

## The Cancer Professionals Podcast

### Polypharmacy: The human side of prescribing

#### Episode transcript

(Intro music)

#### **Carly (00:10)**

Why is polypharmacy such an important issue across healthcare? And what does good person-centred medication management look like in reality?

#### **Sheetal (00:18) (clip from episode)**

What is important is that it's about the actual medicines, not the number of medicines. And I think in cancer, it's really, really important because 70 % of cancer patients are living with one long-term condition. So not only are they exposed to their cancer treatments and medications for that, but they're also taking medications for their long-term conditions.

#### **Carly (00:44)**

Hello, I'm Carly and my pronouns are she/ her.

#### **Emma (00:48)**

I'm Emma and I go by she/ her. Welcome to the Cancer Professionals Podcast, a podcast from Macmillan. In this series, we chat to a wide range of guests, including health and social care professionals, to lift the lid on current issues faced by the cancer workforce.

#### **Carly (01:03)**

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#### **Carly (01:24)**

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#### **Emma (01:34)**

This episode contains conversations about lived experience of cancer which you may find upsetting or triggering. Listener discretion is advised.

**Carly (01:44)**

So hello and welcome to the Cancer Professionals Podcast. In this episode, we're exploring the topic of polypharmacy. So this is a really underestimated issue that reaches beyond the list of medicine. We're going to explore how managing multiple medications influences and shapes the day-to-day reality of people with cancer and multiple long-term conditions. How these effects also ripple outwards to families, carers, healthcare professionals, and really everyone involved in providing support across roles and settings. So we're joined today by Lelly and Sheetal. So welcome to the podcast. So shall we start with you both introducing yourselves, telling us a bit about you, and also what is your connection to the topic of polypharmacy? Sheetal, I'll start with you.

**Sheetal (02:34)**

Thank you, Carly. So my name is Sheetal Ladva, I am one of the Clinical Pharmacy Fellows and I am on a year's fellowship with Macmillan Cancer Support and the Royal Pharmaceutical Society. My fellowship project for this year with both organisations is basically looking at the real world experience of polypharmacy across the cancer care journey. So looking at the perspectives of the MDT team so that's healthcare professionals like oncologists, oncology pharmacists, oncology nurses, GPs, community pharmacists, other healthcare professionals and also patients and carers and just looking at their perspectives to try and work out what the challenges are, what the barriers are and what we can do to ensure that the cancer care journey in polypharmacy is just much more aligned. I'm not a cancer specialist by background. I am a pharmacist. So that's why I'm here today. Thank you.

**Carly (03:37)**

Thank you so much, and Lelly.

**Lelly (03:39)**

Hello and thank you for inviting me. So first of all, in my day job, I'm a consultant pharmacist, care of older people at Guy's and St Thomas's NHS Trust. And I work out in the community, out of hospital, and I do have a caseload of patients that are referred to myself and I go and do medication reviews with them. A lot of them are older people who are living with frailty and multimorbidity and obviously as part of that ~ I often encounter people who have cancer whether it is in the late stages or in the early stages. So that's the first thing. I also work with the South East London ICB as the overprescribing lead pharmacist and basically my role there is to implement the recommendations from the National Overprescribing Review which was published in 2021 right across South East London. And so it's really about the strategic and all the things we can do around managing problematic polypharmacy or overprescribing. And finally, I work with the specialist pharmacy services, NHS.

And there I work as what you call a subject matter expert providing advice and support ~ for anything that has to do with older people and medicines. And my role in terms of polypharmacy in the last two years or so has been developing resources of all kinds for ~ mainly pharmacists, but for all other healthcare professionals. Because I work with patients, I'm always seeing the patient's perspective, how it affects them and the rest of the family. that's one part of my interest. But also,

I've got a personal story, not of cancer, but just kind of working with my dad who had limited life expectancy from frailty. So I'm bringing my expertise of somebody who works with people who are very vulnerable and probably at a high risk of taking many medicines.

**Carly (05:40)**

Amazing, great, thank you. So much experience and skills both of you have to bring to this conversation. So thanks so much for being here. And I think what you said, Lelly, about that patient perspective, it will be really good to pick up on that. So I think that's really integral to this topic. So thank you. So shall we start by, let's set the scene a little bit and can we talk about, and perhaps this might be a question for you, Sheetal. Can we start with what is polypharmacy?

**Sheetal (06:07)**

Yeah, sure. So polypharmacy is essentially when a patient is taking multiple medicines at the same time. There's no single definition for polypharmacy. It could be a patient taking four or more drugs or six or even between eight to 10 drugs or even more than that. But what is important is that it's about the actual medicines, not the number of medicines. And I think in cancer, it's really, really important because 70 % of cancer patients are living with one long-term condition. So not only are they exposed to their cancer treatments and medications for that, but they're also taking medications for their long-term conditions. Some of these long-term conditions could be things like high blood pressure or diabetes or mental health conditions or even obesity. And I guess in terms of further defining polypharmacy, we can think about it as appropriate polypharmacy. So not all polypharmacy is bad. Appropriate polypharmacy might be, for example, a patient goes into hospital with a heart attack and they leave the hospital with medications to help support their health after the heart attack so they could be put on statins and blood pressure medications. That's an example of appropriate polypharmacy and it's evidence-based and it's recommended by NICE guidelines. What we're looking at is inappropriate polypharmacy so that's when a patient is taking a lot of medications but some of those might not be needed. Some of those may no longer be beneficial.

Some of them may be a case where the harms outweigh the benefits. So maybe there's an increased risk of side effects or there's interactions with some of their other medications. And it could also be a case where a patient is on multiple medications, but it's causing a burden on their quality of life. So that's what we mean by polypharmacy.

Some of the consequences of polypharmacy are that it can lead to an increased risk of more intervention with healthcare professionals, so perhaps an increased risk of GP appointments, or it could be that they become so troublesome, all of these multiple medicines, that the patients end up in hospital. And as I mentioned before, it has a real impact on a patient's quality of life.

**Sheetal (08:42)**

And I guess in patients with cancer, it's a case that, you know, some patients at diagnosis may be on lots of medications, but they're never reviewed. So those medications are continued, or they may already have an existing long term condition and new medications are started, but their side effects and their interactions haven't been taken into account. So that's what we mean by polypharmacy. Lots of medicines in a patient and some of those could be inappropriate.

**Carly (09:16)**

Absolutely. And I think 70%, like you said, that really gives an indication of the real sort of scale of this, actually. Is there anything from your perspective, Lilly, that you wanted to add in terms of that kind of overarching polypharmacy from your experience?

**Lilly (09:29)**

Yeah. Absolutely, think Sheetal nailed it there because it's not so much the number. So historically, when you look at all the research papers, people would call polypharmacy four or five medicines. And definitely when I first came to work in the NHS 1999, four medicines was polypharmacy. and it was like, wow, how can you be taking four medicines?

And now on average, in my caseload, the people I see, you're talking about 11, 12, 13, 14, even up to 20 medicines. And so we've really shifted with the patient being considered as something really important rather than just the drugs. We've kind of moved away from just counting medicines because like Sheetal said, you might need to take all those medicines. And I think what we're looking at now is focusing on the inappropriate or sometimes people call it problematic polypharmacy or even more recently we've had the national overprescribing review and they've called it overprescribing and I think the reason I like overprescribing is because it doesn't talk about number of medicines it's just if you're taking medicines that you don't need you don't want to take it's not aligning with your circumstance it has no indication then actually you're being over prescribed medicines, whether that's one or two or three. But obviously, the more medicines you take, the higher the likelihood that there will be medicines that you don't need to take. But just going back to the cancer patient, why this is really important to look at is not just from a number of medicines. So if you think about somebody who has cancer, they would have medicines probably for treating the cancer, depends on the stage. Then they would have, as Sheetal said, that's quite a number of people who have other long-term conditions. So they might be taking medicines for hypertension. With all that diagnosis, they might become slightly bit more anxious or depressed. Then they will need medicines for that. Then they will need medicines to control the symptoms of the cancer. And then they might need medicines to deal with the side effects of the anti-cancer medicines like nausea and vomiting or, you know, laxatives.

Then they might have other medicines to manage other long-term conditions. So the list is huge. And so when you think about it from a patient perspective, somebody has to take all those medicines. Somebody has to order them. Somebody has to pick them up. Somebody has to then administer them. And when you think of the cancer patient, obviously, I'm looking most of the time at the ones who are coming towards the end maybe not the last, you know, few days, but you know, we're talking maybe six months, the carers have to pick it up and they have to on top of every other thing they're doing. And then of course, there's all the clinical reasons like the side effects and all that. So it is really important that while we know that there is a need for this medicine to be taken, there actually might be some of them that might be redundant or the patient might be making a choice to say, I want to prioritise my pain over my stomach and you know if I have to really take five medicines what would be the priority and you know we sometimes we have to have those pragmatic discussions. One thing that's interesting that I found in some of the literature is that there's something we call potentially inappropriate medicines so these are medicines that ideally shouldn't be taking but that could be a reason why they are taking so that's why we call them potential.

But there are some studies that found in cancer patients, we could have anything from 25 % to 90 % of potentially inappropriate medicines. So yeah, that's quite high. So we need to be looking. It

doesn't mean we need to stop them, but definitely we need to be looking at whether these medicines are all relevant and necessary for the patient.

**Emma (13:31)**

Lelly, you mentioned the impact on carers, for example, having to pick up those medications, having to juggle that alongside all the other things they're needing to do. And I wondered whether you had any examples you might be able to share from people you've worked with on what the real impact of multiple medications has for somebody who is experiencing that polypharmacy of those 10, 12 medications.

**Lelly (13:37)**

So I'm just looking at one of the patients I went to see maybe about a year or two ago and she has her cancer, she's probably on the last year of the cancer, probably maybe even shorter. And I was just looking, she's taking about 26 medicines. So she's taking something for keratitis, something in the eye that causes dry eyes. She's taking about five different eye drops for that.

She's taking another four or five medicines for the blood pressure and all the things to do with her kidneys. She's taking about three medicines for pain. She's taking another two medicines for her bone health. She's taking three medicines for constipation. Then she has the lung and respiratory conditions. She's taking five medicines for that. And she's taking folic acid.

and she's taking the cancer, just the one cancer medicine and thyroid. You can imagine all those medicines starting and finishing at different times. So she's constantly ringing the GP. She's in pain. She hasn't got carers as such, anybody in her family. So it's all down to the community pharmacists who's helping her. She has, I think, the neighbor who's helping and it's- just ordering the medicine is a full-time job. And she's having to deal with that. So of course, there many medicines she was running out of. And so that's even in the simplest form. And then she's looking at, we went through all her eye drops. And she was so confused. just the brain space to even think through what she needs to take.

It was just so overwhelming. what she just did, she just did what she could. So there were some medicines that she wasn't taking and there some medicines that she was taking to her best ability. And you know, when I went to see her, she just said, honestly, my priority is just to reduce the number of it just because I can't cope with them.

**Carly (15:35)**

Mm-hmm. Yeah, it's a lot for someone to remember, isn't it? And to, yeah, like you said, overwhelming to have all of that and different ways to take them, definitely.

**Emma (16:04)**

It shows how complex those situations can be, especially if they're all due at different times and you're reliant on the support of so many other people. And I wonder whether we can explore that a bit further, Lelly, in terms of the impact that has on somebody's quality of life and particularly how

we might be able to support people to balance the benefits of taking medications alongside quality of life and ensuring that care is really person-centred.

**Carly (16:06)**

Hmm.

**Lelly (16:54)**

Absolutely. So, I mean, what was really shocking with this patient for me was she was only on one medicine for cancer. And when you think about somebody who has cancer medicines, you're thinking, oh who has cancer? Well, just automatically, I would think with loads and loads of very complex medicines, well, actually the reality is she was just taking just the one cancer medicine. And every other thing was about the general things. A lot of her problems were just around managing the medicines. So I guess the first thing when, I mean I went in there because one of my colleagues referred the patient to me because it's just kind of the nature of it. She was overwhelmed as a pharmacist, just going in to look at that person's medicines, never mind the patient themselves. I always say, let's go in there and just find out what the patient just really needs sorting out. It's how we approach. So we have our clinical hats on, but it's nice to have our clinical thoughts, put them in the pocket somewhere, find out what's really important to the patient, and then we can pull out ~ all our thoughts and see where they fit in.

Because what we don't want to do is we're trying to help the patient, not overwhelm them even further. I just said, you know what it looks like, a lot of medicines to be taking. And I said, you know what, do you want to tell me a little bit? And she was like, where do I start? And she let off a little bit. And then I said, what would be really helpful.

And she goes, do you know what, if there's somewhere of kind of just cutting down. And so for me, that set the agenda. And then all the stuff came out and we went through everything and what she thought was better. And like I said, it was just the bloating and the pain that was the most important thing. And so we started with that. So the patient was fully engaged. But I think that is that approach, irrespective of the detail because the detail can be so overwhelming for everybody and sometimes it's just really what's the broad thing we're trying to do here let's get the agenda right and then we can do all the little details and of course there's no way just one pharmacist is going to go in there and solve all the problems so definitely I was linking with the community pharmacist I was linking with the specialist for certain things I didn't have to work with the cancer specialist but sometimes you have to because is all very specialist and they know why they put people on things. But it was just the simple things. But definitely the GP, definitely the community pharmacist, definitely the neighbour who was helping with her consent. And there was a lot for her to do because she had developed a system to manage and so there was no need to tamper with it because she knew exactly what she was doing. Things were placed.

I think by how she could reach them and she was definitely thinking and for me I think it's important if somebody's got something going, as long as it's not harmful, it might be slightly imperfect from the way I would like to do it as a pharmacist. But you know what we don't want to do again is to put more burden and more pressure on that patient.

**Sheetal (19:28)**

Yeah, I think when you add in symptoms like tiredness, fatigue, the other symptoms of cancer, managing those multiple medications just becomes an overwhelming burden. So I yeah, I don't know how some people survive without the support of loved ones, carers, you know, other people who can help them manage their medications in a safe way.

**Lelly (19:49)**

There was another patient we had and she was living with family. But even then, it was tough. And her daughter was just so confused because the medicines kept changing. Her mom, either it would be a fall this week or the other day they had put on some medicines, I think because the cancer was advancing, she was so forgetful. And she had taken the medicine they had given her for the nausea, because that was the problem at the time. She had thought it was a sleeping pill and so she just finished the whole lot. And the daughter said, I was so worried Lelly because she had been sleeping for so long and she thought, what's going on? And it was only when we looked at it, we found out that. I said, well, as she goes, I've run out of my sleeping, as she was getting quite desperate, I've run out of my sleeping pill, I'll bring it all out, and there were just medicines everywhere. And eventually she had a little box where she kept what she thought was really important to her, because there was a whole lot of medicine she wasn't taking as well. And when she looked in her bag, she was like, can't find my sleeping pill, and she was getting really, really anxious. Anyway, she brought it out, and we looked at it, and there they were, and it was untouched.

**Lelly (20:59)**

And then we're looking through and we found out there was nothing left of her cyclism and she had mistakenly taken that the daughter that was just so confused and she was kind of anxious like, oh God, my mom's not knowing what to do. And it carries a lot of burden, not just on the patient themselves but the people, because she's, like I said, she was living with her family. And so it's really important for us to begin to look at, I mean, for this particular patient, she was taking about 21 medicines, about 10 of them she wasn't taking and she had a rational reason for not taking them. And they were the ones that she wanted to take and she was taking those regularly. So it's really interesting how people make up their minds because it's all about what they're perceiving, what they're experiencing as well. And every time you said, I'm not taking this because it sticks to my throat. I'm not taking this because of side effects. I'm not taking this because of this.

**Lelly (21:55)**

And while they were not scientific reasons, a lot of them made sense because it was what she was experiencing. And it was interesting that the first time I went to see her and met her, she was kind of a bit more alert and alive. And she said, do you know what? just want to hang out my family, my grandchildren, And we're trying to get the medicines to align with.

**Lelly (22:16)**

When I met her after about six weeks when I went for a follow-up review, she just said, you know, Lelly, I don't want any noise. I just want calm. I just want to sleep and sleep deep. And she goes, I don't want the grandchildren. But even within that, you know, there could be a shift in people's needs. And I think the best we can do as practitioners is to continue to follow the patient's lead. So what could be right today might change tomorrow. So it's a dynamic process and it's really complex. It's not what you just do on the back of a piece of paper and say, well, here's the action plan, you know, till the next month. So there's that kind of walking together with the patient and everybody

has a role to play because every time something changes, you need to speak to the community pharmacist, you need to speak to the daughter, you need to speak to the GP and pulling all that together itself is complex.

Yeah, just that kind of what you said about it being dynamic. I found that really interesting. And also when you were talking about having that conversation and the importance of that what's important to you conversation to understand where their sort of priorities lie in terms of their needs.

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#### **Emma (23:28)**

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#### **Carly (23:38)**

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#### **Emma (23:45)**

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#### **Carly (23:50)**

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#### **Emma (24:04)**

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#### **Emma (24:15)**

I think what sticks for me as well, Lily, was when you said walking with the person. And I think that really demonstrates that need for that person-centered care. And I wonder if we could explore that slightly in terms of a question for both of you. How can we draw out what matters to the person when we're discussing their medications and how do we involve someone in that decision-making process in terms of balancing that burden, balancing the benefits?

**Sheetal (24:44)**

It goes back to questions that you have for patients and trying to understand from them what matters most to them, what are their main priorities. And it will be different for different patients. I mean, some people will prioritise trying to make the best out of their health conditions and their cancer journey so that they want to do everything. Some people just want to focus on their pain relief and some people don't want to take lots of medicine so you know then it's thinking about which ones can we stop. For those conversations to happen I think that we really need to you know have time to to have honest reflective conversations and for that time to allow the patient to be comfortable with you as a healthcare professional so that they can be more open and vulnerable and ask the right kind of questions about their medicines. And I guess it's also about healthcare professionals thinking that, yes, we know about medicines and we know about conditions, but the patient knows... well they know about their lives, they're the experts in their own lives and sometimes we need to bring that into our conversations trying to find out what is it about their lifestyle that you know is impacting the way that they're taking their medications, how can we make it easier for them.

**Lelly (26:05)**

Yeah, I mean, totally agree with you, Sheetal. And I think how you start that conversation is really important, especially if you're not the normal GP or the normal specialist or the normal community pharmacist. And you're going in, we need time to build rapport. So everybody depends on what stage they are, what support they have, just how they are as people. Everybody handles cancer differently, And people are in a different place, so I think we need to take time. So as pharmacists, it depends on who you are and your role when you're going in there. We're so anxious to go in there and deprescribe or review or make sure we get the right dose. And I think we need to do that, but it has to be in the context of what's going on.

Otherwise, sometimes we can come across as too black and white, which the patient might not necessarily value. So it's something about how do we build rapport in that short time? How do we, and sometimes it's just best to introduce yourself in lay term. So, know, I'm Lelly. I might just say I'm working with, or your GP contacted me because they thought you would like to have a conversation about your medicines just kind of nice, simple ways so that people can relax. And then it's really trying to set that agenda and saying, for example, you know, like I said, you know, I can see you're taking quite a lot of medicines and I can imagine that that will be difficult to manage or you might not want to presume that you might want to say something else and just giving the patient that time to respond or, know, wow, that's a lot. You know, you could do that or you can say, it depends on why you were referred, your GP did say you're kind of finding it hard to make sure you get all these medicines and I could just say tell me about that. So that could open conversation and keeping all the questions open and genuinely listening because what we tend to do is we're listening and we're trying to link it with what we think is the right thing to do and we're not properly listening some people have they've done some research to say if you give a patient time to talk. They call it the golden minute. Most people, the average, I think is 90 seconds they can talk for. If you don't interrupt them, they will come to a natural end. I think it's just nice to allow the patient to have that time. Because I can bet for most patients like that, there is something they're going to mention that you can link with something you've already thought about.

**Lelly (28:36)**

So if the patient is bothered about their pain and is bothered about maybe over-drowsiness from their pain medicines, and if I'm thinking, I'm not sure, there's too many pain medicines, when they state that problem, we already have something in common to work with and to start with. Do you know what I mean? To build rapport and to do together. And hopefully if we can sort that problem out, that's going to improve the patient's life, it's going to improve their trust and relationship, because that's kind of what it boils down to- is how much you trust your practitioner. That's why they like the specialist because specialists have been on that journey with them. So I think anyone who's coming in, they're just kind of little questions. Tell me how you're managing them. Or if they're not forthcoming because not everybody's that chatty. Sometimes I would go, do you know, I found out that when I visit patients like yourself, just going through those medicines with you and you telling me how you're finding them and what works for you and what doesn't work for you. Lots of people find that helpful, you know, what do you think? Or how can I help? Is there anything I can do to make things just a little bit better? Because sometimes people just offload and, know, when they finish it's just like, do you know what, it sounds very complex and overwhelming.

**Carly (29:52)**

Yeah, absolutely. They were so helpful, those sort of those tips and suggestions and some ideas for some examples of questions you can ask. Sometimes some of those questions you ask, know, are really kind of simple, really open. How can I help? But actually will make a really big difference. And I really like what you said about building that trust. Is there anything you wanted to come in on there, Sheetal? Those conversations or perhaps maybe from your experience is anything that really worked well to really build that trust and to have those conversations to help them feel part of that shared decision making.

**Sheetal (30:28)**

I think Lilly has said everything that needs to be said But I guess from my perspective, I think if there is a chance to slow down and to really listen to the patient, I think a lot of health care professionals and sadly, it's a system thing. It's not blamed towards individual health care professionals, but the appointment times are not really designed to actually be conducive to those types of conversations. I also think that sometimes we forget that it's not just about the patient's conditions, they're not a body of different conditions, but we need to think about the patient holistically, thinking about how the different body systems impact each other, how different treatments impact each other and what kind of impact it's having on the patient's overall quality of life.

**Sheetal (31:18)**

And then I guess the other thing that I would say is that medicines aren't always the answer, so sometimes we need to think outside of the box. Are there any non-medical sort of alternatives that we could consider? Perhaps we should consider something that falls under social prescribing. So you know, is there community health program that we could refer the person to if they have issues with anxiety or depression, is there a talking therapy? So you know, thinking a bit more outside of the box. So if we do need to de-prescribe, let's say an antidepressant, then thinking how we can support the patient, you know, in that process. So yeah, and I guess it's also about just keeping them informed about, you know, the questions that you're asking, like why you're asking them, and to check their understanding as well, because you'd be surprised at how many patients don't understand why they

are taking a particular medication and sometimes it's just me saying this is a medication that's going to stop you from feeling nauseous you know and and really getting them to to kind of feed that back to you so that you've checked their understanding

**Carly (32:18)**

Yeah. Yeah, that was great. That was a really great addition and really helpful. And I think the key there when you were talking about that holistic care and going beyond just the medication and understanding what that looks like for that person holistically. So yeah, that was really great. Thank you. So as you know, in each episode we have our regular feature where we ask particular questions to our guests. And today we're going to ask one of these So the question is, what would you like listeners to take away from this episode? Sheetal, I'll start with you.

**Sheetal (33:05)**

So I guess my takeaway message for the audience would be that polypharmacy is everyone's responsibility. I think traditionally it's thought of as the responsibility of those who are in positions of prescribing, but actually it's every person who's involved in that patient's cancer journey, whether they have any prescribing qualifications or not. I guess it's about being curious, so if something doesn't feel quite right when you are in contact with that patient as a healthcare professional or as a carer. I guess it's just about being curious and finding out what you can do. It could just be a case that you refer that patient to their GP or their specialist.

The other thing that I would say based on that is that, know, yeah, polypharmacy can't be handled by a single professional group. I think it works best when you've got a multidisciplinary team approach so that everybody gets behind that patient's healthcare in whatever capacity that may be and whatever healthcare professional capacity they provide. Collaborating across the different healthcare professionals and across the different healthcare settings because that patient will be seen at every single setting, And then being confident to raise any concerns if there are any even if you don't feel that you have the impact to be able to change something but you can sign post them or refer them on to somebody else so yeah so it's everybody's responsibility.

**Carly (34:47)**

Great, thank you. It's like the three C's, curiosity, collaboration, and confidence.

**Lelly (34:53)**

Now that's going to be a tough act for me to follow now. ~ I think there many things I want to say but I'm going to try and keep it short. I think the first thing is to listen. Proactively listen. I think the first thing is really listen to the patient and bring all that information to bear when you're making decisions together about medicines. So that's the, how, I think how we do that is the tough bit, but I think if we're aiming for that, to listen, to be as much as possible honest that we can't solve, you know, it's, you know, most cancers, I mean a lot of cancers cannot be solved when people get to that stage. You know, it's about how do we make the best out of what they are. Do you know what I mean? And being open and honest and saying, you know, we're not 100 % sure how this is going to

work if we're not sure. And just assuring that patient and giving them a bit of hope and say, let's try this. And just helping that patient to know that we're on a journey together. you know, we need to be ready to work with people in a nuanced way.

**Carly (36:08)**

Mm-hmm. Yeah, absolutely. Thank you. Perfect way to end the kind of conversation. So thank you so much. Thank you.

**Emma (36:10)**

Thank you. Thank you both.

**Carly (36:17)**

Sheetal, Lelly for joining us. Thank you so much for sharing all of your experiences. Thanks so much for bringing the stories and the examples as well to really bring polypharmacy to life and what the impact is on people and their loved ones and actually how all healthcare professionals, have a role in helping with this. So thank you so much for joining the Cancer Professionals Podcast.

**Sheetal (36:43)**

Thanks, Carly. Thanks for having us.

**Lelly (36:43)**

Thank you.

**Outro**

**Carly (36:46)**

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**Emma (37:19)**

If you enjoyed this episode, follow us so you don't miss our next conversation where we'll be joined by Rachel Daly, Andy Woodhead and Lorraine Burgess to talk about dementia and cancer.

**Carly (37:29)**

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**Emma (37:42)**

I'm Emma.

**Carly (37:43)**

And I'm Carly and you have been listening to the Cancer Professionals Podcast by Macmillan Cancer Support.

(Outro music)