. "Helping patients improve their sleep will also improve mood and pain. Also, making sure that if people do have depression, it's managed on its own merit, as that will help their pain," she adds. Dr. Stannard notes that some people will get benefits from a raft of different drugs and they should be offered and closely monitored.

"Pain is difficult to treat – but not because we have not got the right drug," she adds. Natalie Carter, head of research liaison at Arthritis Research UK, says: "Pain is a huge problem for people with

conditions but they are very unhappy with what is currently on offer because either they fear the side-effects or the painkillers are not very effective, especially for people with conditions like fibromyalgia. “We don't think there is anywhere near enough investment in pain research at the moment, and we are aiming to rectify that with a planned investment. We fund a centre of excellence at the University of Nottingham, which is specifically focused on pain. The researchers there are looking at whether painkillers already developed for other diseases can be repurposed and used in arthritis, and osteoarthritis specifically. “We believe there will ultimately be pharmaceutical solutions that will provide a painkiller for people with arthritis and chronic pain that works for them,” she concludes.

(Adapted from “Recent advances in the management of chronic pain Kate Stewart internet resource- available at- <http://onlinelibrary.wiley.com>)

Dr. Malvinder Singh Sahi
Head - Pain Management

RGCON 2018 - 17TH ANNUAL INTERNATIONAL CONFERENCE ON LIVER TUMORS: PRIMARY & SECONDARIES – “DILEMMAS TO DECISION”

RGCIRC organized its 17th Annual International Conference (RGCON) from 9th to 11th February 2018 at Hotel Crown Plaza, Rohini, New Delhi. The theme of this international conference was **Liver Tumors: Primary & Secondaries – “Dilemmas to Decision”**



This conclave was focused for all those who want to know more about liver cancer, threadbare and the treatments available for it. The aim of the conference was to raise awareness about a cancer which has been unexplored till now and to discuss the various newer modalities of investigations and treatment being made available. Our aim was to make the medical fraternity aware of the latest techniques in surgery, radiotherapy, chemotherapy including immunotherapy so that the patients can claim maximum benefits of it. We wanted to convey that selected groups of liver tumor patients should be approached with a more positive outlook.



The conference was inaugurated by the Chief Guest and Guest of Honor, Dr. G. K. Rath, Director – National Cancer Institute, Jhajjar, Haryana. The Lamp was lit by Dr. G. K. Rath, Shri Rakesh Chopra, Chairman, Shri D. S. Negi, CEO, Dr. Shivendra Singh, Dr. Vineet Talwar, Dr. Swarupa Mitra and Dr. Sumit Goyal.

The Raman Chadha Oration was delivered by Prof. Heinz Josef Lenz, Professor of Medicine and Preventive Medicine, Section Head of GI Oncology in the Division of Medical Oncology, Co-Director of the Colorectal Center, The Keck School of Medicine of the University of Southern California, USA while the Dr. K. K. Pandey Memorial session was delivered by Dr. Purvish Parikh, Director of Precision Oncology, Medical Oncologist & Hematologist, Asian Institute of Oncology, Somaiya Hospital, Mumbai. On the 3rd day the abstracts were presented and the winners were felicitated at the valedictory function.



The conclave turned out to be a huge success with doctors from all parts of India and abroad participating enthusiastically. The event witnessed international faculty, who were stalwarts from the field of surgical, radiation and medical oncology across the globe such as Europe, USA, Thailand, Japan, Korea etc. National faculty and delegates from all over the country came for the conference, making it a success. Live operative workshops and video sessions in radiation, radiology and pathology were also conducted for explaining various aspects of complex management of liver cancers.

RGCON was organized by team consisting of Dr. Shivendra Singh, Sr. Consultant & Chief, GI & HPB Oncosurgery, Dr. Vineet Talwar, Co-Director, Medical Oncology, Dr. Swarupa Mitra, Sr. Consultant, Radiation Oncology and Dr. Sumit Goyal, Sr. Consultant, Medical Oncology.

STRIDE AGAINST CANCER - WALK FOR LIFE



On the occasion of World Cancer Day 2018, RGCIRC participated in “Stride against Cancer- Walk for Life” organized by **CanSupport on Sunday, 4th February 2018** at Rajpath, New Delhi. Theme for this event was “Don't leave those suffering behind”. Thus, for this event, Team of RGCIRC; Dr. Rupinder Sekhon and her team, Dr. Swarupa Mitra, Dr. Harsha Agarwal, Mrs. Pankaj Verma, Marketing Team, Staff Nurses, Interns of RGCIRC, Social Worker, Prosthetic Department, Volunteers from Lymphoma Support Group India, Volunteers from Indian Cancer Society, Border Security Force (BSF) Staff walked hand in hand with cancer survivors, cancer patients, caregivers of patients and students of different schools and colleges. People from all walks of society marched past India Gate through Rajpath to support the fighters, salute the survivors and give a message of hope to all. “Walking along people with cancer can give a new lease of life” is what motivated us to participate in this event.

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CME – IMA PANIPAT



RGCIRC organized a CME in association with IMA Panipat on Friday, 2nd February 2018 at Hotel Le – Gem, Panipat, Haryana. Dr. Vineet Talwar, Co - Director - Medical Oncology delivered a lecture on “Immunotherapy in Cancer” and **Dr. Manish Pruthi**, Consultant – Musculoskeletal Surgical Oncology spoke on “Advances in Management of Musculoskeletal Tumors” in the said CME.

CME – DELHI MEDICAL & DENTAL SOCIETY



RGCIRC organized a CME in association with Delhi Medical & Dental Society on Sunday, 4th February 2018 at India Habitat Centre, Lodhi Road, New Delhi. Dr. Gauri Kapoor, Medical Director – RGCIRC, Niti Bagh and Director – Pediatric Hematology Oncology delivered a lecture on “Advances in Blood Cancer & Tips for the Family Practitioners” and Dr. Sajjan Rajpurohit, Consultant – Medical Oncology spoke on “Head & Neck Cancer: What's New” in the said CME.

WELCOME TO RGCIRC FAMILY - DR. MUDIT AGARWAL



Dr. Mudit Agarwal has joined as Sr. Consultant – Head & Neck Surgical Oncology. He is an alumnus from Banaras Hindu University, Varanasi, Uttar Pradesh. He earned his MS (Surgery) from the same Institute and M. Ch. Surgical Oncology from Kidwai Memorial Institute of Oncology, Bengaluru, Karnataka. He has a vast experience in his chosen field. He has worked in various premier institutes of the country. He has been trained in advanced and newer technology at best centers in the world like Endoscopic Thyroid Surgery from Hanoi, Vietnam, Transoral Endoscopic Laser Surgery at Genoa, Italy, Head & Neck Robotic Surgery, Seoul, Korea and Lateral skull base surgery at Piacenza, Italy.

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