Laura, maybe we could start off by you telling us a little bit more about what exactly is palliative care. I get the sense that there are still some misperceptions about what the term really means.

That’s a common point. It’s something that a lot of people still wonder about, so I’m really happy to give another sense of what it is.
Palliative care is a medical subspecialty that focuses on quality of life for patients with serious illness of any type and their families. And we also focus on relieving suffering, so again, it’s really about quality of life and relieving suffering as much as we can. This all takes place in the setting of an interdisciplinary professional team. And we really focus on physical symptoms. Coping and the stress that patients and families deal with around serious illness as well as trying to streamline and support good communication for patients and families so they get their questions answered as well as possible. But that sounds like a combination of pain medicine and psychology and it’s a bit of social work mixed in. Tell us more about how that works and how that’s different from people’s usual doctors who also may be very interested in their quality of life? First of all, you know, we really hope that all health care professionals get some training in palliative care and that they provide what we would call primary palliative care...
These are primary skills in addressing basic pain management and providing an initial level of support around coping as well as some nice early communication.

Palliative care goes beyond that in terms of being very specialized and part of that is because we do have a team model of care. Not all institutions are equal in terms of how many resource supports they are able to put toward palliative care, but in our setting at Smilow and across Yale, we’re really focused on having a robust team, which includes social work, chaplaincy, nursing, both at an RN and an advanced practice nurse level. We also are very fortunate to have our team psychologist as well as a pharmacist and art therapist, so this is a very broad approach.

We acknowledge that pain and other symptoms are sort of a total phenomenon,
meaning that people can have pain and anxiety and depression that is in different domains, meaning the spiritual, the physical, emotional and so are different team members can play really important roles in addressing symptoms across this kind of spectrum of suffering and really trying to again improve quality of life. As you think about suffering, particularly of our cancer patients, and many of them have symptoms. Whether it’s symptoms related to treatment or whether it’s symptoms related to the cancer itself, one can’t help but think that the whole Covid crisis kind of exacerbated that suffering, especially when you put it into those domains of not just the physical suffering, but emotional suffering. Financial suffering. All of the things that covid kind of brought to the forefront. Did you find an uptick in the need for palliative care during the crisis? You know, I think you’re absolutely right. Covid sent us something that we were really challenged by
especially initially figuring out how we could best support both our colleagues and our patients and families. I think the need shifted. I think at first we weren’t sure because of just the exposure issues and how to still be as helpful as possible, but I think what really happened was of course, as we all know, in the earlier surge there was such a concern about how sick people were, and of course unfortunately a lot of people were sick enough that they were in a place where they were not able to get better and were dying. And so for us in particular, we were really brought in for physical symptom management, especially around shortness of breath. Which is where we saw COVID hit us all very hard. So managing shortness of breath for people that were really suffering with that and trying to improve their day-to-day and in cases where people were sick enough that they were dying, we were really pulled in to be present with them as much as possible, but to really be involved in reaching out to their families. Trying to help our medical
0:07:24.53 –> 0:07:27.25 colleagues in the ICU’s with
0:07:27.25 –> 0:07:29.97 spending extra time
0:07:29.97 –> 0:07:32.146 being available to families,
0:07:32.15 –> 0:07:36.494 especially and to really try to help there.
0:07:36.5 –> 0:07:41.456 Be some contact before someone died.
0:07:41.46 –> 0:07:43.662 So that was challenging
0:07:43.662 –> 0:07:45.85 in a different way for sure.
0:07:45.85 –> 0:07:47.726 And fortunately I think,
0:07:47.726 –> 0:07:50.54 now that we’ve gotten on top
0:07:50.632 –> 0:07:53.2 of Covid and learned so much,
0:07:53.2 –> 0:07:55.546 and people are really
0:07:55.55 –> 0:07:57.52 doing a lot better now,
0:07:57.52 –> 0:08:00.264 certainly not as many people are dying,
0:08:00.27 –> 0:08:03.12 but we still have those roles
0:08:03.12 –> 0:08:04.545 currently trying to
0:08:04.55 –> 0:08:06.062 still be present to have these
0:08:08.062 –> 0:08:10.39 harder discussions and prepare patients
0:08:10.39 –> 0:08:13.12 and families for what can happen.
0:08:13.12 –> 0:08:17.216 I actually just took care of a patient a
0:08:17.216 –> 0:08:21.291 week ago who was in her 90s and
0:08:24.78 –> 0:08:27.797 And was actually in a mode where
0:08:27.797 –> 0:08:30.261 the patient and daughter were
0:08:30.261 –> 0:08:33.495 accepting that she might not live
0:08:33.495 –> 0:08:36.639 through this covid episode for her,
0:08:36.64 –> 0:08:40.064 but in fact she has been able to
0:08:40.064 –> 0:08:43.109 be stable and come through that
0:08:43.109 –> 0:08:46.229 and actually come out of sort
0:08:46.336 –> 0:08:48.986 of a comfort focused time.
0:08:48.99 –> 0:08:52.026 And now we’re focusing on how
0:08:52.026 –> 0:08:54.51 to think about supporting her
the best we can for her to ultimately try to recover. So things are a little different now. I can imagine that, particularly during the covid crisis and even now for patients in isolation, that comfort and that support and that communication, particularly with the family, must be really difficult. I mean, how do you do that when both the family wants to be with their loved ones who are facing a potentially terminal crisis, and patients themselves are suffering. And dealing with more than the usual because not only do they have their physical symptoms, but also the emotional isolation. How do you kind of bridge that and be with with the patient and be there for the family as well? It’s such a privileged place to be. It’s awfully difficult as well, but I think all of us on the team, whether it’s one of our chaplains or one of our social workers, our nurses, I think all of us just try to bring 110% of our presence to open up conversations to just try to give
people the space and opportunity to express the deepest part of what’s weighing on them and what they are most worried about and to acknowledge the sadness. The heaviness of the situation. Sometimes we’re able to be in person with the patient. Occasionally, if someone really is seemingly in a place where they may be dying in the next hours, family may be able to visit briefly and we try to be present for those opportunities and to advocate for them when possible. We’ve also had the opportunity, obviously, to use technology and have families through FaceTime or through Zoom. and be able to see their loved one. Sometimes that person can respond and sometimes they can’t. I think we try to always make it as personalized a situation as possible. Sometimes there’s music that is meaningful to the patient or family members. Last week I had a patient who was dying and the family was able to let us know that that person really enjoyed jazz music and we were able to have that present and you
know it seemed to be part of the quality that we could add to a sad situation for sure. I think earlier when we had more people who seemed to be facing death, we had a lot more technology and a lot more Zoom meetings, we would have occasionally a family who would get connected from around the world and Zoom together and sometimes they would stay on for 12 or 24 hours with their loved one. Until they passed away. It’s such a time to reflect on what matters to people and to try to help families be able to focus in on how much time we think we may have and what is possible to try to make things you know a little more meaningful to everybody. Yeah, it’s so important, particularly at the end of life, and the suffering that the families go through doesn’t end when their loved ones pass. In fact, sometimes is just starting to surge their own grief over the loss. What about palliative care for them? Does your role continue? Or how does that work?
Yes, thank you for asking that question because it’s so important to acknowledge that there’s so much more to the journey for family members, especially, even after someone dies. So we’re very fortunate within our Hospital system and Smilow that within our palliative care program we do have a bereavement service that’s been really a critical part of what we do for a number of years now. We have two full time social workers, bereavement specialists, who work within our program and so when we do have a death on our service, we let our bereavement coordinators and specialists know about that particular family and then they are able to follow up. We have a number of really wonderful support group opportunities as well as the option for a referral for more formalized counseling or psychotherapy as well within our community, but I think the really important first step is just to make sure that we do have that follow through to be able to check on families and to really check in with them.
specifically weeks after to just see how they’re coping. and to acknowledge all the normal parts of grief and the bereavement process. So that’s absolutely critical to our community and something that I think is unique that we are able to provide in that regard. Great, we’re going to take a short break for a medical minute. Please stay tuned to learn more information about palliative care with my guest Dr. Laura Morrison. Support for Yale Cancer Answers comes from AstraZeneca working to eliminate cancer as a cause of death. Learn more at astrazeneca-us.com. This is a medical minute about lung cancer. More than 85% of lung cancer diagnosis are related to smoking and quitting even after decades of use can significantly reduce your risk of developing lung cancer. For lung cancer patients clinical trials are currently underway to test innovative new treatments. Advances are being made by utilizing targeted therapies and immunotherapies. The BATTLE II trial aims to learn if a drug or combination of drugs based on personal biomarkers can help
0:16:41.68 → 0:16:44.68 to control non small cell lung cancer.
0:16:44.68 → 0:16:47.455 More information is available
0:16:47.455 → 0:16:48.565 at yalecancercenter.org.
0:16:48.57 → 0:16:52.908 You’re listening to Connecticut Public Radio.
0:16:52.91 → 0:16:53.3 Welcome
0:16:53.3 → 0:16:55.27 back to Yale Cancer Answers.
0:16:55.27 → 0:16:57.628 This is doctor Anees Chagpar
0:16:57.63 → 0:16:59.802 and I’m joined tonight by
0:16:59.802 → 0:17:01.95 my guest doctor Laura Morrison.
0:17:01.95 → 0:17:03.518 We’re talking about palliative care and Laura,
0:17:03.518 → 0:17:05.38 care and Laura,
0:17:05.38 → 0:17:08.1 before the break we were talking a lot
0:17:08.174 → 0:17:11.1 about how palliative care has a role
0:17:11.1 → 0:17:13.35 in supporting patients and families,
0:17:13.35 → 0:17:14.758 particularly at
0:17:14.758 → 0:17:17.841 the time of of death and when
0:17:17.841 → 0:17:19.625 patients are really suffering.
0:17:19.63 → 0:17:22.388 But I think one of the misconceptions
0:17:22.388 → 0:17:24.04 is this whole idea
0:17:24.04 → 0:17:26.652 of palliative care versus
0:17:26.652 → 0:17:29.264 Hospice versus death panels.
0:17:29.27 → 0:17:33.526 Can you clarify where palliative care sits in this whole spectrum?
0:17:33.526 → 0:17:37.768 Yes, absolutely.
0:17:39.12 → 0:17:40.186 It’s an important distinction,
0:17:40.186 → 0:17:42.318 so palliative care again is for any patient
0:17:42.32 → 0:17:46.47 with a serious illness in their family.
0:17:46.47 → 0:17:50.31 That’s a pretty broad group,
0:17:50.31 → 0:17:52.98 but not everyone is referred to us so
0:17:52.98 → 0:18:01.79 theoretically, anyone with a serious illness could request palliative care.
care through their physician so palliative care can be involved for that extra attention to really improving quality of life and relieving suffering. That’s part of many people’s experience with serious illness and so with palliative care we coexist and co manage our patients together with their specialists and physicians and primary care doctors. So for Smilow patients, that means that we’re often co managing with the oncologist or the hematologist. Hospice is a separate entity. Hospice is an opportunity for patients and families when a patient is coming to a time where their life is likely going to be limited in time. And so if someone has six months or less in their disease course, they may become eligible for Hospice and that happens in conjunction with making decisions usually to steer away from more therapies that would prolong life, and so it’s a time when people are really focused on comfort and
really having as their primary aim the quality of life and comfort, and potentially no longer pursuing curative or life prolonging therapy and so Hospice is a time when usually people are not as involved with their oncologist or hematologist anymore. And really palliative care can enter at any time and stay with people even if they are able to be cured. Or just have a long period of time in their illness course, and so I think that’s really important, because palliative care then does not mean that there is any sense that your life expectancy is somewhat limited. It simply means that you have some suffering, whether that is physical suffering, emotional suffering, spiritual suffering, or other needs in terms of communication or spiritual needs that could use the services of a dedicated interdisciplinary team? Is that right? That’s absolutely right, yes. I think it often starts just acknowledging what a change it is for people to be diagnosed with a serious illness and how stressful that is, and simply the stresses of being in
the hospital and not being in your own realm of control in the same way. So it really starts at that very basic human level of just acknowledging that things are really changing for somebody. And as you pointed out, we do have that. And it may be that one member of our team is a little more relevant at one time or another, but we do have the full team to draw upon. So for instance, we have some patients, many patients in active treatment, and sometimes our real goal is just to get them through their active treatment in the best supported way possible. And that may mean that they’re coming to an art therapy group. You know, while they’re getting treatment for their breast cancer or their acute myeloid leukemia. Maybe at a later time they’re coming into our clinic when they come in to see their hematologist, because we’re helping them with pain or their fatigue. So we do have an inpatient, and an outpatient presence as well. I think that that’s so important, particularly now during covid when you know the real thrust was to try to manage patients in an outpatient
setting as much as possible.

So for patients who are not in hospital, who may be at home, tell us more about how the outpatient palliative care services work.

It seemed from our earlier discussion that the inpatient service was this multidisciplinary service integrated with the managing team, the oncologist, and together managing patients in the hospital. But for patients who are at home, how do you do that? Is that by virtual visits.

How does that really manifest?

We have a really vibrant palliative care clinic that is located in New Haven within Smilow, so people come into the 4th or 8th floor usually. And then we also have one of our colleagues see patients as well at a number of the care centers around New Haven in North Haven and Guilford and Trumbull. Torrington, so there’s a fairly good access to our services. As you’re pointing out, the Covid situation has altered our practice patterns there as well, and we’ve come in and out of virtual...
and in person visits a couple of different times with the surges. But you know, eventually, obviously we hope to be back to mostly in person, but I think we all acknowledge that virtual visits are going to carry forward with us. At the moment, the majority of our clinic visits are virtual at this time, but you know you schedule an appointment with us just like you do with any other clinic if they are in person, if they are in person, then we often try to pair them up with someone’s oncology or hematology visit so that people aren’t making multiple trips, so we really do try to be wary of those extra burden issues for patients and families. So when you pull up caring and alleviation of suffering, whether that’s pain or fatigue or nausea or any number of symptoms, some patients may be at home and suffering that way. Is there such a thing as home palliative care?
Where people can deliver therapies at home?

Yes, so it follows a model that is similar to home nursing services that we typically get through Medicare or private insurance so people can have what is called home palliative care. It's typically through the same kind of agency that regular home nurse would be set up, but these are specialized groups within that, so a number of our local organizations in the community around Connecticut have home palliative care services, and what that looks like for patients is really at the most a daily visit for an hour or two perhaps. They can also include physical and occupational therapy services within that, but the nursing component often isn’t even everyday. It’s sort of based on what the need of the patient is as far as the frequency. But these are typically nurses who may have had a prior opportunity to do some Hospice work. Or may have a particular interest or training in more on the palliative care side, and those skill sets are quite similar and they bring a more holistic approach to really assessing
and trying to manage symptoms. The management part is still handled by a physician who is covering and supporting that Nurse. Offering that kind of nursing service would exist on its own for some patients that might then later transition into a Hospice type of approach as well.

And so you mentioned insurance briefly, but expand on that a little bit more in terms of palliative care you had said, anyone who has a serious illness can request palliative care, but I’m sure many of our listeners might be thinking, it sounds like this is yet another cost. Whether it’s in the inpatient or the outpatient or the home setting, is that yet another medical bill that’s going to add to the financial suffering that people have? Are these services generally covered by insurance? Thankfully, yes.

Palliative care is considered a medical subspecialty, just as infectious disease, cardiology, neurology. So that part of the financial picture is
really handled in a billing fashion just like any other subspecialty. Even similar to oncology or hematology. For the most part that would be covered by a private insurance as well as Medicare and Medicaid. Doctor Laura Morrison is an associate professor of medicine and geriatrics at the Yale School of Medicine. If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at yalecancercenter.org. We hope you’ll join us next week to learn more about the fight against cancer here on Connecticut Public Radio.