WNPR Radio Voice Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital. Welcome to Yale Cancer Answers with the director of the Yale Cancer Center, Dr. Eric Winer. Yale Cancer Answers features conversations with oncologists and specialists who are on the forefront of the battle to fight cancer. Here's Dr. Winer.

Dr. Eric Winer [00:00:25 – 00:01:18] "Tonight, we're going to be talking about a different kind of topic. We're not going to be focusing on an individual type of cancer or on prevention. We're going to be talking about how we deliver cancer care and particularly how we deliver cancer care in the hospital. So, when people think about getting care for cancer, they think about surgeons and medical oncologists and radiation oncologists. They may think about radiologists and pathologists. But more and more, in many hospital systems, we have a group of physicians who are referred to as hospitalists—a name that I've often thought is a little funny. But we have hospitalists who are the main people taking care of patients who are physically in the hospital at any given time. We'll hear how this group of physicians developed and why they're so important. I can share with all of our listeners that without hospitalists, at virtually every academic medical center and many community hospitals around the country, we would simply not be able to take care of all of the patients that we see. So tonight, I'm joined by Dr. Jensa Morris, who leads the Smilow Hospitalist service at Yale-New Haven Hospital. Jensa is an internist by training and has been focused on in-hospital medicine for quite a number of years. And recently, over the past several years, she has focused really exclusively on the oncology population in the hospital. So welcome to the show. I'm really thrilled to have you here."

Dr. Jensa Morris "Thanks for having me."

Dr. Eric Winer "So let me just ask you, how did you get interested in this whole area of medicine that takes place in the hospital? A lot of people really love taking care of patients. They find that taking care of patients who are hospitalized is often very intense, sometimes a little more challenging than other types of medicine. But what drew you to this?"

Dr. Jensa Morris "There is no better profession. We may have a funny name—hospitalist—but we get to see it all and do it all. And it satisfies the curiosity that I get to take care of patients with all different illnesses, generally very, very sick, from the beginning of their hospital stay right through to the end. It's an intense experience because you're with people at their very, you know, most vulnerable time, and you're with them for the whole experience—from the initial crisis to, hopefully, getting better and going home. And it's satisfying in that way. And of course, being at an institution like Yale, I feel like I'm in the epicenter of all the evolving research and new drugs, and it's just—it's a constant learning environment too. So, one could say maybe I couldn't decide what I wanted to be, so I get to do it all here."

Dr. Eric Winer "Well, it's an incredibly important role because patients may not always remember every CT scan they get. They may not remember—for

those who are getting infusions like chemotherapy and immunotherapy—they may not remember every time they get a treatment in the infusion room. But I find that people really remember hospitalizations."

Dr. Jensa Morris "It's true. And they remember it because it's so traumatic. You're suddenly, you know, having to bring your toothbrush from home to the hospital—if you even have time to get it. And it's something that reminds people that they really are maybe sicker than they thought they were, because being in the hospital feels so foreign, and you feel like you lose so much control."

Dr. Eric Winer "From sort of a psychological and emotional standpoint, how do you find patients when they come into the hospital? And is part of the reason you like this because you can make that whole experience so much easier?"

Dr. Jensa Morris "Eric, I think you know me well, and that's—I mean, that's exactly what I love doing. Being hospitalized is, as you said, traumatic. If there were a stronger word, I would use it."

Dr. Eric Winer "Yeah, I'm with you."

Dr. Jensa Morris "Dehumanizing. You go from being a fully active human—wife, mother, daughter, CEO, manager—the person that you are on the outside, to becoming a patient. You sort of lose your identity and your confidence and hope. It just strips everything away. When you get into that hospital gown and are placed in an anonymous bed—and worse yet, spend 6 to 8 hours in the emergency room, or longer—it is truly traumatic. So, one of the things that I do enjoy about my work is trying to make a horrible time a little less horrible. And if that means spending more time at the bedside, making sure that our patients know they are not anonymous and that they are connected to the team they are familiar with. They may not know me, but of course, I'm working closely with their primary oncologist. I make sure that they know we are all part of a team, so they can feel like, as awful as it is, they can trust that we are on their side and doing our very best to get them through this crisis."

Dr. Eric Winer [00:07:11 – 00:07:57] "You know, some patients wonder why we need a hospitalist. You know, why is it that my regular doctor, who I see in the outpatient setting all of the time—and now I'm really talking about patients with cancer who are maybe seeing me every week, every two weeks, every three weeks, every four weeks—why can't I just be there with them when they come into the hospital? And of course, I can be there maybe once a day, maybe once every other day, but there's no way that I can be taking care of patients in clinic or doing other parts of my job and have the presence on the hospital floor that I think is necessary. And I think that what's happened with hospitals—and this is meant to be more than rhetorical, but just to make sure you agree and maybe you can say a little bit more—I think it's just really important that there be somebody who's there on the hospital floor most of the time who can deal with little problems and big problems. And you're not waiting until the end of the day for your doctor to happen to wander by."

Dr. Jensa Morris [00:07:57 – 00:09:24] "I could not agree more. Taking care of patients in the hospital is not a part-time job. As much as you, Dr. Winer, can do anything and everything for everybody, even you cannot see your patients in clinic, run your board meetings, and take care of your hospitalized patients all at the same time. It's all-consuming—not only the sort of initial clinical evaluation of the day, making the plan, following up on the plan, and coordinating with so many subspecialists—but also returning to the bedside for that ongoing communication with the patient and their family, the consultants, and the primary oncologists. And that's just the beginning. Then there are bedside procedures. We actually run what we call the Rapid Response Team in the cancer center. So, if someone becomes critically ill urgently, there is a hospitalist at the bedside instantly to take care of that urgent problem. That is not something that can wait until the end of the day. I like to think that we live in the hospital. From 7 a.m. to 7 p.m., the day doctors are here, and from 6 p.m. until 7 a.m., the nighttime hospitalists are here. It's a constant presence. The work just doesn't end. It is one continuous care team. People in the hospital are much sicker now than they were 20 years ago, when it could be done with a check-in in the morning and a check-in in the evening. That is no longer the case."

Dr. Eric Winer [00:09:24 – 00:10:16] "And they're really sicker for a few different reasons. They're sicker because we no longer hospitalize patients who aren't sick. We used to. People would come in for diagnostic workups and hang around for five days while various tests were done. That never happens anymore. And they're sicker because some of our most complex therapies that ultimately do the most good also tend to make people pretty sick."

Dr. Jensa Morris "Really sick. Yeah."

Dr. Eric Winer "And so it's—it's complicated. You know, the other thing that I think people may not realize is that for those of us who are predominantly in the outpatient setting, we lose the ability to know how, just logistically, to make everything work in the hospital. The right numbers to call to get something done. And it's—it's just a little complicated. And then, of course, I may be a breast cancer expert, but I'm no longer remotely an expert in what's the best antibiotic to give for a given kind of infection or what's the best drug to give to slow down someone's rapid heart rate. And those are things that all of you really need to know."

Dr. Jensa Morris [00:10:16 – 00:12:15] "Indeed. I would say that we are clearly the experts in the conditions that you see in the hospital, like sepsis, blood clots, heart attacks, seizures, strokes, kidney failure, pneumonia—all of those conditions. That is what we do. There are very clear guidelines and medical literature that set the standard. And for an outpatient doctor to stay updated on this massive body of medical literature that guides in-hospital management would be near impossible. So that is truly our focus."

Dr. Eric Winer "So, in your role and the role of your colleagues, who you lead as

oncology hospitalists, what's the connection with the outpatient oncologists—the patient's primary doctor, if you will? You're coming in at a time of great need, but you're not going to be seeing that patient on an ongoing basis. So what's the give and take between you and the outpatient oncologist? And I should be clear that we have things set up so that the outpatient oncologist or a member of their team is coming by and seeing the patient as well on an essentially daily basis."

Dr. Jensa Morris [00:12:15 – 00:13:59] "Eric, that's the most important question. That is the crux of everything we do—the partnership between the oncologist and the hospitalist. And it's a funny thing. When we first started the program, we spent a lot of time discussing how we're going to structure the communication between the oncologist and the hospitalist. To the point where we had algorithm charts, graphs: When are we going to call? How are we going to call? Who's going to call? Who's going to lead care at this moment versus that moment? But the truth is, we are talking all day long. We are talking by phone, by secure chat, we are communicating in the chart. Our office sits right at the entrance to the unit, so there is nobody who walks onto the unit without popping their head in and talking to us first, and then carrying on to see the patients. And then doing the reverse on the way out. It is one long conversation, and it is almost—this partnership is so seamless that it's almost like we always needed each other. We couldn't operate without each other. We finally found this perfect connection where we have some resources, and the oncologist has the other resources, and together we can fit the puzzle together. But it's a little bit like sourdough bread starter where you have to keep feeding it and replenishing it to make that relationship work. And I think that it's easy to imagine that in some systems, it can fail. But if you have a commitment to it, it really potentially provides the very best care."

Dr. Eric Winer "Listen, we're going to have to take a very brief break. I will be back with you, Jensa Morris, Oncology Hospitalist leader at Smilow Cancer Hospital."

WNPR Radio Voice [00:14:27 – 00:14:53] "Funding for Yale Cancer Answers comes from Smilow Cancer Hospital, where a team of specialists provide genetic testing to inform patients of their cancer risk. Learn more about Smilow's Genetics and Prevention Program at SmilowCancerHospital.org." "The American Cancer Society estimates that over 200,000 cases of melanoma will be diagnosed in the United States this year, with over a thousand patients in Connecticut alone. While melanoma accounts for only about 1% of skin cancer cases, it causes the most skin cancer deaths. But when detected early, it is easily treated and highly curable. Clinical trials are currently underway at federally designated comprehensive cancer centers, such as Yale Cancer Center and at Smilow Cancer Hospital, to test innovative new treatments for melanoma. The goal of the Specialized Programs of Research Excellence in Skin Cancer grant is to better understand the biology of skin cancer, with a focus on discovering targets that will lead to improved diagnosis and treatment. More information

is available at YaleCancerCenter.org. You're listening to Connecticut Public Radio."

Dr. Eric Winer [00:15:54 – 00:16:21] "Welcome back to Yale Cancer Answers. I'm Dr. Eric Winer, and I'm joined tonight by Dr. Jensa Morris, who leads our hospitalist program at Smilow Cancer Hospital. We've been talking about the really critical role that oncology hospitalists play in taking care of our patients who need to come into the hospital. And of course, I should say that we never like to bring people into the hospital if we can avoid it. We always have a preference to manage people as long as we can do so safely in the outpatient setting. But nonetheless, it happens a lot that people come into the hospital. So, Jensa, maybe you could just describe some of the common reasons people are hospitalized when they have cancer."

Dr. Jensa Morris [00:16:21 – 00:17:40] "I think the most common reason for hospitalization in folks with cancer is infections. Infections are common in the general population, but cancer patients are particularly vulnerable—sometimes because they're receiving immune-suppressing therapy or chemotherapy, and sometimes because of certain topical changes or surgical interventions. And that is the most common complication. A simple infection can rapidly lead to sepsis, which is a life-threatening condition. And that's what we're here for."

Dr. Eric Winer "Sepsis typically means that there's a severe infection, and there's often bacteria in the bloodstream itself. The blood pressure can go down, people can develop shortness of breath, and it can really be very, very serious. We try to identify that as early as possible because early identification of sepsis really changes the clinical course. And so having the hospitalist—the doctor who's right there at the bedside—is really critical in changing outcomes in sepsis."

Dr. Jensa Morris "Yes. Effective management of these kinds of complications is part of the reason why people, even with very advanced forms of cancer, live longer than was ever the case in the past."

Dr. Eric Winer "And then there are other problems—there are blood counts, there are adverse reactions to treatment. You know, these must come up. Although it's interesting, with blood clots, we used to always bring people into the hospital, and now our therapy has evolved, so it's not so common."

Dr. Jensa Morris [00:17:40 – 00:18:45] "Yeah, we actually just completed a clinical pathway that can manage not only blood clots in the legs but even blood clots in the lungs. Lower-risk blood clots in the lungs can be managed very comfortably and safely at home, which is terrific because it just saves hours in the emergency department, an inpatient stay, and all the things people don't want to do."

Dr. Eric Winer "There is something to be said occasionally for bringing people into the hospital. And sometimes I think that we struggle to keep people out when it's just almost easier for them—either because they don't have the right

support at home, or because they're just really a little sicker than they can manage at home—to be in the hospital and to allow them to recover in the hospital."

Dr. Jensa Morris "Yes, there's definitely truth in that. I think that is one of the complexities of cancer care in particular. It isn't a single episode of illness—it is an ongoing process. And the amount of social supports that are required to get someone through that sort of intermittent illness is much, much greater than a single healthy patient who gets pneumonia and then returns home. It's really very different."

Dr. Eric Winer [00:18:45 – 00:20:41] "So I want to talk about something a little different, and this relates to the financial aspects of healthcare. Of course, we want to send people home as quickly as we can, but sometimes I think patients are worried, and doctors feel pressured, to get people out of the hospital as soon as possible. Because, certainly when we talk about government payment for healthcare, it's set up that for a given diagnosis, the hospital is paid a certain amount of money. And that sum doesn't get bigger the longer someone stays in the hospital. I'm just curious how much pressure you feel at times—or you think your colleagues around the country feel—to get people out."

Dr. Jensa Morris [00:20:41 – 00:22:24] "It's a dilemma. The metric that we use is length of stay, and there is an enormous amount of pressure to reduce length of stay. I have trouble conceptualizing it that way from a financial perspective—that's just not the way my brain is wired. So I have to reframe it in my mind and in how I discuss it with my colleagues as patient-centered care. What is best for the patient? And if the best for the patient is not to be in the hospital, then we are going to do everything we can to create a safe discharge plan. And in general, high-quality care is associated with shorter lengths of stay. The other thing that I emphasize to my colleagues is that the main way to reduce length of stay is to be absolutely meticulous with your daily care. Listen very carefully to the patient, know exactly what's going on, plan carefully, communicate early, communicate with the family, communicate with the consultants. If you are taking really good care of your patient, you will have a shorter length of stay."

Dr. Eric Winer [00:22:24 – 00:23:21] "I absolutely love the way you said that, because I couldn't agree more. We should never feel pressured to get people out before they need to be out. And if, in fact, we take great care of people—and I'm going to add one more piece to this—but if we take great care of people, we're going to shorten the length of stay. And then, of course, the other piece is just providing efficient care, which you said without saying. You know, at times—still today, and oftentimes in the past—people would stay an extra day or two because some test just didn't happen to get done or because a prescription wasn't written. And those are the kinds of things—these sort of mechanical parts of healthcare—that we need to attend to as well."

Dr. Jensa Morris [00:23:21 – 00:24:20] "Yes, you have certainly hit a nerve. I know, based on my experience, that the longer you spend with the patient

listening and taking a careful history, the fewer tests you're going to need to do, and the less time it will take you to get to the diagnosis. So, if you put all your energy and time into that initial history-taking, you can save a whole lot of tests for the patient. If you simply take a minor history and say, 'They have chest pain,' well, there are about 26 different studies you're going to need to do to figure out what's causing their chest pain. So really spending the time is the key."

Dr. Eric Winer [00:24:20 – 00:25:01] "You know, another topic that I just want to get to briefly is about participation of family members and friends. Because, you know, in the past, there was certainly a tendency—and now I'm talking about 30 years ago, 40 years ago, 50 years ago—to get family members out. There would be limited visiting times, and somehow they were thought to be a nuisance. And it is just so important to have someone else around as much as they can be around, because they're there acting as the patient's advocate at a time when the patient may not feel quite up to asking all the questions themselves."

Dr. Jensa Morris [00:25:01 – 00:25:41] "No truer words. Absolutely. If we could have someone stay with all our patients 24/7, that would be the ideal. It would provide the safest, best care. Everything would be better. The folks who are alone in the hospital late at night tell me that they can't sleep. They're just thinking about their diagnosis, they're thinking about what's going to happen. And if you don't sleep, you can't heal. Just having a reassuring presence at the bedside is so critical to your clinical improvement."

Dr. Eric Winer [00:25:42 – 00:26:15] "So we're doing better in cancer medicine. More people are cured. More people are living longer. But I think, as everyone listening to this show realizes, there are people who still die from cancer. And although many times—in fact, the majority of times—people are able to be cared for in their home, there are occasionally times when people come into the hospital and will pass while they're in the hospital. And there are many more times when people come in for what may be comfort measures or end-of-life care and then go home. How is that? How is that for all the doctors in the hospital? It's a pretty tough thing to see a lot of sick people and people who are near the end of their life. And how do you optimize the care that people get?"

Dr. Jensa Morris [00:26:15 – 00:28:07] "There are a few critical elements to that question. Yes, many of our patients—we see them on multiple visits. Sometimes we see them from the beginning of their cancer diagnosis when they first present, maybe a few times in between, and then we see them near the end of life. Someone once told me that we have to redefine what success is in cancer care. We really have to know how we can help in the given situation. And so I do think that near the end of life, our job is to provide the most compassionate care, to understand the patient's wishes, the family's wishes, and how to provide the most comfortable death if that is inevitable. The other part of the question is, what is it like for doctors who are caring for patients always in—or often in—end-of-life situations? The great thing for an oncologist is they see all the

successes, all the patients who go on and do really, really well. I think it's an extraordinary group of doctors who chose this particular specialty for a reason. But I do think we have to be really aware and make sure that the group can continue to provide the highest quality, compassionate, empathic care at the bedside."

WNPR Radio Voice Dr. Jensa Morris is an associate clinical professor at the Yale School of Medicine and director of the Smilow Hospitalist Service. 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 time to learn more about the fight against cancer.

Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.