Real compassion is about moving things forward

➜ Simon Crompton

The decision to focus on infections associated with cancer treatments, back in the early '70s, put **Jean Klastersky** on a path that would lead to him pioneering the field of supportive care in cancer. His research has helped establish the value of good communication, yet he warns that compassion in a doctor means more than empathy, and getting too emotionally involved can lead to burnout.

Professor Jean Klastersky is quite clear about his achievements, and what drove him towards them. It wasn't a personal commitment to help people with cancer. It was an early aspiration to contribute to scientific progress – to be a Great Physician: a Freud, a Babinski, an Osler.

It's not that compassion hasn't been intrinsic to his ground-breaking work on infection and cancer, and the development of supportive care. "But I always told myself that real compassion in a physician," he sums up succinctly, "is to keep things moving, to make progress."

And that's what he's done over 40 years. From carrying out early and influential trials on sepsis in neutropenia, through putting both supportive care and infection in cancer patients on the international map, to writing highly influential works on lung cancer and doctor burnout, Klastersky has pushed the cancer agenda forward.

In the early 1970s, when he was setting out on his work investigating infections related to cancer treatments, patients with acute leukaemia were (in his own words) still "dying like flies" before they reached remission. "I think that our concepts and research changed that a lot. Actually the improved care for patients with infection was the first example of supportive care in cancer medicine," he says.

Trim and still energetic in his 71st year, I'm speaking to him at the Institut Jules Bordet, a specialist cancer hospital and research unit in Brussels, where he was head of the Department of Medicine for 27 years until his official retirement in 2005. The institute is part of the Free University of Brussels, where he started his career and where he has remained for nearly its entirety.

Without a trace of vanity, he says that he would probably have succeeded in any area of medicine, acknowledging that ambition and occasional opportunism have moulded his career. He comes from an old Czech family "of low-rate nobility", which can be traced back to the 16th century. His family left Prague when he was six, at the end of World War II, when his father came to work at the Czech embassy in Brussels. But when the Communist Party took over in 1948, his family stayed in Brussels as political refugees, and

Klastersky has been based in Belgium ever since, raising his own family there.

It was the high-quality science teaching at a Belgian public school that gave him a commitment to go into medicine in his early teens. He was particularly inspired by a small book by the great French physiologist Claude Bernard, entitled *An Introduction to the Study of Experimental Medicine*. "Bernard defined the principle that the laboratory and the clinic should go together, and you should go from one to the other. I was very, very impressed by the concept." It was a crossover that ended up defining his career.

Training in internal medicine as an intern and then a resident at the Free University of Brussels between 1962 and 1965, he came under the influence of Henri Tagnon, who was trying to reshape the Institut Jules Bordet into one of the best cancer centres in the world. He suggested that the young Klastersky should start specialising in infectious diseases – particularly since the institute currently had to rely on external microbiology services. A Fullbright fellowship got him to Harvard Medical School where he spent three years as a chief resident and then research fellow.

One foot in the clinic one in the lab

He returned with a solid training in infectious disease, and in 1971 became the youngest associate of the Faculty of Medicine at the university. Tagnon gave him the responsibility of setting up a new microbiology lab on completely new principles. "I applied the principles that I discovered in the States – that the infectious disease concept has one foot in the clinic, and one foot in the lab. The whole service between the two was all directed by one person – that was me. It was a completely revolutionary concept."

Embodying the strong link between the lab and the patient, Klastersky had an opportunity to research and trial innovative treatments. He focused on research that would significantly improve survival rates in patients whose immune systems were compromised by chemotherapy, and developed the concept of synergistic antibiotics (effective combinations of different antibiotics) for neutropenic patients (who have low levels of neutrophil blood cells). He also developed the concept of endotracheal treatments for patients with gram-negative pneumonia (which are fed through the trachea).

As his work progressed, he looked on as Tagnon established, and then led (as president) the European Organisation for Research and Treatment of Cancer (EORTC).

A new type of treatment. Klastersky with palliative care specialists Gary Morrow (US) and Andreas Du Bois (Germany) discussing how to define 'supportive care' at one of the first meetings of the newly founded Multinational Association for Supportive Care in Cancer

"I saw this concept of European organisations and thought, why shouldn't we do that for infection in cancer patients?" So in 1973, with collaborators from the UK, US and Australia, he founded the EORTC international antimicrobial therapy cooperative group. Over 20 years it published 20 pivotal papers on infectious disease in immunocompromised patients. The first, in the *Journal of Infectious Disease* in 1976, reported on the first ever large randomised comparative study on the management of sepsis in neutropenic patients. It gave international relevance to the innovative activity in Brussels and it made Klastersky's name.

When Tagnon retired in 1977, Klastersky, at just 37, was chosen as his successor. But there was a problem: it would be unusual for the Head of Medicine at a world renowned oncology centre to be a specialist in infection rather than cancer. So straight after his appointment, Klastersky took a sabbatical of several months in America to train as an oncologist. It was a logical conclusion for him, further forging the links between oncology and microbiology.

At the institute, he made a point of seeing patients with all types of cancers and having as broad a perspective on medical oncology as possible. He became professor of medicine, professor of medical oncology, and professor of physical diagnosis, and the teaching his department provided attracted fellows from all over Europe. Under his stewardship, medical oncology beds expanded from 40 to 100, new haematology, intensive care, supportive care and psycho-oncology units were established, the research facility was expanded, the number of physicians increased from 15 to 60 and the research budget went up to €3 million.

The concept of supportive care

It was his broad insight into the factors that affect the welfare of patients with cancer apart from the cancer itself that gave rise to the concept of supportive care, for which Klastersky is arguably most famous. Thousands of oncologists around the world have read his handbook *Supportive Care in Cancer.*

He focused on improving survival in patients whose immune systems were compromised by chemotherapy

Klastersky is keenly aware that definitions of supportive care differ from country to country and are hotly debated by health professionals. But in 1992, when he and Hans-Jörg Senn of the St Gallen Tumour Detection and Prevention Centre in Switzerland created the Multinational Association for Supportive Care in Cancer (MASCC), things were clear.

"Something was definitely going on at that time," he says. "We felt that supportive care was really a fifth modality in cancer treatment and should be to some extent separate from other modalities." The definition they came up with was simple. "It was all the care you provide to cancer patients outside specific anticancer therapy. It means you are preventing complications not only related to the cancerous disease itself, but also related to the therapy. Supportive care starts with the diagnosis of cancer, and goes through the whole evolution, encompassing psychological support, end of life, pain, antiemetics, antibiotics and so on. Besides anti-cancer therapy, everything is supportive care."

The concept worked well, says Klastersky. There was a need for specific research in the area, dedicated meetings, and medical oncologists with a particular interest. It is a mark of how well the important principles of supportive care are now understood that they have become integrated into cancer care, and are no longer seen separately, he believes.

"I think medical oncologists now understand that it is a question of quality of life, as well as quantity of life. The patient also understands this, and requires this perspective. Attention to quality of life necessitates all the supportive care methods being integrated into medical oncology, and this happens at the good centres. They need to be seen to have a supportive care programme."

Good communication between clinician and patient is an intrinsic part of good supportive care, and this is another area where Klastersky made his mark. The institute's onco-psychiatry unit trains Belgian physicians in good communication techniques, and its supportive care unit provides intensive support – and plenty of talking time – for patients with chronic problems related to their illness, such as pain. His research has indicated the value of good communication to patients and clinicians alike.

Here again things are improving on an international level. Laws and regulations in some European countries now compel clinicians to tell patients the truth, and make clear what they know and what they don't know. And multidisciplinary working has made treatment decisions better discussed and more democratic.

"I think that doctors coming along and telling people what to do has almost completely disappeared," he says. "I think that patients are also becoming more aware that things aren't always black and white, and that decisions might be complicated and need discussing."

It's an optimistic viewpoint. In fact Klastersky is generally extremely positive about the way cancer services are progressing internationally. "I often think of the picture on the front of *Scientific American* in 1971, with President Nixon signing the National Cancer Act, and declaring war on cancer. Well, of course, cancer is still here, but since then so much energy has been devoted to fighting it that 40 years later we can see a tremendous difference – particularly technological achievements that are making cancer a type of chronic disease."

Who sees the patient as a whole?

But he does have worries. If his own career has been testimony to the benefits of acquiring as wide a perspective on cancer as possible, it is not surprising that his main concern about the future of medicine is how limited the field of vision of many physicians is becoming.

"My fear is that the training of the oncologist will become more and more narrow. I can see that you can

Focus on febrile neutropenia. With Canadian specialists Ron Feld of the Princess Margaret Cancer Center, in Toronto (*right*), and Andy Padmos, then head of medical oncology at King Faisal's Hospital, Saudi Arabia, at an early international meeting on preventing and treating one of the most serious side-effects associated with some chemotherapy regimens

A transatlantic supportive alliance. Stephen Schimpff, head of the University of Maryland Cancer Center in Baltimore, Maryland (*left*), organised the first symposium on supportive care in 1987, and is pictured here in Brussels for the second symposium held a year later. Also pictured is Klastersky's wife Marie-Thérèse Klastersky-Genot, an oral surgeon specialised in treating patients with severe oral mucositis

have breast cancer people who do not go into the treatment of colorectal cancer, and that you might have people within breast cancer who are more specialised in hormonal therapy, for example. But it worries me that, at some point, too many medical oncologists will have very sophisticated medical skills but will fail to really see the patient as a whole. I think we should be very attentive that medical oncology remains a broader type of activity." He remembers witnessing at one hospital six different specialists attending a patient – none of them was taking overall responsibility for the patient. If something went wrong, would they all blame someone else, he wondered.

"I come from general internal medicine, and I know it's tough nowadays not all to specialise in small areas. But I think there's a potential danger when you don't have one person who can clearly put together the whole picture of a patient under one head."

Fascinatingly, another worry surrounds doctor–patient communication: not lack of it, but too much. For all his research showing the benefits of good communication, Klastersky has also demonstrated that it can be counterproductive if physicians become too emotionally involved with patients. In a paper on physician burnout published in the *Journal of Cancer Education* last year (March 2010) his team of researchers found that heavy clinical workload and the overuse of facilitative communication skills were associated with cancer physician burnout.

"I think that sometimes, if communication becomes too detailed, a mutual emotional involvement begins which can be very difficult for some physicians – it's closely related to their personalities. We had a very nice medical oncologist here, who burnt out completely. Her problem was that she spent hours discussing issues with one patient, and she was no longer the solution, she was part of the problem."

"It's very difficult to regulate, and every personality is different, but you need to maintain emotional detachment." That's why he believes the physician's role transcends relationships. It's about making progress.

If there's one small hint of regret from Klastersky during our conversations, it centres on his specialism in lung cancer. Not long after he became Head of the Department of Medicine at the Institut in 1977, he decided to make lung cancer a specialty – mainly, he acknowledges, because "[I] had to make myself known" in the field of oncology, and most areas apart from lung cancer already seemed to be well-served with experts at the institute.

He created the EORTC Lung Cancer Working Party, and was president between 1978 and 2003. The group's first study demonstrated that cisplatin was active in non-small-cell lung cancer. Its second demonstrated that the combination of cisplatin plus VP16 was active. A series of influential studies followed over the next 10 years.

Yet concentrating increasingly on supportive care in the 1990s distracted him from achieving more in this area, he believes. "I think it was a mistake for me when I decided not to be more super-active in the field of lung cancer," he says. "I could have been more successful in that field."

"Every personality is different, but you need to maintain emotional detachment... It's about making progress"

"For all your passion and values, if you don't know your weaknesses, you may not succeed"

A WINNING FORMULA

Klastersky is conscious of his deep desire to achieve. He analysed it and broke it down last year when asked by the MD Anderson Cancer Center in Houston to talk to fellows about the recipe for a successful medical career. "First, you need the person to be driven by an internal passion – the need to be a physician or whatever. Then you need values, so you know what to do with your passion – to make money, or leave a message for posterity and so on. Then you need to be able to evaluate your skills, to be aware of your strengths and weaknesses. And for all your passion and values, if you don't know your weaknesses – for example being too empathetic with a patient – you may not succeed. You may burn out."

A "relatively peaceful life", he adds, is an important factor for success in any professional career, "and I was lucky enough to have an understanding and supportive wife to share the good and less good aspects of it."

The acclaim he's received throughout his career – he's won the Guy R Odom Award in 1990 for outstanding achievements in infectious disease research, the Lucien Cox Award in 1997, the Louise Biernaux Foundation Award in 2001 and the Hoyez-Van Cutsem Award in 2003 – testifies that the formula has worked pretty well for him.

Still seeing patients as a consultant at the Institut Jules Bordet, he's now co-ordinating a programme of collaboration between nine Brussels cancer hospitals called the 'programme des soins oncologiques'. Looking back, he says, it's the teaching aspect of his role – the passing on of knowledge and experience to others, that he has found perhaps most satisfying. As professor of medicine at the faculty of medicine, Free University of Brussels, he spent 30 years teaching until 2005. He is still attending professor at Charles University in Prague, where he goes every three months to give a series of lectures (in Czech).

Aside from the enjoyment it gives him, teaching gives Klastersky a sense that he's filled in the picture of a great physician that he started drawing in his schooldays.

Passing on the baton. In 2005 Klastersky ceded leadership of the Jules Bordet Department of Medicine to Martine Piccart, after 27 years in the post

"I always thought that this idea of the great physician carried with it the need to transmit important messages – by communication, but also by example. That's been important to me, and has taken a substantial amount of my time."

"Again, you have to know what your values are. It has often been said to me that I didn't achieve all I could have on the political side – making a career in EORTC, for example, and becoming President. But you cannot do everything at the same time, and you have to make your choices according to your values. My values are more to do good international research, good teaching."

And are there any particular ways in which he would like his students to follow his example? "As long as oncologists make efforts to keep themselves competent and continue to see the patient rather than the tumour, there is no better recipe than that."