Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.
Welcome to Yale Cancer Answers with 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 the role of a hospitalist in oncology care with doctors Jensia Morris and Sarah Schellhorn. Dr. Morris is director of the Smilow Hospitalist Service and Dr.
Schellhorn is an associate professor of medicine and medical oncology at the Yale School of Medicine, where Dr. Chagpar is a professor of surgical oncology.

Jensa, maybe we’ll start with you.

So I’m a hospitalist at Yale New Haven. I came to Yale a long time ago, in 2002, directly out of my training, when hospitalist wasn’t really even a word. It was a new field. There were just 2-3 doctors and about 5 physician assistants when we started,
and the field has grown dramatically.

It’s now an enormous, enormous group of hospitals, about 100 of us at Yale, taking care of hospitalized patients. And as you’re going to learn tonight, we’ve gone from taking care of general medicine patients now to subspecialties and in particular, we’re caring for oncology patients with our oncology colleagues like Dr. Schellhorn. Sarah, maybe you can tell us a bit more.
about yourself and what you do. I am a medical oncologist specializing in the treatment of breast cancer. So breast cancer has several different specialties involved in its treatment and I’m the medication piece of that. I treat, as I said, exclusively breast cancer practicing both at Yale New Haven Hospital as well as one of our outlying Smilow sites in Guilford. And I attend on the medical oncology service taking care of patients who’ve been hospitalized with cancer and complications from cancer and its treatment and work closely.
00:02:22.024 --> 00:02:24.054 with the oncology hospitalists
NOTE Confidence: 0.9353995
00:02:24.054 --> 00:02:27.840 like Doctor Morris to provide the
NOTE Confidence: 0.9353995
00:02:27.840 --> 00:02:29.990 subspecialty piece of hospital care.
NOTE Confidence: 0.92767453
00:02:31.210 --> 00:02:33.964 So Jensa to go back to what
NOTE Confidence: 0.92767453
00:02:33.964 --> 00:02:36.649 you were talking about at the top,
NOTE Confidence: 0.92767453
00:02:36.650 --> 00:02:39.010 it might be somewhat of a foreign concept,
NOTE Confidence: 0.92767453
00:02:39.010 --> 00:02:41.490 this idea of a hospitalist.
NOTE Confidence: 0.92767453
00:02:41.490 --> 00:02:43.422 I mean, many people may understand
NOTE Confidence: 0.92767453
00:02:43.422 --> 00:02:45.290 the concept of having a doctor.
NOTE Confidence: 0.92767453
00:02:45.290 --> 00:02:47.888 And if you’re a cancer patient,
NOTE Confidence: 0.92767453
00:02:47.890 --> 00:02:50.350 you likely have an oncologist
NOTE Confidence: 0.92767453
00:02:50.350 --> 00:02:52.810 or a team of oncologists.
NOTE Confidence: 0.92767453
00:02:52.810 --> 00:02:55.925 And for many, they may think,
NOTE Confidence: 0.92767453
00:02:55.930 --> 00:02:58.457 my doctor is going to take care
NOTE Confidence: 0.92767453
00:02:58.457 --> 00:03:01.250 of me whether I’m in the hospital
NOTE Confidence: 0.92767453
00:03:01.250 --> 00:03:04.010 or whether I’m an outpatient or
sometimes even when I’m at home. Has that concept changed and can you talk a little bit more about how a hospitalist fits into that? Yes, there’s a little bit of history that’s important here. So to take you back and it’s really not in the distant past, but the model used to be that a primary care doctor would come into the hospital in early morning round on his or her patients and then go back to their clinic and see all their patients all day long and then perhaps come back at the end of the day to...
see their hospitalized patients. And that became absolutely unmanageable. The pace of care in the hospital ramped up, the number of tests and treatments, that amount of communication required with patients, families, with subspecialists. It just couldn’t be managed in half an hour in the morning and half an hour in the evening. And that’s sort of how the hospitalists as a field developed. We are physicians who live and work exclusively in the hospital, provide all that complex inpatient...
care and work really, closely with the docs who know the patients best. They’re outpatient doctors. That’s how it developed in a general medicine setting. But of course, it quickly became obvious that this could be applied in subspecialty settings. Most large cancer centers now have oncology hospitalists who are internal medicine doctors generally who really have an interest in oncology care and spend all their time caring for the patients who are admitted with complications of their cancer.
And in our case, we are there all day long at the bedside from 7:00 AM to 7:00 PM working extremely closely with the patient’s primary oncologist. But the primary oncologist simply can’t be there all day long.

They have patients to care for in clinic, they have labs to run, research to do, to continue to push the field forward.

Sarah, what do you have to add there?

I can add to that a little bit.

I think there’s a lot that can happen in the hospital,
some of which is related to cancer, some of which is related to the cancer treatment and some of which is unrelated. And the pace of the field has rapidly picked up over the last decade such that there are a lot of complicated medical issues happening in the hospital and to our patients who are living longer and longer with cancer that the oncologists simply can’t keep up with because it’s a field outside of oncology. So you think about cardiac complications. Well, it’s been now more than 15 years since I cared for somebody with a cardiologic
issue in the hospital or endocrinology type problems that require really dedicated endocrinologists to be involved. I haven’t cared for someone like that in a very long time. So the benefit in my mind is not only the ability of the hospital to be present for the patient and their families and to communicate closely with us as oncologists, but to really be much more in tune with all of the medical issues that a patient might be facing and being able to provide a more comprehensive big
picture view of what’s happening and keeping the patient in the hospital.

Yeah, I think medicine is catching up to the rest of the world and understanding that team based approach is the way to go, that we can’t know everything and we need each other to provide the best possible care for our patients.

So Sarah, when we think about oncologists and the relationship that patients have with their oncologist, it tends to be a very close relationship.

And so how do you find patients
adjust to this idea?

I mean, it sounds like you’re very happy with the idea that you’ve got a partner in the hospital as a hospitalist who’s taking care of these myriad of other issues that can affect cancer patients. Do patients see it the same way? I think patients really do appreciate it once it’s explained. It’s not that I’m no longer their doctor,
00:08:02.350 --> 00:08:04.090 it’s that I’m not the doctor
00:08:04.090 --> 00:08:05.926 responsible for all of their care
00:08:05.926 --> 00:08:08.075 that’s keeping them or their care
00:08:08.075 --> 00:08:09.866 that’s going on in the hospital.
00:08:09.870 --> 00:08:17.778 So it’s a matter
00:08:14.592 --> 00:08:19.337 and we kind of introduce it as
00:08:21.670 --> 00:08:23.752 I’m still your oncologist and I’m
00:08:23.752 --> 00:08:25.608 responsible for your cancer treatment.
00:08:29.352 --> 00:08:32.056 hospital is XY and Z and Doctor Morris
00:08:32.056 --> 00:08:35.342 or another doctor
00:08:35.342 --> 00:08:37.470 who are many of our hospitalists is
00:08:37.528 --> 00:08:39.453 going to be the person who’s going
to touch base with you every day,
NOTE Confidence: 0.9279063
who’s going to be examining you,
NOTE Confidence: 0.9279063
is going to be reviewing every
NOTE Confidence: 0.9279063
single thing that happens to you in
NOTE Confidence: 0.9279063
the hospital and is responsible for
NOTE Confidence: 0.9279063
getting this acute issue dealt with
NOTE Confidence: 0.9279063
and then planning for your discharge.
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Patients I think really understand
NOTE Confidence: 0.9279063
that and they understand the complexity
NOTE Confidence: 0.9279063
of medical care in general.
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And Jensa,
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the flip side of that too is that
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while you may be caring for that
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patient while they’re in the
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hospital with the myriad of medical
NOTE Confidence: 0.9273708
problems that they may face,
ultimately that patient is going to be discharged and when they come back, if they come back, they may have a different hospitalist. And when they leave the hospital, there’s a lot of coordination that needs to happen both with their oncologist as well as, for example, their cardiologist, their nephrologist, their endocrinologist to take care of that whole myriad of problems that Sarah was talking about. How does it feel from a hospitalist standpoint in terms of not being involved in the longterm care of that patient and what
are the complexities of really coordinating care with all of these other physicians who will have to carry the baton after the patient’s hospitalization is over? So I think there are two parts to that and one part is the question that a lot of physicians ask, what is the satisfaction in that curtailed relationship when it’s not a longitudinal relationship. And I think the satisfaction is being there for someone in the real time of crisis because you’re hospitalized that is really the worst,
the most challenging time.
And there's a lot of satisfaction to truly being at the bedside in that worst possible time and really having the conversations and making it just a little bit easier for people.
And then when things are really bad and we have to have the conversations about prognosis and how much time is left and to be able to work with patients and families and give the gift of honesty and kindness and empathy, that’s really important to me and that makes the job very fulfilling.
The other part is you’re absolutely right. There sure is a lot of coordination.
and communication.

I mean I spend my entire day talking to other physicians,
talking to the patients, triangulating with the nurse and the family members and all day long is spent on the phone and at late hours of the night I'm talking to the oncologists who are still working and still in clinic and we're at the bedside and sometimes we're bringing the oncologist into the conversation at the bedside either by FaceTime or by other means. And so yes,
that is a key part of our job is all interdisciplinary communication.

Our hospitals are really a special group. They have tremendous skill in communication, not just with patients but with other clinicians. They have an ability to see the big picture which sometimes gets lost when we think about a single specialty. They’re tremendously organized which you kind of have to be in order to take care of all of these various issues and they’re incredibly empathetic and spend time and love talking to patients and their family members and help with transitions.
NOTE Confidence: 0.9420835
00:12:22.976 --> 00:12:24.954 of care at whatever point the
NOTE Confidence: 0.9420835
00:12:24.954 --> 00:12:26.490 patient is along the cancer journey.
NOTE Confidence: 0.93172455
00:12:27.810 --> 00:12:30.645 And we couldn’t do it without you
NOTE Confidence: 0.93172455
00:12:30.650 --> 00:12:32.620 helping us along and reminding us of
NOTE Confidence: 0.93172455
00:12:32.620 --> 00:12:34.090 all the things we may have forgotten.
NOTE Confidence: 0.93172455
00:12:36.130 --> 00:12:37.282 So Jensa, you know,
NOTE Confidence: 0.93172455
00:12:37.282 --> 00:12:39.719 one of the things that you mentioned is
NOTE Confidence: 0.93172455
00:12:39.719 --> 00:12:42.734 that you spend all day, every day in
NOTE Confidence: 0.93172455
00:12:42.734 --> 00:12:46.420 the hospital from 7:00 AM to 7:00 PM.
NOTE Confidence: 0.93172455
00:12:46.420 --> 00:12:48.555 But one of the questions that our
NOTE Confidence: 0.93172455
00:12:48.555 --> 00:12:50.049 listeners might have is, well,
NOTE Confidence: 0.93172455
00:12:50.049 --> 00:12:51.794 who’s looking after them the
NOTE Confidence: 0.93172455
00:12:51.794 --> 00:12:54.100 other 12 hours of the day,
NOTE Confidence: 0.93172455
00:12:54.100 --> 00:12:56.180 the 7:00 PM to 7:00 AM?
NOTE Confidence: 0.93172455
00:12:56.180 --> 00:12:59.000 Do they have a different hospitalist
NOTE Confidence: 0.93172455
or is that really the purview of the nursing staff and the house staff or do they call you after hours? How does that work? So we do have night hospitalists as well and they would be taking care of the patients taking over the baton pass off from 7:00 PM to 7:00 AM and they’re following up on things that have happened during the day. They’re following up on any recommendations that may have been placed by other teams. They’re handling urgent situations that may happen overnight. They’re continuing
to communicate with families.
There really is just a continuity of that same care that’s provided during the day.
Terrific.
Well, we’re going to take a short break for a medical minute.
Please stay tuned to learn more about the role of a hospitalist with my guests, Dr. Jensia Morris and Sarah Schellhorn.
Funding for Yale Cancer Answers comes from Smilow Cancer Hospital.
where their hematology program offers diagnosis and treatment of blood cancers including lymphoma,
leukemia, and myeloma.

More at smilowcancerhospital.org or e-mail Cancer Answers at yale.edu

The American Cancer Society estimates that nearly 150,000 people in the US will be diagnosed with colorectal cancer this year alone. When detected early, colorectal cancer is easily treated and highly curable, and men and women over the age of 45 should have regular colonoscopies to screen for the disease. Patients with colorectal cancer have more hope than ever before thanks to increased access to advanced therapies and specialized care.
Clinical trials are currently underway at federally designated comprehensive cancer centers such as Yale Cancer Center and Smilow Cancer Hospital to test innovative new treatments for colorectal cancer. Tumor gene analysis has helped improve management of colorectal cancer by identifying the patients most likely to benefit from chemotherapy and newer targeted agents resulting in more patient specific treatment. More information is available at yalecancercenter.org. You’re listening to Connecticut Public Radio.
Welcome back to Yale Cancer Answers.

This is Doctor Anees Chagpar, and I’m joined tonight by my guests, Dr. Jensa Morris and Sarah Schellhorn.

We’re talking about the role of an inpatient hospitalist.

And right before the break, Jensa, you were talking about the idea that hospitalists are really there to be kind of the extension of the patient’s oncologist and their internist, their cardiologist, and their endocrinologist. They’re really there to help these patients at a time when they are in the most need of this kind of
coordinated care and provide them that care in that hour of need. And it really seems to me that the hospitalist really is at the center of coordinating this and not only communicating back to the patient’s regular oncologist and other healthcare professionals, but then there’s also a nighttime hospitalist.

So can you talk a little bit about the handoff that occurs between the daytime hospitalist and the nighttime hospitalist? I mean, do patients feel like, you know, I’m kind of
I don’t know who my doctor is because at 7:00 AM my doctor might be doctor X, but at 7:00 PM, my doctor might be doctor Y. And then when I get out of the hospital, my doctor is doctor Z? I think you bring up a really important point. I worry the most about fragmentation of care. I think that is the highest risk for poor quality safety outcomes. It’s certainly alienating for the patient to not know who is my doctor and can I trust them that I think that’s definitely the biggest concern in how we practice medicine is yes,
we absolutely need the expertise of all these different people who have different knowledge and skills.

And yes, we need to work as a team.

But how confusing is that for the patient when there are different physicians coming in and out all day long, day and night?

Hopefully we can do some things to ease that.

One is that our doctors work 12 hours. They work seven days straight.

Yes, it’s extremely demanding but it means that there’s great continuity with the patients.
They are there and they’re truly there day in and day out. And in all fairness, then they have seven days off. Yes, indeed. And so they work 80 hours and we call it a compressed workweek. But I think it benefits the patient that kind of compressed workweek because there are fewer comings and goings. And the same applies to the nighttime hospitalists that are there for that full 12 hour time. Often times the hospitalists kind of alternate. So it might be a pair of hospitalists 1 takes the first week,
the second takes the second week and then back to the first one for the third week.

So for someone who has a prolonged hospitalization, they’ll often see the same people time and time again. And there are a limited number of hospitalists. So for people that are admitted multiple times, they can end up seeing the same doctor. I’d love to ask Jensa a question, the hospitalists have been around now for a couple of years. What changes have we seen in the care of our patients and are we improving on anything for those patients who are
in the hospital with cancer related issues?

The program was developed with a few goals in mind and one of the goals was certainly that nobody wants to be in the hospital. The hospital is the absolute worst place to be. As much as we try to make it a kind and welcoming environment, nobody wants to be here and certainly nobody wants to be here any longer than they have to be. And so one of the goals was to expedite patients care, how to get the work done, get the tests done, intervene,
get patients better so that they can get home.

And you know in medical terms we call that length of stay, how can we reduce the time patients are spending in the hospital. And the flip side, of course, is to increase the time that they're spending at home. And we did see significant reductions in length of stay with hospitalists. And it makes perfect sense. If you're there all day long, you can keep pushing the care forward. You get a result at noon.
You can order the next test or get the consultant in by 2:00 PM and you can keep moving things forward and perhaps the patient can go home by 6:00 PM. So that’s sort of the natural effect of having hospitalists. There was another effect that was that hospitalists were able to work really closely with the patients and sometimes have some difficult conversations that really require a lot of time. Really the whole family needs to be
present to talk about end of life care,
about how people want to spend
Sometimes those conversations either
aren’t appropriate in the outpatient
setting because patients are doing great,
we don’t need to have this
conversation or perhaps there
just isn’t time because we’ve got
to talk about chemotherapy,
we’ve got to sign a consent.
And there’s so many other things that
have to be done in that brief 30 minute,
15 minute appointment as an outpatient
that we can do on the inpatient
side that because we have the time.

And what we found as a result was patients were opting at much higher rate to choose less aggressive care, to choose palliative care and sometimes to choose to discontinue care and pursue Hospice.

And we actually perceive that to be a good effect of the hospitalist program because we're allowing patients to choose how they will spend their time.

And oftentimes especially near the end of life in someone with an aggressive Stage 4 cancer,
the likely benefit of therapy or what are the likely harms of therapy and what’s important to a patient. And really spending that time discussing all possible potential therapeutic options including Hospice is as Jens said time consuming but so valuable. And once those conversations can happen, oftentimes patients make very personal, very difficult decisions. The oncology group also feels that not only is decreasing length of stay incredibly important, we want patients to spend time where they want to spend time and most of
00:22:25.827 --> 00:22:27.719 the time that’s not in the hospital.
00:22:27.720 --> 00:22:28.320 And
00:22:30.720 --> 00:22:35.016 improving the numbers of patients
00:22:35.016 --> 00:22:37.674 who may or increasing the number of
00:22:37.674 --> 00:22:40.110 patients who may choose less aggressive
00:22:40.110 --> 00:22:42.095 options makes it so that patients
00:22:42.095 --> 00:22:43.670 aren’t faced with really difficult
00:22:43.724 --> 00:22:45.716 decisions while being in the hospital.
00:22:45.720 --> 00:22:49.270 I mean we never want anybody to die
00:22:49.359 --> 00:22:51.812 in the hospital getting chemotherapy if
00:22:51.812 --> 00:22:54.236 that’s not consistent with their wishes.
00:22:54.240 --> 00:22:55.848 We want their wishes to be
00:22:55.848 --> 00:22:57.520 honored as much as possible.
00:22:57.520 --> 00:23:00.478 So these are both really important
00:23:00.480 --> 00:23:01.844 improvements that the hospitalist
00:23:01.844 --> 00:23:03.200
The program has given to our Cancer Center.

And certainly, it sounds like especially reducing the length of stay would improve patients’ quality of life.

I mean, have you gotten feedback from patients either in a rigorous study where you’ve actually looked at quality of life before and after an intervention with a hospitalist or even anecdotal data from patients about how they perceive their quality of life to have improved or not so much?

I don’t think that there have been any truly robust scientific randomized trials looking at...
quality of life before and after the implementation of a hospitals program. But I think that the length of stay data speaks for itself because one’s own bed is more more comfortable than a hospital bed any day of the week. And one’s own home environment with their own TV and their own cable is far more comfortable than having to watch QVC in the hospital or whatever else is on and being able to be visited by whomever, whenever at whatever time and not limited to the restrictions of visitor.
policies especially now coming out of a three-year long pandemic where there were pretty stringent visitor policies is far more comfortable than the alternate. So I don’t think that there’s any doubt that this has improved patients lives. I think that’s a very difficult metric to capture. And certainly you know the flip side of having too many visitors in hospital with the nursing staff coming in every four hours to do vitals and so on and so forth and bells and whistles and sounds. And yes, it’s just not a pleasant
place to to have to spend time, especially when the amount of time that one might have left is limited. Have either of you had patients tell you stories about their experiences with hospitalists that you might want to share with our audience to kind of give us a flavor of what a patient’s experience might be like? I’ve already alluded to one of my dear patients that I’ve cared for for many years who’s been in and out of the hospital over the last year, who’s had the same hospitalist and who I think basically trusts that hospitalist.
more than she trusts most of her doctors

and really raves about that hospitalist.

I will share another anecdote.

I spoke to one of the hospitalists,

Doctor Parker, this morning about a patient

of mine who’s currently hospitalized

with a complication of her treatment.

And we quickly reviewed all of the damaging

that had been done over the last day or two.

We reviewed all of the testing and the

plan for getting the patient out of the

hospital and then I was able to go talk

to the patient specifically about it

sounds like things are getting better.

Here’s the plan from a hospitalist

standpoint or from a what’s keeping

except for 43
And here's the plan for when you come see me in the clinic to talk about how we're going to adjust your treatment. And she is certainly not happy to still be in the hospital, but she really appreciates how things were expedited. And I know Doctor Parker did a tremendous job to move up one of the tests to get it done quickly and we were able to review it. And so her care has been pushed forward as as Doctor Morris indicated, you know every hour the care is...
00:27:07.226 --> 00:27:08.880 moving toward getting the patient
NOTE Confidence: 0.928033200000001
00:27:08.880 --> 00:27:10.160 out of the hospital.
NOTE Confidence: 0.928033200000001
00:27:10.160 --> 00:27:12.407 It’s really a tremendous
NOTE Confidence: 0.928033200000001
00:27:12.407 --> 00:27:14.675 add to the hospital care of
NOTE Confidence: 0.928033200000001
00:27:14.675 --> 00:27:16.315 our patients with cancer.
NOTE Confidence: 0.928033200000001
00:27:16.320 --> 00:27:19.480 And I’m so grateful to have the
NOTE Confidence: 0.928033200000001
00:27:19.480 --> 00:27:21.560 opportunity to get to know Doctor
NOTE Confidence: 0.928033200000001
00:27:21.560 --> 00:27:23.460 Morris and her colleagues and
NOTE Confidence: 0.928033200000001
00:27:23.460 --> 00:27:25.000 to have them care for my patients.
NOTE Confidence: 0.928033200000001
00:27:25.000 --> 00:27:26.480 They’re getting fantastic care.
NOTE Confidence: 0.93346673
00:27:28.230 --> 00:27:29.810 You know, Jensa,
NOTE Confidence: 0.93346673
00:27:29.810 --> 00:27:31.390 to Sarah’s point though,
NOTE Confidence: 0.93346673
00:27:31.390 --> 00:27:33.740 with that patient who has
NOTE Confidence: 0.93346673
00:27:33.740 --> 00:27:35.150 her favorite hospitalist,
NOTE Confidence: 0.93346673
00:27:35.150 --> 00:27:37.432 it’s fortunate that she was able to
NOTE Confidence: 0.93346673
see the same hospitalist on the two occasions that she was in hospital.

But at the beginning of the show, you had mentioned that there are so many hospitalists now, and because we’re small, we have about 12 hospitalists now and working every other week. So really it’s six hospitals a day.
five to six hospitalists a day who are working. And because of that, it is actually quite likely that we will see a lot of the same patients and the same patients will see us. Doctor Jens Morris is director of the Smilow Hospitalist Service and Doctor Sarah Schellhorn is an associate professor of medicine and Medical oncology 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. Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.