Welcome to Yale Cancer Answers with your host doctor Anees Chagpar. Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week it’s a conversation about palliative care with Doctor Laura Morrison. Doctor Morrison is an associate professor of medicine and geriatrics at the Yale School of Medicine, where Doctor Chagpar is a professor of surgical oncology.

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.
0:02:46.037 –> 0:02:48.462 care or basic palliative care.
0:02:53.77 –> 0:02:57.435 These are primary skills in addressing basic
0:02:57.435 –> 0:03:01.859 pain management and providing an
0:03:01.859 –> 0:03:06.367 initial level of support
0:03:06.367 –> 0:03:10.55 around coping as well as some
0:03:10.55 –> 0:03:12.406 nice early communication
0:03:12.406 –> 0:03:13.798 support as well.
0:03:13.8 –> 0:03:16.29 Palliative care goes beyond that
0:03:16.29 –> 0:03:19.328 in terms of being very specialized
0:03:19.328 –> 0:03:22.499 and part of that is because we
0:03:22.499 –> 0:03:25.397 do have a team model of care.
0:03:25.4 –> 0:03:27.256 Not all institutions are
0:03:27.256 –> 0:03:30.04 equal in terms of how many
0:03:30.04 –> 0:03:32.542 resource supports they are
0:03:32.542 –> 0:03:35.609 able to put toward palliative care,
0:03:35.61 –> 0:03:39.777 but in our setting at Smilow and across Yale,
0:03:41.154 –> 0:03:44.85 we’re really focused on having a robust team,
0:03:44.85 –> 0:03:48.04 and for us that includes
0:03:48.04 –> 0:03:49.704 social work, chaplaincy, nursing,
0:03:49.704 –> 0:03:52.887 both at an RN and an advanced
0:03:52.887 –> 0:03:54.69 practice nurse level.
0:03:54.69 –> 0:03:58.071 We also are very fortunate to have
0:03:58.071 –> 0:04:00.972 our team psychologist as well as
0:04:00.972 –> 0:04:03.237 a pharmacist and art therapist,
0:04:03.24 –> 0:04:05.62 so this is
0:04:05.62 –> 0:04:07.604 a very broad approach,
0:04:07.604 –> 0:04:10.58 and I think the special part
0:04:10.687 –> 0:04:13.219 about it is that you know,
0:04:13.22 –> 0:04:16.289 we acknowledge that
0:04:16.29 –> 0:04:19.305 pain and other symptoms are
0:04:19.305 –> 0:04:22.32 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 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 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
colleagues in the ICU’s with spending extra time being available to families, especially and to really try to help there.

Be some contact before someone died. So that was challenging in a different way for sure. And fortunately I think, now that we’ve gotten on top of Covid and learned so much, and people are really doing a lot better now, certainly not as many people are dying, but we still have those roles currently trying to still be present to have these harder discussions and prepare patients and families for what can happen. I actually just took care of a patient a week ago who was in her 90s and dealing with covid and in isolation. And was actually in a mode where the patient and daughter were accepting that she might not live through this covid episode for her, but in fact she has been able to be stable and come through that and actually come out of sort of a comfort focused time. And now we’re focusing on how 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 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
0:12:09.775 –> 0:12:12.663 I know it seemed to be part of the quality that we could add to a sad situation for sure.
0:12:20.84 –> 0:12:24.515 I think earlier when we had more people who seemed to be facing death,
0:12:32.153 –> 0:12:34.058 we had a lot more technology and a lot more Zoom meetings,
0:12:36.86 –> 0:12:39.8 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.
0:12:58.531 –> 0:13:01.268 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.
0:13:29.54 –> 0:13:32.9 the suffering that the families go through doesn’t end when their loved ones pass.
0:13:36.22 –> 0:13:39.622 In fact, sometimes is just starting to surge their own grief over the loss.
0:13:43.38 –> 0:13:46.236 What about palliative care for them?
0:13:48.144 –> 0:13:50.524 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
to control non small cell lung cancer.

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Welcome back to Yale Cancer Answers.

This is doctor Anees Chagpar and I’m joined tonight by my guest doctor Laura Morrison.

We’re talking about palliative care and Laura,

before the break we were talking a lot about how palliative care has a role in supporting patients and families,

particularly at the time of death and when patients are really suffering.

But I think one of the misconceptions is this whole idea of palliative care versus Hospice versus death panels.

Can you clarify where palliative care sits in this whole spectrum?

Yes, absolutely.

It’s an important distinction,

so palliative care again is for any patient with a serious illness in their family.

That’s a pretty broad group,

but not everyone is referred to us so 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 in their illness 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
and so I think that
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
with 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
0:22:45.12 –> 0:22:47.208 setting as much as possible.
0:22:47.21 –> 0:22:50.77 So for patients who are not in hospital,
0:22:50.77 –> 0:22:54.54 who may be at home,
0:22:54.54 –> 0:22:58.047 tell us more about how the outpatient
0:22:58.047 –> 0:23:00.04 palliative care services work.
0:23:00.04 –> 0:23:02.77 It seemed from our earlier
0:23:02.77 –> 0:23:05.27 discussion that the inpatient
0:23:05.27 –> 0:23:08.04 service was
0:23:08.04 –> 0:23:09.54 this multidisciplinary service
0:23:09.54 –> 0:23:12.04 integrated with the managing team,
0:23:12.04 –> 0:23:14.04 the oncologist, and together
0:23:16.54 –> 0:23:21.54 But for patients who are at home, how do you do that?
0:23:28.13 –> 0:23:30.75 How does that really manifest?
0:23:32.05 –> 0:23:35.542 We have a really vibrant palliative
0:23:35.542 –> 0:23:39.827 care clinic that is located in New
0:23:39.827 –> 0:23:43.96 Haven within Smilow, so people come
0:23:43.96 –> 0:23:49.28 into the 4th or 8th floor usually.
0:23:49.28 –> 0:23:52.264 And then we also have one of our
0:23:52.264 –> 0:23:54.12 colleagues see patients as well
0:23:54.12 –> 0:23:57.22 at a number of the care centers
0:23:57.22 –> 0:24:00.664 around New Haven in North
0:24:00.664 –> 0:24:03.5 Haven and Guilford and Trumbull.
0:24:03.5 –> 0:24:05.978 Torrington, so there’s
0:24:05.98 –> 0:24:08.878 a fairly good access to our services.
0:24:08.88 –> 0:24:10.472 As you’re pointing out,
0:24:10.472 –> 0:24:12.86 the Covid situation has altered our
0:24:12.93 –> 0:24:15.09 practice patterns there as well,
0:24:15.09 –> 0:24:17.34 and we’ve come
0:24:17.34 –> 0:24:19.65 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 and families 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
0:27:19.969 --> 0:27:22.429 and trying to manage symptoms.
0:27:22.43 --> 0:27:24.985 The management part is still
0:27:24.985 --> 0:27:27.029 handled by a physician
0:27:27.03 --> 0:27:29.346 who is
0:27:29.346 --> 0:27:32.82 covering and supporting that Nurse.
0:27:36.41 --> 0:27:39.392 Offering that kind of nursing service
0:27:39.392 --> 0:27:43.569 would exist on its own for some patients
0:27:43.569 --> 0:27:46.713 that might then later transition into
0:27:46.801 --> 0:27:49.909 a Hospice type of approach as well.
0:27:51.36 --> 0:27:53.598 And so you mentioned insurance briefly,
0:27:53.6 --> 0:27:56.705 but expand on that a little bit more in
0:27:56.705 --> 0:27:59.587 terms of palliative care you had said,
0:27:59.59 --> 0:28:01.97 anyone who has a serious
0:28:01.97 --> 0:28:04.08 illness can request palliative care,
0:28:04.08 --> 0:28:06.324 but I’m sure many of our
0:28:06.324 --> 0:28:07.82 listeners might be thinking,
0:28:07.82 --> 0:28:10.06 it sounds like this is yet another cost
0:28:10.06 --> 0:28:12.68 with a specialized interdisciplinary team.
0:28:12.68 --> 0:28:14.816 Whether it’s in the inpatient or
0:28:14.816 --> 0:28:17.17 the outpatient or the home setting,
0:28:17.17 --> 0:28:19.27 is that yet another medical bill
0:28:19.27 --> 0:28:22.012 that’s going to add to the financial
0:28:22.012 --> 0:28:23.704 suffering that people have?
0:28:23.71 --> 0:28:25.43 Are these services generally
0:28:25.43 --> 0:28:26.72 covered by insurance?
0:28:28.07 --> 0:28:30.8 Thankfully, yes.
0:28:30.8 --> 0:28:33.648 Palliative care is considered
0:28:33.648 --> 0:28:35.784 a medical subspecialty,
0:28:35.79 --> 0:28:38.642 just as infectious disease,
0:28:38.642 --> 0:28:42.408 cardiology, neurology. So
0:28:42.408 --> 0:28:45.586 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.