

Welcome to Yale Cancer Center Answers with your hosts doctors Francine Foss and Anees Chagpar. Dr. Foss is a Professor of Medicine in the Section of Medical Oncology at the Yale Cancer Center and is an internationally recognized clinician and clinical researcher. Dr. Chagpar is Associate Professor of Surgical Oncology and Director of the Breast Center at Smilow Cancer Hospital at Yale-New Haven. Yale Cancer Center Answers features weekly conversations about the most recent advances in the research diagnosis and treatment of cancer and if you would like to join the conversation, you can submit questions and comments to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC. This week you will hear a conversation with Dr. Laura Morrison. Dr. Morrison is Director of Hospice and Palliative Care Medicine Education and Director of the Hospice and Palliative Medicine Fellowship at Yale School of Medicine. Here is Dr. Francine Foss.

Foss Let's start off by having you give us a brief introduction to how you got into this field and how you actually came to Yale?

Morrison I would like to say first that I am very pleased to be at Yale. I came to Yale by way of Ohio and Texas. I did my initial medical school and residency training in Ohio, in Cleveland, and then moved on to Houston, Texas where I ended doing geriatric fellowship training as well as palliative care training. I then joined the faculty at Baylor College of Medicine for about nine years before moving on to this position at Yale. I ended up coming here because the opportunity was a really exciting one. I think people are somewhat aware that Smilow Cancer Hospital and Yale have really started to prioritize building a palliative care program and as part of that there was an opportunity to come and be part of starting this new fellowship and start to increase and emphasize palliative care education both at Yale, with medical students, residents, and various fellows in training, as well as in the community and among our interdisciplinary colleagues.

Foss Could you tell our audience what palliative care is and how it is different from hospice care?

Morrison Palliative care is first and foremost what we would call an extra layer of support and I think that is really the key concept that we try to communicate to people. Beyond that it really focuses on relieving suffering or preventing suffering if we can, and improving quality of life for patients and their families. This is practically seen in the way that we look at symptom management and make sure people are comfortable whether they are in an early stage of treatment for a disease like cancer, or in a later stage of illness. We look at things like pain, nausea, anxiety, depression, bowels, whether they are slow or too fast, and we also focus a lot of attention on supporting families

around decision making with patients that can take the form of advanced care planning. Often it is just simply re-clarifying treatment goals and making sure that people are really understanding what options are available and how those might impact their goals and really understanding if there are tradeoffs to be made or not.

Foss And how does that differ from hospice?

Morrison This is a question that I get almost every time I meet a new patient or family member. Hospice and palliative care are similar but they are different. They both focus on the quality of life and

4:36 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3 trying to prevent suffering. Hospice by contrast though, is limited in that it is designated as a system of care in this country and in that sense, we are limited in prognosis to a certain time. We need to be able to say that we think it is possible someone might die in the next six months, and it is also limited by the treatment options that someone is choosing. So when someone enters hospice, in most situations, they are going to be making a decision to no longer pursue something that would be curative treatment or something that would be outright life prolonging or something that would be trying to still modify a disease. So again, palliative care by contrast, and this is important, can be involved at anytime in someone's course of disease. Palliative care is for anyone that has a serious illness and can be involved early on in diagnosis all the way to end stage and palliative care is able to be involved with any other treatment option that is going on.

Foss How would a patient get referred to you for palliative care?

Morrison In our setting, we are primarily hospital based. We do have a growing clinic, but the emphasis and most of our resources are in the hospital right now, so normally the physician that is taking care of a patient in the hospital will consult our service. At this point in time, we are not the attending physician, we are not leading the care team, we come in as that extra layer of support, also for all the other clinicians and physicians involved in the care of a patient. So we are not taking over, we are simply coming in and partnering with everyone else.

Foss Do your referrals then come from the physicians taking care of the patient or from the nursing staff or from both?

Morrison Generally speaking, it tends to be from doctors. Certainly, I think in some cases, nurses may suggest the consult to a physician. So we certainly work with everyone who is clinically involved with our patients.

Foss It is sounds like you are not, as you said, necessarily taking care of patients at the end of the course of their disease. What kinds of issues would earlier stage patients have that you would be addressing?

Morrison That is a great question. The scope of issues is extremely broad, and that is one reason I was drawn to the field is because this continues to be challenging and we hope we can help people and often find rewarding ways to help people, but some of the common problems would be there are the symptom issues that I mentioned before. Pain especially in the cancer population is very prevalent, fatigue, or low energy, is also very common. We see a lot of anxiety, some depression, although depression does not always come with cancer. We also see, as I mentioned before, bowel issues. Aside from the physical symptoms, we also address the whole scope of the person. We call it ‘whole person care’ and we recognize that people can have what we call total pain and that means we are looking at the spiritual dimension, the social dimension, the psychological and emotional dimensions, and so we may be dealing with someone who is having spiritual distress.

8:56 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3

That is why our team is interdisciplinary, and so the chaplain on our team may be able to help focus on that issue. People also have many stressors for the caregiver and for family members, so we often are involved in addressing the plan for what is going to happen at home after someone leaves the hospital because they may be a lot weaker than when they came in, what kind of additional care is going to be needed? We help families look at those options. We also often see that caregivers are extremely distressed. They may be having a hard time coping with all of the issues with their loved one. We try to provide both the ability to be present and counsel patients in those areas, but also to look at resources that may be available.

Foss You mentioned an interdisciplinary approach, can you elaborate a little bit on that and tell us do you have interdisciplinary rounds on patients?

Do you talk about these issues as a group and how does the whole team come together ultimately to help the patient?

Morrison I think it is important for people to know that both hospice and palliative care function ideally with an interdisciplinary team and that is one of the best parts about our field. All of us value that very highly and see how much that model can bring to patients and families. Our team, and most palliative care teams that I am familiar with across the country, do meet, if not daily, then weekly as a team. Our team currently meets daily in some form to check in on all of our patients and that would include our chaplain, our social worker, we have a number of mid-level practitioners, nurse practitioners and physician assistants, and our physician. We often have a pharmacy colleague or pharmacy resident working with us as well. So we have plenty of opportunities to meet. One of our team members may have new information to focus on. Our chaplain may offer certain points about where she is seeing particular distresses for a family member and that may be around faith issues or around spiritual issues that are undefined. Our social worker may add other issues around how tired and fatigued the caregiver is or the concerns for young children that may be involved and how someone is getting weaker and not able to be as present for the children. So all kinds of issues, and we do address them all together as a team offering input discussing ideas and bouncing them off each other to come up with a team approach to how we can address the various issues from different angles and hopefully offer at least support if not some practical help.

Foss I am wondering if the family members have direct access to you, for instance, if a family member wanted palliative care to get involved, how would they do that and once you are involved with the patient in the hospital, how can a family member contact you directly?

Morrison That does come up. We are occasionally contacted tangentially, usually by family members. By far most of our contacts come through our physician colleagues, or nurse colleagues. If a family member was able to get in touch with us, we would advise them to ask their physician to then put in a consult for us. Once we are involved, we are able to freely share our contact information. So families and patients should not have much difficulty getting in touch with us. We always advise them that the clinical team knows how to reach us at anytime.

13:43 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3

Foss This has been very informative to learn a little bit about palliative care. We have to break shortly for a medical minute. Please stay tuned to learn more information about palliative and hospice care with Dr. Laura Morrison.

Medical

Minute There are over 12 million cancer survivors in the United States right now and the numbers keep growing. Completing treatment for cancer is an exciting milestone, but cancer and its treatment can be a life changing experience. The return to normal activities and relationships may be difficult and cancer survivors can face other long term side effects including heart problems, osteoporosis, fertility issues and an increased risk of second cancers. Resources for survivors are available at federally designated comprehensive cancer centers such as Yale to keep cancer survivors well and focused on healthy living. This has been a medical minute brought to you as a public service by the Yale Cancer Center. More information is available at yalecancercenter.org. You are listening to the WNPR Connecticut's public media source for news and ideas.

Foss Welcome back to Yale Cancer Center Answers. This is Dr. Francine Foss and I am joined today by my guest, Dr. Laura Morrison. Today we are here discussing hospice and palliative care. Laura, we spent a lot of time at the beginning of the show talking about some of the palliative care issues that you deal with. One of the things that you mentioned was pain control and some of the pharmacy issues and one of the things that strikes me in particular about our cancer patients is that they often have very long lists of medications or polypharmacy. I am wondering if you address that as part of your approach to the patient and how you help a patient simplify that?

Morrison Absolutely, we do see that issue a lot and I would say that as we come in and start to address physical symptom issues for patients part of that is always reviewing a medication list trying to make sure that what someone is taking at home makes sense with what they are taking in the hospital and that that communication also goes smoothly. Obviously our pharmacy colleagues help tremendously with that. As I mentioned earlier, I am also trained as a geriatrician. So our group and my colleagues have that frame of mind to be looking at medications and making sure that there are no harmful drug interactions and that we minimize side effects as much as we can and that we do eliminate medications if possible that are no longer useful. We focus a great deal actually on medication management. We are always aware when we start a new medication that we need to educate the patient and family about possible side effects and we are watching that very closely, so it is a very relevant issue.

Foss Along those same lines, a lot of patients are actually afraid of pain medication. You hear so much about pain medication in the news and often times when I try to introduce that to a patient, they are afraid. They say "oh,

I do not want to start taking that. I might become addicted to that.” How do you deal with that in a patient that you know really needs this medication?

Morrison That is also a very common issue that we see and it is hard, honestly we see people on both ends of the spectrum and many people right in the middle. The people that have had some addiction

17:23 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3

issues in the past and others who have never been on anything but are equally worried about starting a new medicine, especially a pain medicine. The opioid medications need to be monitored closely. We try to let patients know, especially those with cancer, and in our current setting here at Yale we are seeing non-cancer patients as well, so there is a whole spectrum of people with dementia to organ failure of any kind as well as cancer. Cancer is very prominent but with those particular patients we try to talk it through with them, the presence of pain in their life and help them realize that it may be worth trying a very gentle first dose and seeing how someone can tolerate that balancing side effects, and knowing they are under close supervision can be helpful, but people who have cancer pain may find temporary or permanent relief, but many will continue to have pain as part of their course whether they end up being cured or not for a long period of time. We really do want to let them know that there are ways to treat their pain. We also look to non-drug therapies like complimentary therapies and fortunately in our setting at Yale we do at times have access to methods like guided imagery or massage and sometimes those are things we can add. There are also pain medicines that do not have an addiction potential. Things like antiinflammatory medications or other non-opioid pain medicines. We have many tools to potentially use and sometimes as far as using these stronger pain medicines, the opioid pain medicines, that can take some really close partnering sometimes.

Foss You mentioned the complimentary care as well and I am really glad that you mentioned that because a lot of patients are asking about herbal therapies and acupuncture and Reiki and some of those other modalities that we as physicians are not as good at knowing about. How do you educate people on that point and what do you tell patients about the benefits of those types of therapies?

Morrison Being relatively new to the setting myself, I just arrived in the New Haven area in the fall, I am actually still learning about all that we have to offer and I have been really excited about having these resources because

in my prior practice setting I had no access to offering massage and Reiki and guided imagery and other things to patients. So this is really wonderful. The evidence base for all of those therapies remains pretty early and is not really strong yet, but we are getting more studies. I generally present the option as a sort of complimentary option to drug therapy. It is rare that we can avoid drug therapy altogether, but certainly if we could it would be wonderful to introduce one of these complimentary therapies instead, but I tend to tell patients that I think it is worth a try and kind of gradually keep with them at suggesting it if they are resistant and just try to gradually open their mind a little bit and see if one of those options is one that is a little more appealing and try to get them to give it a shot.

Foss Laura, it sounds like a lot of what you do is focused on communication and is a key element of your practice. Can you talk a little bit about the whole issue of communication with patients and how you set goals with patients? What are the key elements that you strive to achieve in that communication?

21:53 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3

Morrison I would say that the element of communication and the intensity that we tend to experience with it is probably what drew me to this field initially, and I think that is true for many of my colleagues in this area. In some settings I would say I have spent probably close to 80% of my clinical time with patients in family meetings and in other forms of working on communicating. Our number one goal is always to help patients and families verbalize what the goals of their situation are, given that they have this particular disease, and we know this about the stage of their disease, or the involvement of their heart, lungs or your liver, what is it that is most important to you right now in your treatment? Where is it that you want to be spending your time? Do you want to be spending most of the time in the hospital or in the home setting? What kind of care are you looking for? And for many people that is very straight forward, especially earlier on in a disease process because they have just gotten into it. They are informed about their treatment options and that is where things are focused. But as time goes on, and if a disease progresses and someone begins to have their function change, they are less able to do things for themselves needing a lot more help and there may be more of a care load on family members. It is important to reassess where those goals are and sometimes options keep coming because our medical system is advancing and medical care is so complex that it can be very important to take say, "Well,

let us just recheck where we are.” This is what we know about the disease now, this is what we know about our options, but if you do this option you are likely to be spending most of your time in this setting, or there may be more symptoms, whereas if you choose this option, you may have less time or quality of the time may be different. So we spend a lot of time around those issues and are often brought in by our colleagues to help clarify those issues, especially around cancer and dementia and these major issues, heart disease, lung disease. Sometimes people are hearing information, but having someone else say it in a slightly different way, even different members of our team can have varying degrees of success based on a different way of communicating, so having that whole spectrum is key, and part of that communication and the richness and challenge as a clinician in palliative care is that we also interact so much with our physician colleagues, I am calling my colleagues and saying, tell me where you think things are for Ms. so and so because I want to make sure I am getting it right and seeing it and sometimes I say, well it looks to me like things might be a little different and so there is so much communication between physicians, other team members, patients and then sometimes the communication can be completely different even with family members and then if we add in the trainees and learners who are with us, often there is a whole different communication challenge. So we are constantly talking about small pearls of wisdom in the words that we choose, but we are also making sure that we are a team and that we are practicing the best quality of care that we know in our communication.

Foss I can actually echo what you are saying being on the other side. Patients that I have taken care of in the hospital, one of the things that strikes me is that patients will sometimes tell your team something that they are afraid to tell our team, their care team, perhaps related to their cancer or whether they do or do not want to take another treatment. So, it is very valuable that you have that open communication with the patient in a different way than we do as the primary caregiver.

27:03 into mp3 file http://yalecancercenter.org/podcasts/2014_0302_YCC_Answers_-_Dr_Morrison.mp3

Morrison I think it does happen occasionally that way and I think that emphasizes the need to be generous and to really focus on listening with everyone who is involved in the situation and build trust, I think that is other thing.

Foss You are alluding to your trainees, and it is great that we finally have this fellowship program here at Yale. Can you tell us a little bit about this program?

Morrison We are very excited. This will be a one year clinical fellowship in hospice and palliative medicine. The specialty became official in 2007 and the number of fellowships in the country has been growing dramatically. It is still not meeting the need that we have from our doctors but we are getting there and Yale is very excited to have its own fellowships. At this time, it will be the only such fellowship in Connecticut. There are quite a few others in the New England area but we are going to have two fellows start in July of 2014 and we are building an exciting curriculum and this is going to be an opportunity for trainees to spend time on our consultation service in the hospital here at Yale-New Haven and Smilow. They will also be out in the community at some of the hospices in the area, they will be spending some time in long-term care seeing older patients in hospice, they will be seeing some pediatric patients, so this is going to span the age range, it is also going to be spanning settings and as you have heard from me there will be a strong concentration in communication skills and also I think a special focus in our program along with everything else on physician self care and how do we keep our colleagues healthy in dealing with all of these, demanding situations where people care so much about their patients.

Foss Laura, before we end the show, you mentioned a website and I just want you to tell our listeners quickly.

Morrison For general palliative care knowledge I would recommend that people take a look at www.getpalliativecare.org.

Dr. Laura Morrison is Director of Hospice and Palliative Medicine Education and Director of the Hospice and Palliative Medicine Fellowship at Yale School of Medicine. We invite you to share your questions and comments with Dr. Foss and Dr. Chagpar. You can send them to canceranswers@yale.edu or you can leave a voicemail message at 888-234-4YCC. Archived programs from 2006 through the present are available in both audio and written versions at yalecancercenter.org. I am Bruce Barber hoping you will join us again next Sunday evening at 6 for another addition of Yale Cancer Center Answers here on WNPR Connecticut's Public Media Source for news and ideas.