Welcome to Yale Cancer Center Answers with Dr. Francine Foss and Dr. Anees Chagpar. Dr. Foss is a Professor of Medical Oncology and Dermatology, specializing in the treatment of lymphomas. Dr. Chagpar is Associate Professor of Surgical Oncology and Director of the Breast Center at Smilow Cancer Hospital at Yale-New Haven. 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 1-888-234-4YCC. This week, Dr. Chagpar welcomes Dr. Andrew Putnam. Dr. Putnam is Assistant Professor of Internal Medicine and part of the Palliative Care Team at Smilow Center Hospital. Here is Anees Chagpar.

Chagpar Let's start off by having you tell us a little bit about how long you have been here at Yale and what you are going to be doing now that you here.

Putnam I just started, in fact I am still in my first month. I started September 1, 2012, as a palliative care doctor at Smilow Cancer Hospital. I spent the last 11 years down at Georgetown University in Washington D.C. doing palliative care with patients as well as teaching palliative care and pain management to students at the Georgetown Medical School.

Chagpar That's fantastic. There has been a lot of talk about palliative care and I think there are many different perceptions about what palliative care really is. Can you define the concept for us and tell us a little bit more about what exactly it is and what exactly you do on a day-to-day basis.

Putnam Palliative care has been a specialty only for about five years and so people naturally are confused, physicians, nurses, as well as laypeople. If you are a cardiologist, everyone knows you treat the heart. If you are a pulmonologist, it is the lungs. With palliative care the main idea is trying to keep people comfortable and help them when they are sick. So, the first part is the difference with hospices, hospices is end-of-life care and that is when you are getting very sick and there is not much more that can be done to treat the cancer or whatever your disease is. But about 80% of the patients that I take care of are palliative care patients, but are not eligible for hospice. For example, about three years ago I had a patient who had prostate cancer and he had his prostate removed and all he had left was a single metastasis on his spine, but he could not lie down and get radiation that was going to cure him because it hurt too much. So the radiation oncologist asked me to treat him and get his pain under control, which I did and then he was able to get his radiation and to the best of our knowledge he is cured and out playing golf somewhere, that is also palliative care. So, palliative care really is pain and symptom management as well as helping people identify goals of care and what they want in their life at any point in their disease process. If I have a cancer patient that I am helping along with the oncologist, they are still the captain of the ship, and still very much involved, however, while the captain is fighting the cancer, I try and make the patient feel better. We work with the patients, we work with the family as well to help them deal with what is going on. This is not all just me, I' am part of a team, and we have physicians, we have nurse practitioners, we have a physician's assistant, social workers as well as a chaplain and

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we work as a team, as a palliative care team to try and work on the patient as a whole person and that also makes it difficult to really pin down what palliative care is because we do not treat one part of the body, we treat the whole person as well as the family.

Chagpar It sounds like you are really involved in that multidisciplinary cancer team in taking care of the whole patient along with the oncologist, the surgeon, the radiation oncologist, the whole group.

Putnam Yes, we are part of the team, we add an extra layer of care beyond what the others are doing and this allows the oncologist to focus on the cancer, the radiation oncologist to focus on the radiation, and we focus on making the patient feel as good as we can while all of this is going on.

Chagpar At what point are you involved? Are you involved with every single patient? Are you involved in general at the very beginning, or does it vary by patient?

Putnam I am here working with Dr. Jennifer Kapo, who was hired here back in the spring to run palliative care and so I am basically here to help her and help expand the program along with Dr. Lawrence Solomon who has been here forever, but doing palliative care for about five years and so we are a consult services, which means we need to be called in by the oncologist and we can be called in at any time. The World Health Organization said back in 1990 that they thought every patient should have a palliative care doctor as well as an oncologist, however, unless I can clone myself and Jennifer and Lawrence and make a few thousand of us, that's not possible. But what we would like to do is be involved at the point where we are needed. Sometimes that is when the patient first comes to see the oncologist, they may have severe pain, severe nausea, vomiting and the oncologist could use us to help then. Other times we are not involved until much later. So the answer is we are involved when we are called and when we are needed.

Chagpar But you are available.

Putnam We are available.

Chagpar That is fantastic. Another thing that came up in the literature and even in the lay press a few years ago was about a study looking at palliative care and you mentioned that so many of us had always thought about palliative care as being equivalent to hospice, or end-of-life care, but this study talked about the fact that palliative care does not in fact shorten life, it actually could prolong life, is that right?

Putnam Yes, the study was done at Mass General Hospital a couple of years ago and in fact Dr. Tom Lynch who is Director of Yale Cancer Center was one of the authors of that paper. They looked at lung cancer patients and took one group and had them get palliative care consults and be followed by palliative care and another group who just had the regular good care that the others did, the only difference was palliative care was involved and the people who had palliative care consults

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surprisingly lived several months longer on average than the people who did have palliative care consults. Now that is one study and people all over the country are redoing those studies to try and see if it is repeatable, but when I think about it, it make sense to me that if someone's pain is controlled, if they are not throwing up all the time, if they are much more comfortable and able to enjoy life while they are getting treated, they would probably have more will to live and probably live longer. Although except for that one study there is no evidence of that, that is just my bias.

Chagpar Right, but there are no studies to show that palliative care shortens life either?

Putnam No, not at all. Even for hospice, when someone goes to hospice, hospice does not do anything to shorten life. Hospice just emphasizes the goals of care now to keep someone comfortable. So instead of giving them chemotherapy and trying to fight the cancer, it is how do we keep this person comfortable? I've had patients who lived three to four years on hospice.

Chagpar Wow.

Putnam And I have had patients who we thought were going to do very poorly and they did well and so they literally got kicked off of hospice because they were too healthy. Hospice does not do anything to bump people off, so to speak, but they just emphasize the comfort, so they would not necessarily make people die sooner either.

Chagpar And it sounds like one of the things that is really central to the whole palliative care concept is an emphasis on quality of life as well.

Putnam That is exactly right, if you have cancer and you are trying to live as long as you can that is great, but if you are feeling awful the whole time, there is not much point to that, although you may get a longer life. So with palliative care, that was a great way of saying it, emphasizes the quality of life as opposed to the quantity, where we let the various oncologists work on that.

Chagpar I want to get back to something that you mentioned that I think is so integral, not just in palliative care but in cancer care in general, which is this team approach. Tell me more about how that works and how it fits in both in terms of the palliative care team, but also how what team integrates into the bigger team and why this teamwork is so important?

Putnam The basic palliative care team around the country is a doctor, a nurse, a social worker, and a chaplain, each using their special abilities to help treat patients. Some places also have a physical therapist, music therapists, and acupuncturists, anything that can help the patient feel better. The idea is that what is bothering sometimes is physical pain or nausea, in which case it is probably best that I work hard there, but there is always going to be concern about the disease, worry about the future and so for some people, the social worker will be involved and I won't be, or the chaplain may be the best person, and so having that team approach means that one or two people can

10:20 into mp3 file http://yalecancercenter.org/podcasts/2012%201021%20YCC%20Answers%20-%20Dr%20Putnam%20copy.mp3 take the lead or we can all be involved and really treat different aspects of what is going on, so that is the palliative care team and as I said earlier, trying to treat the whole person. We get involved with a patient who already has an oncologist, has nurses, already has people with whom they have relationships, who have been treating them, maybe for a long time, maybe not so long. We do not want to get in the way of those because the nurse-patient relationship, the doctor-patient relationship is so important in Western medicine that we have no desire to get in the way of those or push them aside. All we are trying to do is supplement their abilities with our techniques, our abilities to take care of what is bothering the patient physically, emotionally, and psychologically.

Chagpar You are a physician as well, so you integrate very well into that team. The social workers integrate into the oncologic team, nurses, and so on. Tell me a little bit more about how you become a palliative care doctor, is that a specialty in and of itself, or was it just an interest that kind of developed?

Putnam The first palliative care doctors in the United States were probably back in the 1970s, although I doubt it was called palliative care then and those people through the 70s and 80s had developed as an interest, what to do with people to treat their pain, treat their symptoms, end-of -life care, and people who were interested in those things gravitated toward that type of care. In the late 80s and 90s as there were more and more people doing this, some training programs were developed, what are called fellowships, around the country and it became called palliative medicine and people began to make that their specialty, and it became a recognized specialty in 2007. There were fellowships and now palliative medicine is a recognized specialty just like cardiology, radiology, and pulmonology and so the track to get there is you do your residency in internal medicine or family medicine, pediatrics, psychiatry, and then you go on and do a one or two year fellowship in palliative medicine to get those abilities afterwards, and then you can go out and be a palliative care doctor. I did two years of palliative medicine at Massachusetts General Hospital in Boston before going to Georgetown, and before coming here.

Chagpar So it really is a specialty where you have special skills that you bring to that team?

Putnam Yes. That is very true. It is the same idea as if someone has a heart attack, in many parts of the country it is going to be the internist or the family doctor who takes care of that patient if it is within their abilities, and then at some point if they say okay this is too complicated for me, I need to get a cardiologist involved, it is the same thing with palliative care. Most oncologists or all oncologists can do some pain management and can deal with things like nausea, vomiting, and things like that to various extents. At some point, if they say okay, I have reached the level that I am comfortable at, I need extra help, that is when we can be called in.

Chagpar And when you are called in, you bring your whole team, which really elevates that symptom management to a whole new level.

14:03 into mp3 file http://yalecancercenter.org/podcasts/2012%201021%20YCC%20Answers%20-%20Dr%20Putnam%20copy.mp3Putnam I have had patients in the past who have been called in, not just the one I talked about earlier, but people who needed radiation in order to treat their cancer and they were having to go back and forth from home everyday and they just could not do it until we got them more comfortable, so we are able to make their treatment possible.

Chagpar Excellent. We are going to take a break for a medical minute, please stay tuned to learn more information about palliative care with Andrew Putnam.

Medical

Minute The American Cancer Society estimates that the lifetime risks of developing colorectal cancer is about 1 in 20 and that risk is slightly lower in women than in men. Early detection is the key. When detected early, colorectal cancer is easily treated and highly curable. Men and women over the age of 50 should have regular colonoscopies to screen for this disease. Each day more patients are surviving the disease due to increased access to advanced therapies and specialized care. New treatment options and surgical techniques are giving colorectal cancer survivor more hope than they ever had before. Clinical trials are currently underway at federally designated comprehensive cancer center like the one at Yale to test innovative new treatments for colorectal cancer. New options include Chinese herbal medicine being used in combination with chemotherapy to reduce side effects of treatment and help cancer drugs work more effectively. This has been a medical minute and more information is available at yalecancercenter.org. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.

Chagpar Welcome back to Yale Cancer Center Answers. This is Dr. Anees Chagpar and I am joined today by my guest Dr. Andrew Putnam and we are discussing palliative care. So Dr. Putnam, before the break we were talking a little bit about how palliative care is much more than simply hospice and that it is more than end-of-life care and you were talking about how in this approach to improving quality of care that you work as a team in order to address what patients want. I would imagine that some of that would extend though, into patients as they change those goals. Can you talk a little bit about that?

Putnam Certainly that is a very important point in taking care of people with these diseases. For someone with cancer, often when they first get diagnosed, no matter how bad, the first thought is, I want to fight this, I want to get cured, I will do anything I can to get better. Not everyone, but that is what many people say and some of the people do get cured, but for someone who does not get cured and the cancer progresses, it is very important that your goals and your hopes as a patient change with a realistic view of what is happening and so at some point the doctor may say, we are not going to be able to cure this, but let us see how long we can help you live. Let us see if we can help you live a normal life. Let us see if we can help extend life as long as we can and then if the cancer still progresses, for some people they just want to keep control of their life. They want to stay in their own home. They know things are getting worse, but they want to stay in their own home or they want to have enough independence to be able to get dressed or bathe themselves and at the end, because we all do die one day, they may just want a good death. They want to be comfortable at the end and so it is really important that people's goals and hopes change as time goes on and as the disease progresses. There is a lot of talk in the medical community and among lay people about how we do not want a patient to lose hope, do not talk about death, because we do not want them to lose hope and for palliative care the question is hope for what? Because again a hope, realistic hopes, should change as a disease progresses. Any time that there is bad news, the disease has progressed or come back, if someone needs to go into a nursing home for a while, it is important to have these conversations about what do you want? What is important to you? For someone who has tried several different chemotherapies and they are not working and now there is one that has maybe 10% to 15% chance of response which might just be holding the cancer at bay, having a conversation with the patient about, well we can do this but you may get nausea, vomiting, and spend lots of time in the hospital. On the other hand, maybe you want to spend more time with your family, maybe you want to spend more time at home in which case this particular chemotherapy may not be the best thing to do and so bringing up other possibilities for what the patient wants is also very important.

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Chagpar It sounds like palliative care really helps patients with whatever their goals are, whether it's, I am going to take this therapy and fight this, but

I want you to help me with my symptoms, or I want to have more control so I can have what can be referred to as "a good death."

Putnam Yes, my job in many ways is easy compared to the oncologists. For an oncologist, what they have to do from the very first day is be the cheerleader of let's fight this cancer, and then even the best oncologist may get to a point where they have to say, I am sorry, I do not have anything more to offer you, let's help you be comfortable, and it is a 180 degree turn for them, which must be extremely difficult to do as opposed to palliative care doctors where from the first day it is we are going to keep you comfortable. We are going to help talk with you about what you want to do, we are going to help you make decisions. If you have questions, we will help you with that and that never changes. All the way through to the end, a good death is a comfortable one where we have family there, and also in palliative care we also worry about the family as being an extension of the patient.

Chagpar Let's talk a little bit about that, because I can imagine that part of the battle with cancer is one that the patient fights, but it can't be easy for a patient's family who wants to support their family member going through this. Tell me more about what palliative care can offer the family and how you support the family, while they are trying to support the patient?

Putnam I am glad you asked that, it is a really important part of palliative care. American medicine, for the most part, is focused on the patient, the person who gets chemotherapy or the person who has the heart attack, or the person with the emphysema and we have wonderful ways of fighting all these diseases and helping people, but the people who often get lost are the caregivers or the family members who are working hard and are suffering watching their loved one be sick and get

21:27 into mp3 file http://yalecancercenter.org/podcasts/2012%201021%20YCC%20Answers%20-%20Dr%20Putnam%20copy.mp3 worse but often we do not take care of these people and the problem is if the family gets exhausted, or you know the wife gets exhausted taking care of her husband who is up all night because he cannot sleep. If she gets exhausted then his care falls apart and he may end up in a nursing home or something like that because being home is no longer safe, and our social workers is fantastic, our chaplain is fantastic, working with families to help them understand that yes they are going through this too, yes we care about them, and yes we need to help them as well as the patient. It is really the patient's family caregiver who needs the help not just the patient.

Chagpar So it sounds like if you are a patient and you are at home and you have got a family and they are taking care of you at home, palliative care can still help people even when they are not in the hospital?

Putnam In palliative care we do lots for our consults when the patient is in the hospital, however, people have pain, nausea, vomiting, difficulties making decisions, spiritual crises, while they are at home as well and so just like a patient can come to a clinic, can come to the hospital here and see their oncologist and then go home after the visit, you can do the exact same thing with a palliative care doctor. We have clinic as well at the multi-specialty clinic, and people can make an appointment to come see us as outpatients and then go home after and we can adjust their medications things like that when they come to clinic.

Chagpar And we talked a little bit before the break about palliative care being a specialty in its own way. So if I am a cancer patient, it sounds like palliative care has a lot to offer me in terms of making sure my pain is under control, my nausea is under control, but can I make that appointment and still have it covered by insurance, or is it something that I need to pay out of pocket for?

Putnam No, it is the exact same as other specialties, we tend to have our chaplain and our social worker, our physician assistant in clinic as well when we see the patients but that is not an out of pocket expense anymore than the oncologist is, and we charge the insurance just like other physicians, it is exactly the same thing and we are recognized as specialists and we get paid as specialists.

Chagpar That is fantastic. Let's talk a little bit about palliative care, the specialty in and of its own right. You had mentioned that is a fairly young specialty and so do you think that this is something that is growing, is it something that is taking hold in society? What are the areas of research and growth in palliative care?

Putnam Good question. Palliative medicine as a specialty is definitely growing, now, far more than 50% of large hospitals, meaning more than 300 beds, have palliative care programs, which was not true ten years ago, and there are a growing number of fellowships that educate palliative care physicians. I think it is up around 86 to 87 fellowships around the country now whereas 15 years ago there were 5, so the numbers of people who are interested in going into palliative care, the number of people

25:07 into mp3 file http://yalecancercenter.org/podcasts/2012%201021%20YCC%20Answers%20-%20Dr%20Putnam%20copy.mp3 applying to fellowships, is increasing and the number of patients who are seeing palliative care specialists is increasing, so I would say around the country it is a growing, although as you said, it is still very young and in many cases not well known at this point.

Chagpar What about areas of growth in terms of research? Are there burning questions in palliative care that you think really need to be studied? Areas where we can move this field forward because it sounds like it is a very important area?

Putnam For so much of what we do to make people feel better in medicine, there is no evidence for it. We know that if we give someone morphine and they say they feel better, than they feel better, it's not something you can prove with a scan or a blood test, but which drug is better, is it better to give them Advil or is it better to give them morphine in certain situations, or between different narcotics, which is better? Really there is no way of knowing, you have something like nausea where there are many different classes of medications, not just different medications but classes, which ones work better and at what time? Again, there is not really evidence for that, so we use what we know, what seems to work. In some patients it does and in some patients it does not and I am sure that as time goes on and we learn more about the genetic basis of why medications work, we are going to find that for a lot of these medications there is a genetic basis for why they work better in some people and not in others.

Chagpar It sounds very much like personalized medicine that we talk about on this show often.

Putnam Yes, very much so. It is the individual that we need to take care of; the cookie-cutter approach just does not work very well.

Chagpar An interesting thing that you mentioned earlier is that it is not even just the different classes of medications, but an incorporation of things like acupuncture and Eastern medicine. Talk a little bit about that, does that have a role in palliative care?

Putnam It certainly does, mind-body medicine, acupuncture, all of these things can help make people feel better. There is growing evidence for some things like acupuncture that there are certain times where they are better than many medications. And so patients who ask me about them, I will often send them to a specific acupuncturists or a massage person if that is what they are interested in doing. I cannot say there is medical evidence that this helps you feel better or that this is going to work, but I am very open to the idea that if someone wants to try something and see if it works, there is nothing wrong with that because many people are helped by these other complimentary therapies.

Chagpar Right. And that might be another area of research?

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Putnam There is research going on to try and figure out how to incorporate these into the current medical model.

Chagpar That is fantastic. As we talk, so much of what you have said about palliative care is really about making patients feel better and being there for them in really what is their hour of need, whether it is when they are having pain and they cannot lie down on the radiation table, or whether it is when they are having nausea in the middle of their chemotherapy treatment or they are closer to the end of life, but I cannot help but imagine the impact that that has on the caregiver, not just the family but on the palliative care team. Can you talk about the impact that this has on you as a physician and on the palliative care team?

Putnam You mean as someone gets sicker?

Chagpar Yes. The emotional impact of taking care of people, how does that work for you?

Putnam It can be very hard. Certainly, if it is near the end of life of someone we have known for a long time, we get very involved with people and care a great deal about them and so as they get sicker, it can be very hard and it is a struggle. It is a struggle for nurses, for other physicians in the hospital when people get worse or when they die and it is a struggle for us too.

Dr. Andrew Putnam is Assistant Professor of Internal Medicine and part of the Palliative Care Team at Smilow Cancer Hospital. If you have questions or would like to add your comments, visit yalecancercenter.org, where you can also get the podcast and find written transcripts of past programs. You are listening to the WNPR Health Forum on the Connecticut Public Broadcasting Network.