

Dr. Lawrence Solomon and Leslie Blatt, APRN, Palliative Care for Cancer Patients August 8, 2010 Welcome to Yale Cancer Center Answers with Dr. Ed Chu and Dr. Francine Foss, I am Bruce Barber. Dr. Chu is Deputy Director and Chief of Medical Oncology at Yale Cancer Center and Dr. Foss is a Professor of Medical Oncology and Dermatology specializing in the treatment of lymphomas. If you would like to join the conversation, you can contact the doctors directly. The address is canceranswers@yale.edu and the phone number is 1888-234-4YCC. This evening Francine is joined by Dr. Lawrence Solomon, Associate Professor of Medicine and Director of the Yale-New Haven Hospital Adult Palliative Care Service, and Leslie Blatt, APRN who is the Clinical Director of the program. Here is Francine Foss. Foss Let's start off by talking about a very basic question, what is palliative care and when is it typically recommended for patients with cancer? Solomon Palliative care is a relatively new medical specialty, and it is directed towards improving the quality of life of patients and their families who are faced with a life threatening illness. Its goal is to identify and treat both symptoms and concerns whether they be physical such as pain, emotional, social, or spiritual. To do this it requires the skills of a multidisciplinary team consisting of physicians, nurses, social workers and pastoral care representatives, among others. Historically, palliative care was focused on patients with incurable forms of cancer, but this specialty has a role in assisting patients with many other serious illnesses such as those associated with severe impairment of heart, lung, kidney, liver, or neurologic function. Foss That is really an important point Larry, because most of us think about palliative care only in the setting of cancer. Solomon This has been a real shift over the last 5 to 10 years to include these other disorders as well. Foss Let me ask both of you how you got involved in palliative care. Could we start with you Leslie? Blatt I feel I have been doing pieces of palliative care throughout my nursing career. I initially worked in the intensive care unit and I did some hospice nursing for a while and then as a psychiatric liaison nurse. I think for me palliative care combines all my areas of interest, which is acute medicine but also focusing on how that illness impacts the patient and their family because I do not think you can really separate the disease from what else is going on in the patient's life. As Larry was saying earlier, it encompasses all the things that make up a patient. So that's how I got interested. Foss Leslie, you are an APRN, which is an advanced practice nurse, could you just tell our audience how that differs from an RN? 2:54 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> Blatt I have gone back to school and I have gotten my masters degree and that allows me to have prescriptive authority, so I am able to write prescriptions and medications for patients. Foss Larry, how did you get involved in palliative care? Solomon For me it was somewhat a matter of serendipity related to time and place. I actually started my career in this area in the 1970s in cancer treatment and about that same time is when awareness of the many needs of patients with incurable illnesses was coming to the forefront in medical communities. It is also the time that Florence Wald established the first hospice in the United States right in New Haven, Connecticut where I was working. Later, I had the opportunity to work at that institution and was

just amazed at the impact good symptom management by an interdisciplinary team could have on a patient and their family, and this experience ultimately lead to my current work in palliative care.

Foss You mentioned hospice, could you just clarify for our audience who may not be familiar with that term, what is hospice?

Solomon Hospice is involved with the care of patients towards the ends of life when treatments that try to either cure or control an illness are no longer effective. That was actually a starting point for approaches to keeping patients comfortable and helping with all phases of their life in the face of such illness, and eventually extended into palliative care.

Foss I did not know that the first hospice was here in Connecticut.

Solomon Absolutely, Florence Wald was the main driver of that movement with some colleagues here following the leadership of Cicely Saunders in England and bringing that program here.

Foss Larry, could you talk a little bit about the term 'palliative care' and tell us when palliative care was first introduced in the medical world?

Solomon It came as an offshoot, if you will, or rather an extension of hospice care. Hospice care in the 1960s started recognizing the patient's family needs towards the end-of-life. These program approaches to improve quality of life grew and became more and more effective and it became recognized that these approaches, and the support for the family, was valuable not just at the end of life, but throughout the course of the significant illness, and this concept led to palliative care becoming recognized as an approach about a decade later and just four years ago it became a formal specialty here in the U.S.

Foss Physicians now can be so called board certified in palliative care?

Solomon Yes.

Foss And those palliative care physicians are they primarily oncologists, or do they represent all different subspecialties?

Solomon Actually, they are spread all over the clinical map. A lot of them came from oncology initially, but a lot come directly to this specialty from a variety of places as diverse as generalized internal medicine, radiation therapy, radiology, and emergency room medicine. All those are sources of potential palliative care physicians.

Foss As a palliative care physician, do you consider yourself a general internist; I mean you cover all different areas of involvement for that patient?

Solomon One of the greatest challenges of palliative care is to keep your mind open as to what can be going on and impacting on a patient's life, and to that end, I do think of myself as an internist to look for opportunities to improve the wellbeing of patients by understanding that other things may be going on over and above the underlying illness.

Foss Leslie, you also mentioned that your background in psychiatry and other areas has contributed significantly to your ability to work with this group of patients.

Blatt Yes, I think that one of the things that we both do pretty consistently is just listen to people and help them through difficult transitions that they go through, and so communication is a really important part of what we do.

Foss Could we talk a little bit about the differences between end-of-life care and palliative care?

Solomon Those distinctions are very, very important. As I mentioned, hospice became an area of care that was focused towards the end of life. This was a time when treatments directed to either curing or controlling an illness were no longer effective. In contrast, palliative care begins early in

the course of a life threatening illness. It works concurrently with all efforts possible to cure or control the disease. Foss So palliative care doesn't necessarily mean that a patient isn't undergoing treatment. Solomon Absolutely right, and that treatment can even eventually result in cure. Foss In your mind then, do you distinguish between end-of-life and palliative when you see an individual patient? Is there a marker between those two or is it a transition? 8:16 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> Solomon Definitely the latter. This is part of the continuum which may end either successfully with cure of the disease, or with the patient's death later on, but nonetheless the same techniques remain to improve quality of life throughout the course of the illness. Blatt It takes the best of the hospice model, which is really focusing on the patient and their family and brings it much more forward in the course of the care, and if you think about it, if the disease does not just affect the patient, but their whole life, to have the recourses available to help people and their family deal with the changes that occur with any chronic or life threatening illness is really important, and I think that is what palliative care brings. Foss Can you tell us a little bit about how a palliative care program is put together, the program at Yale- New Haven? How long has it been in operation and what are your roles in the program? Blatt We have been in existence approximately going on three years and we continue to grow. We average about 40 to 50 new consults a month and I have a daily census of about 12 to 15 patients. We are really excited about the growth of our program and that we receive consults from all over the hospital, although at this moment the majority of our patients do have a cancer diagnosis. The attending physician invites us to come in and often consults are at the prompting of the nurses or the social workers or Chaplains on the unit. This is often how we get our consults. Our role is that we usually see patients together for the first consult and the reason for that is partly because we both hear the information from a different perspective as well as trying to limit the amount of time somebody has to tell their story, because if you have ever been in a hospital, you know that there are a ton of people that come in and ask people to repeat the same information over and over again. After that, I am usually doing the follow-ups and if there are any questions or concerns we discuss the cases pretty much on a daily basis. Foss If a patient were to initiate a consult, they could do that by talking to their nurse, for instance, or their physician if they wanted to talk to a palliative care doctor. Blatt Yes, usually we do like the attending physician to invite us into the case and most of the time when patients have asked for our services, everyone usually complies. It is also important to note that palliative care programs also lead to patient's satisfaction. So that can also look good for that hospital, the attending physician, and us as well. Foss Now it gets back to a basic question, which is, if a patient is in the hospital for particularly a prolonged period of time, how does a patient actually find out that palliative care is even out there? Solomon There are many ways that they may hear about our services; one is of course from the clinician themselves, secondly, palliative care is very much in the new these days about these options in 11:34 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer->

answers-solomon-blatt.mp3 their care and they may hear about it from family members and friends. They may hear about it from other healthcare workers as well. Foss Are there conversations within the hospital, interdisciplinary conversations, where palliative care gets brought up say in the management of a patient? Blatt It does happen and oftentimes it happens on the daily rounds on an individual team, and I know the nurses and social workers are well acquainted with what our services can offer and oftentimes it starts with anybody that is having a symptom that needs additional management and that's often how we get involved initially into the consult. Foss Can you tell us a little bit about what the major issues are that patients are facing financially, with family, etc. What are the key issues for patients nowadays? Blatt It is varied, as our patients are varied, so are their issues, but oftentimes it involves a lot about transition points in their care. Frequently, it is related to loss. This happens right along through any chronic illness as well as the other transition phases that may occur. Oftentimes when treatment goals need to change or psychological or spiritual issues may also impact that. I think it is a combination of things, not just the physical issues, not just transition points, but also how that illness has impacted them in their daily life, how it changes their roles in the world, and in their family. Foss With the current economic situation, have you seen more patients who have financial concerns as well that impact them? Blatt I think financial concerns are always there and yes, I would have to say that is true because the economic times make it even more difficult than it has been previously. Foss I would like to talk a little bit more about what you are doing with specific patients and specific diseases when we come back. We are going to take a break now for a medical minute. Please stay tuned to learn more about palliative care with my guests Dr. Lawrence Solomon and Leslie Blatt. 14:34 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> Foss Welcome back to Yale Cancer Center Answers. This is Dr. Francine Foss and my guests tonight are Dr. Lawrence Solomon and Leslie Blatt who join me to talk about palliative care. We talked a little bit about what palliative care is and I would like to ask a question which is, how has palliative care changed over the last couple of years? Solomon That is a very important question Francine because, in fact, understanding the role of palliative care by both patients and physicians is still often limited. Palliative care continues to be equated with hospice and end-of-life care and it is still frequently considered to be a last resort, even though palliative care can be very much a part of a therapeutic program aiming to cure or control an illness. In addition, many patients and physicians continue to believe that in hospice care and palliative care, the use of morphine and related medications actually shortens survival and produces serious side effects; this is simply not the case. In fact, a recent study from Harvard, presented just this month at the American Society of Clinical Oncology Meeting actually showed that palliative care given to patients within curable lung cancer not only improved the quality of life, but actually increased survival as well. Foss That gets us to another issue, for many cancer patients one of the major things that they grapple with in addition to their diagnosis are all the side effects and the fatigue and the emo-

tional stress related to the treatment itself. Do you actually help patients to manage this? Solomon Yes, we are involved with that as well. Most oncologists are very aware of these frequent side effects that are absolutely devastating and frightening to patients as they anticipate their treatment. These include nausea, diarrhea, and loss of appetite, weakness, and increase in pain. All of these impact on the emotional well being of both the patient and their family. The oncologist can anticipate many of these and does control them very well with medications both before and during the administration of chemotherapy. On other occasions, we can be helpful in identifying additional factors that can contribute to these symptoms and provide new therapeutic approaches to help control them as well. Foss Do you also help patients in terms of integration of other modalities, say if they need dietary advice or exercise or other quality of life issues? 17:34 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> Solomon Absolutely, and I think we should talk about the interdisciplinary team. I mentioned just a small portion of that, but involvement of a dietician, physical therapist, and a pharmacist to help with more usable forms of mediation are all important to optimizing what can be done for a patient. Foss Can you describe what a typical meeting or session with a patient is like? Blatt There is actually not a typical session or meeting, but what we try to do is give a comprehensive assessment that includes not only the physical, but also the psychological and spiritual realm and see what we can do to help improve the patient and their family's quality of life. We try to get a sense of who they are and what their goals are so that we know how best we can help. We actually take our lead from them much of the time. Foss Do you oftentimes meet with family at the same time that you meet with the patient? Or do you have individual meetings with family at separate times, how do you work that in? Blatt We like to meet with the families and if they are in the room when we are doing our initial assessment, we certainly invite them to stay if it is okay with the patient, and most of the time it is. If we do not meet them on our initial visit, at some point during the person's hospital stay we will meet with them and sit down and talk with the patient and the family as a whole and if the family wants to see us separately we do that as well. Foss Another thing for patients to know is that you actually bridge the inpatient and the outpatient, your practice is in both arenas. Solomon Absolutely, we are seeing patients right now a half day a week in clinic. Many of these are follow-ups of patients we have met for the first time in the hospital, but also we are getting to meet many patients earlier in the course of their disease through the outpatient clinic. Foss Why is it so important for physicians to be aware of the benefits of palliative care? Solomon In this day-and-age, physician training is often very specialized to be on the top of what you do and provide quality of care in all areas of medicine. You have to be aware of a body of knowledge that is expanding at a very great rate and physicians are also facing enormous demands on their time. In palliative care, we can compliment what physicians are doing for the care of their patient's by providing additional time to identify and address patient's family concerns and providing additional expertise in symptom management. Foss I know that you also work ex-

tensively with other staff in the hospital, in fact you have mentored a20:21 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> number of our medical students and fellows and physician assistants, and that is a big part of the program for you. Solomon Training is key. Being able to help others implement techniques which we know are effective is an important goal for us. Leslie and I often lecture to the physicians, nurses, and students in all realms of the clinical arena to help them learn approaches to pain and other symptom management. Foss I know Larry, that you have gotten a number of our oncology fellows interested in this whole area of palliative care and have successfully sent a couple of those folks out into practice, which is really remarkable. Solomon We have had some wonderful young people to work with and that is an exciting part of what we do. Foss Leslie, from the point of view of nursing, is there now a nursing specialty for APRNs for palliative care? Blatt There is a nursing specialty, but like with the physicians who can come into palliative care with a wide variety of masters programs. It is also board certified, so most APRNs in palliative care are board certified in that specialty as well, and I would just like to say that we also have been involved in teaching some of the masters students and actually our newest addition to our service will be somebody that shared their clinical experience with us. Foss Leslie, could you talk a little bit from the point of view of the family members, we have talked about some of the issues for the patients, but it is hard for family members to accept the whole concept of palliative care too. How do you work with them around that issue? Blatt I think the concept of palliative care is really that we help their family member have as good a quality of life as possible, and once you get to know us, we joke around and say you cannot really get rid of us, but people do seem to like us as a team as well. Some other things that we can help families do is clarify the medical information that they get. We have the luxury of having the time and ability to be able to listen to a lot of their questions. Now-a-days people get so much information that they think they understand it, but it is really only after being able to talk about it a couple of times that they are able to really comprehend it cognitively in their minds, so we give them the time, we provide support and reassurance and I think we also allow them to be able to discuss some of their fears and worries that they have about their family member and it is really helping them live oftentimes in parallel realities. We often say it is hoping for the best, but also being prepared for the worst as well as emphasizing what can be done. I think this is the most23:22 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> important point, that there is always something that can be done for the patient and for the family whether it symptom control, emotional support, preservation, or dignity. Foss That's a key point for patients and for families, that even if the situation looks bleak, there is always some element of hope that you can help those folks in some way. Solomon Importantly, hope can be focused on medications, cure, or treatment of the disease, it can also be focused on completion of life goals with family, friends, and spiritual completion as well. Hope is an ongoing element that we support. Foss Another important point that I have certainly noticed in my relationship with your practice is that there is of-

tentimes a dichotomy between what you tell the patient and their family and what they really understand, and you have often been able to get involved in those discussion as well and help to focus back to the reality and help everybody to get on the same page because you have probably a better handle on what people are really thinking.

Solomon It's not so much a better handle as this is what we are focused on doing. It is an old medical axiom that most of what you solve in terms of patient's need starts and ends with the history and having the time to listen to what the patient has to say, and to asks questions back to be sure they understand our words and we understand their words, and it helps to move the process forward.

Foss So you have developed this outstanding palliative care program at Yale-New Haven and I am wondering, are there programs like this at other hospitals?

Blatt There actually are and I think the growth of palliative care programs has increased in the last eight years or so and the latest figure right now is that 81% of hospitals with greater than 300 beds have palliative care programs.

Foss What are some of the future goals for palliative care, specifically at Yale-New Haven?

Solomon At this point we have three major goals. First and foremost we are in the process of increasing our staffing so that we can expand our services both in the outpatient clinic arena and also broaden the spectrum of illnesses that we see both inpatient and outpatient. Second, we believe that teaching is extremely important and ultimately we hope to expand our role in that to include a palliative fellowship program, and last, but not least, all medicine has to move forward by careful investigation and we believe research to improve what we do is essential and that this must be done without compromising either the comfort or safety of our patients and their families.

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Blatt Just one other goal that we have is to hopefully become involved at the beginning of a life threatening illness or serious illness.

Foss Now is there a way for that to happen from a practical point of view?

Solomon Time, we hope as people become more exposed to what we do and more comfortable that we are not an alternative, but a concurrent form of treatment, I hope that will happen. We work very hard to communicate back to the physicians who refer to us so they understand the process of what we are doing, that's one part, second that we ensure continuity of care and consistency of care of our patients and we hope that approach overtime will lead to earlier involvement with patients with these illnesses.

Foss If a patient wants to find out more about palliative care, are there websites, is there a palliative care foundation or other resources available?

Blatt There are lots of websites about palliative care and actually on Smilow Cancer Center website there is a palliative care component so people can look at Yale to get a better idea of us, and you can Google palliative care and you will come up with a large number of palliative care resources.

Foss Larry, could you talk a little bit about what clinical trials you think might be interesting in the future to do in palliative care?

Solomon We have a wish list of things that we would like to focus on, simple things that need to be better understood. We know some medicines that have been effective in improving side effects related to radiation therapy in one area of the body, and have not been used in another, so we would like to look

at that. We know that we make a lot of assumptions about how medicines are absorbed, but those assumptions are based on people who are otherwise well and we want to make sure that the same thing applies to patient with the kinds of illnesses we deal with and we want to look at the timeline of our involvement and patient care and the use of sort of unusual agents in helping with neuropathies and other side effects of treatments, so there are many things that we have to think about and as time permits we will begin to look in the coming year. Foss And the use of pain control is something that obviously you are involved in as well? Solomon I think pain control is central to everything we do in that pain impacts on so many other things, it affects mental status, emotions, general well being, and the ability to function, so looking for ways to make that better is always on our agenda. Foss Thank you both for joining me tonight. It has been really great to get some detailed information29:08 into mp3 file <http://yalecancercenter.org/podcast/aug0810-cancer-answers-solomon-blatt.mp3> and understanding about palliative care. This is Dr. Francine Foss from Yale Cancer Center wishing you a safe and healthy week. If you have questions or would like to share your comments, visit yalecancercenter.org where you can also subscribe to our pod cast and find written transcription of past programs. I am Bruce Barber and you are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.