

Support for Yale Cancer Answers is provided by AstraZeneca, a biopharmaceutical business with a deep-rooted heritage in oncology and a commitment to developing cancer medicines for patients. Learn more at astrazeneca-us.com Welcome to Yale Cancer Answers with doctors Howard Hochster, Anees Chagpar and Steven Gore. I am Bruce Barber. Yale Cancer Answers is our way of providing you with the most up-to-date information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer.

This week it is a conversation about palliative care for cancer patients with Dr. Laura Morrison. Dr. Morrison is an Associate Professor of Medicine at Yale School of Medicine and an Attending Physician on the Palliative Care Consultation Service at Smilow Cancer Hospital. Dr. Hochster is a Professor of Medicine and Medical Oncology at Yale School of Medicine and the Clinical Program Leader of the Gastrointestinal Cancers Program at Smilow.

Hochster We usually start out with people introducing themselves a little bit. Do you want to tell us a little bit about your background, what training is involved in becoming a palliative care specialist?

Morrison Sure. Thank you, Howard. I am delighted to be here as a hospice and palliative medicine specialist or what we call a palliative care doctor. Most of us now go through 1 year of fellowship training that includes clinical rotations, learning about both hospice and palliative care, and we have 2 or 3 fellows coming through annually.

Hochster And your personal background, how did you get into palliative care?

Morrison I actually had, I came through it in an interesting time when palliative care was not really a known specialty. So, I did not learn about it until after I finished my internal medicine residency, and I felt a pull in that direction really toward these opportunities to have more difficult discussions with patients and make really strong connections and have deeper relationships with patients around challenging illnesses and helping them really clarify what their wishes are for the kind of care they receive. And so, at that time, I went ahead and did a geriatrics 1-year fellowship and then went on and did an additional 1-year training program in palliative care, but the training that we have now is really much different, it is accredited and fellowships have now been more official for over 10 years.

Hochster From the American Board of Internal Medicine?

Morrison What is interesting is that palliative care is one of the few specialties, subspecialties that people can enter from 10 different primary specialties. So, someone can actually enter palliative care and do a 1-year fellowship from pediatrics, surgery, psychiatry, internal medicine and a number of other subspecialties.

Hochster And do you find most of the people are still internal medicine trained or mostly?

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Morrison Well, again it is a great question, and what we see is really interesting because the majority currently are still internal medicine, second would be family medicine, but we are seeing a huge trend of people entering from other subspecialties. One of our fellows this year is from emergency medicine.

Hochster That is a difficult place to have a palliative care conversation, I guess in the ED. So, you talked about geriatrics, talked about palliative care and then a lot of people know about hospice, so these are all kind of somewhat interrelated but different. Can you kind of lay it out for us like how these things all work, the similarities and differences?

Morrison Yeah, thank you for asking this question because I think on a daily basis I would say that I have the opportunity to try to explain these differences to at least 1 person if not more. So, people should not feel like they are in the minority if they are kind of confused about the differences. I think it is most helpful to start by explaining what palliative care is, because it is the broadest really. Palliative care is specialized medical care for anyone who has a serious illness and their family, and it focuses on really improving the quality of life that that person has by addressing pain as well as other distressing symptoms. What we usually say is that we provide an extra layer of support, and I think that one of the critical things to realize is that palliative care is not limited in anyway by time or the type of treatment someone is receiving. So palliative care can coexist with any other treatment and with any other physician that is involved. So, in our setting, we are not taking over any of the management where they are going along with all the other care that someone is getting already.

Hochster So, this is 'YaleCancerAnswers', you work Smilow, but it is not necessarily limited to cancer right?

Morrison Correct, right. So, any serious illness - current statistics would say that probably over half of the people we see at Smilow have cancer, but we are available throughout the whole Yale New Haven Hospital System and we can see patients with heart failure, dementia, any other organ failure, chronic obstructive pulmonary disease... Hochster So people who have serious problems from a serious illness, you are there to help relieve symptoms.

Morrison Absolutely.

Hochster And how is it different for hospice for example?

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Morrison Right, so that is the perfect next question. Hospice by contrast is one element of palliative care, but the thing that distinguishes it which is critical to know is that it is limited by both time and the kind of treatment someone can be receiving. So, as a physician for someone to be eligible for hospice, I need to

be able to say that if their serious illness follows its natural course, that they are likely to die in the next 6 months, or that I would not be surprised even though that obviously is unfortunate.

Hochster And again that is not limited to cancer, they have renal, kidney failure, dementia whatever.

Morrison Exactly. So, any life-limiting illness potentially if it seems like someone would be likely to die in the next 6 months, important to know though that there is not any penalty if someone lives longer than 6 months, and we often see that with hospice support people can live longer than 6 months. The other important criterion is that someone is not pursuing curative or life-prolonging therapy any longer, and so once again just to summarize for the larger palliative care that we provide here at Smilow in the hospital, people can be getting any sort of treatment whether it is curative or life prolonging and they can potentially be even curable and still be getting palliative care, but for hospice, we are anticipating that the illness is going to take someone's life and they are no longer pursuing curative or life-prolonging treatment.

Hochster So, for the cancer patients as a palliative care doctor, you are trying to relieve pain probably most commonly.

Morrison Exactly...

Hochster Some other symptoms – nausea, vomiting, anorexia, other things that people have either from their disease or treatment?

Morrison Right. So, for almost every serious illness, people will have multiple symptoms. Fatigue is perhaps the most common, pain is quite common as well, but there is a wide range of symptoms like nausea, issues with the bowels- like constipation, depression and anxiety are something we work on a lot with people, and I think in that regard not only are we focusing on physical symptoms but we are also focusing on what we call emotional coping or support, and we are also focusing a lot on support around communication, and in that regard what I mean is, really helping people identify what their goals are for their care. And so, there is a lot of communication support as well.

Hochster Like when I see a patient as their oncologist, I do not really usually ask them what are your goals, but you always ask them what are your goals?

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Morrison We try to ask, I mean that question in itself can be challenging for some people, some people do not necessarily think about their goals every day, but I think what we look for is to make sure that the treatment they are receiving is really in alignment with what they are hoping for or what maybe what is most important in their life at that time. For instance, I have had a patient who is trying to get to a grandchild's graduation or some of these other really important events like a trip, and we would try to focus things around that and

maybe even their treatment schedule or their pain management, just trying to help them figure out how to be able to get to the event, be present and really participate in the event by focusing on their symptoms.

Hochster So, oncologists such as myself, we give a lot of treatments with a lot of side effects and we are pretty focused on helping manage the side effects. What kind of thing do palliative care doctors add to that?

Morrison That is a really important question too, because I want people to realize that oncologists also do palliative care, some have had even a whole fellowship, 1 year of fellowship training in palliative care, so it is really not that oncologists are not incorporating palliative care into their practice. I think what we realize is that one person can only do so much, and you are bringing up something that is somewhat unique to palliative care in that it is not just a physician, it is a whole team of people, and so I think the oncologists and hematologists can also benefit from this whole additional team, not only a physician colleague but nurse practitioners, chaplains, social workers, therapists, pharmacists that are really focused on these areas. And so to answer your question, it is a whole team approach. So, for instance, if someone is having anxiety, there are certainly some initial approaches that an oncologist may take as well and some of us will think of some medication management, but it may be more about their spirituality or it may be more about their coping and something they are worrying about, about a future decision or perhaps accomplishing something they are trying to do. And so, a whole team, this addition of palliative care may really be able to help support someone more fully where an oncologist may be limited in time and not have the whole team.

Hochster That is very helpful. There was a study that was published in New England Journal recently that came out of Boston that compared patients just being treated by their oncologists to patients who had their oncologists plus palliative care. Right from the beginning and not at the end, the people with palliative care seemed to do better. So, why what do you attribute that to?

Morrison I think that is a great question. That study is one that was a major study that came out in the palliative care field and I think for oncology as well, I think a lot of it does come down to the team, the number of opportunities there are for interaction I think increases for support from multiple people and so I think there is an opportunity to really get at more of that emotional coping, but there are also then more opportunities to move communication forward and really allow patients and their family members to voice maybe deeper concerns that they are not able to get at in fewer interactions, concerns about advanced care planning, concerns about their finances.

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Hochster Yeah, those are important today.

Morrison Well, we are going to take a short break now for a medical minute.

Please stay tuned to learn more information about palliative care with Dr. Laura Morrison.

Medical Minute Support for Yale Cancer Answers is provided by AstraZeneca, working to change the cancer paradigm through personalized medicine. Learn more at astrazeneca-us.com. The American Cancer Society estimates that over 53,000 new cases of pancreatic cancer will be diagnosed in the United States this year. This number represents about 3% of all cancer in the US and about 7% of all cancer deaths. Clinical trials are currently being offered at federally designated comprehensive cancer centers for the treatment of advanced stage and metastatic pancreatic cancer using chemotherapy and other novel therapies. FOLFIRINOX, a combination of 5 different chemotherapies is the latest advance in the treatment of metastatic pancreatic cancer and research continues at centers around the world looking into targeted therapies, and a recently discovered marker HENT-1. This has been a Medical Minute brought to you as a public service by Yale Cancer Center. More information is available at YaleCancerCenter.org. You are listening to WNPR, Connecticut's public media source for news and ideas. Hochster

Welcome back to Yale Cancer Answers. This is Dr. Howard Hochster and my guest Dr. Laura Morrison who is joining me tonight to discuss palliative care for cancer patients. So, we were just talking about a study that was recently published in a prominent journal, comparing chemotherapy alone or medical oncology treatment alone to medical oncology treatment with early palliative care for lung cancer patients, and the group that got palliative care had a lot of better outcomes, so what did they find in that study and how does that dovetail with your personal experience.

Morrison Yeah, that is a really terrific question. This study was really unique in looking at a group of newly diagnosed patients with non-small cell lung cancer, and all of these patients actually had metastatic disease at diagnosis. So, they already had very advanced illness. One group was randomized to normal oncology treatment and the other one got the same treatment but had a palliative care intervention, which largely included contact with palliative care when they were in the hospital, but more so when they were following in clinic, and so the interesting results were that the people who had the palliative care added had less depression, documented higher quality of life measures and over time towards the end of their life, it appeared that their wishes were followed more closely when they expressed wishes for less aggressive treatment and more of a comfort focus at the end of life including getting to hospice more. Later analysis also showed that the people in both groups got the same amount of chemotherapy, so the amount of treatment really did not change as far as the cancer-directed therapy and I think the other part you were referring to was that the patients that got palliative care were documented to actually live almost 3 months longer than the patients who did not get palliative care, and so obviously that was a major finding.

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Morrison Similar followup studies have shown a similar trend and so what I think we take away from that is that not every patient is going to live 3 months longer but certainly life span is not going to be shorter, so that is very reassuring and kind of goes along with what I said earlier about some people living longer in hospice, and so again, I think it is that the support, the added support on top of the support that the oncologist and the staff were providing seems to really have a positive outcome and people really being on top of getting the care that they are really looking for.

Hochster So, it is like additional life line or phone-a-friend, you have got another group of people to go to, to help you out with problems, to ask questions...

Morrison Absolutely, and typically that would again include hospice has a similar team dynamic of multiple people there, but palliative care does as well and so, all of those folks would have had a chaplain, a social worker, registered nurses as well as nurse practitioners available to them along with perhaps other therapists like art therapy or music therapy.

Hochster And do you see the role of what you do a little different when it is earlier on in patient's course of disease and later on, and how do you transition people with end-of-life issues?

Morrison Right. So, what we see now nationally is that the trend really is towards earlier referral and so I think that is a key message we want people to understand is that palliative care can have a role much earlier in cancer but also in heart failure and dementia. From the study we have been talking about, it became very clear on a national level that it probably makes sense for many patients with lung cancer, colon cancer, some of specifically tumors to perhaps be referred to palliative care as soon as we know that they have cancer that has spread or what we call metastatic disease, but any patient, even as early as diagnosis is really eligible for palliative care, and so as a palliative care specialist, I do now have more opportunity to see people very early. I have seen patients in the last couple of years who are 5-10 years into their course. I remember a specific breast cancer whom I saw probably 8 or more years into her course and we met and I remember her essentially saying why did not I hear about you 5 years ago. She was really feeling that she could have benefited from some of this extra support much earlier. And so, we do see people now much earlier and I think the oncologists are really seeing the benefit of bringing us in. But as you are pointing out, we also have opportunities to take care of people that are much later in their course. We are always still hoping that things will go as well as they can and perhaps there will be some curative options, but we do find that we take care of many people who have their disease that is progressing through treatment and we are at the end of life for them. And so, we really do help a lot with that whole area of support, that whole person and their family towards the end of life as well.

Hochster And so, how should physicians introduce to patients and what should

patients take away if the doctor says, "I would like you to go to the palliative care clinic." I mean they are already tied up with coming every couple of weeks for chemo and the nurses and the treatments and calling with the side effects and whatever, it is another clinic visit. So...

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Morrison Right. I think there are 2 parts there are to that question. One is how does an oncologist or how does a cardiologist or how does a geriatrician bring in palliative care, and I think a lot of our healthcare provider colleagues, even nurse practitioners, physician's assistants, registered nurses, I think underestimate their role at sort of providing that link to our care that we can provide in palliative care. The voice of oncologist and the voice of even registered nurses at the bedside is very strong in helping patients and families realize how much they can benefit from that extra support. And so, I think as I was saying before I think there is much more recognition now that especially when people have metastatic cancer that that can be one point of at least reassessing whether palliative care could have a role or finding now interesting that it is not uncommon at all to receive referrals⁷ to us where the patient or family have actually initiated wanting palliative care, so that is a new trend as well. But your point about adding on additional visits is a challenging one and certainly when I meet a patient and their family in the hospital, we talk about whether it makes sense to add on clinic. In our own settings, sometimes we are able to coordinate the visits so that it is not an extra trip, but I think when people are in other hospital settings and other healthcare settings, it certainly can be a bit of an added burden in itself to add another doctor, to add another potential clinic, but I think it is a matter of kind of weighing the burdens and benefits so to speak.

Hochster Right. Obviously, there are particular people who are looking for these things. So, patients should not feel embarrassed, should not feel shy about saying to their oncologists, their nurse practitioners whatever or even is another serious illness that is life threatening, I would like to see a palliative care team.

Morrison Yeah, so one thing I can share additionally is that in the last 15 years, the number of palliative care services nationally has grown tremendously. So, almost by far the majority of hospitals in the United States now have palliative care services that may vary from a huge full team to maybe even just having one nurse practitioner or one doctor. So, in some settings, it is still quite limited as far as the person power to be out seeing patients, but our listeners need to know that throughout Connecticut, palliative care is really quite available, not just here at Smilow and that care is available throughout the spectrum as well. In hospitals, there are palliative care clinics, although those are less common and then as well, there is opportunity now in many places to have palliative care home nursing services that are really focused on palliative care and that is separate from those outpatient hospice services.

Hochster Right. So, when we are treating the patient, we are pretty much focused on the patient and what we are doing for them, what we are doing to them, what we are doing to help them cope with what we are doing to them, but there are a lot of other people involved and sometimes I find like the caregivers are kind of the unsung heroes especially when people have long illnesses, they can get treated for years today, that is a big burden on the caregivers. So, you provide services to the caregivers too unlike the primary oncologists.

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Morrison Well, I think all of us know that oncologists are trying to be tuned into the family members as well, but again time is limited and the training is limited, and having a whole team that can attend to family members as well as the patient is very powerful at times, and so yes I agree with you that caregivers are often are so inspiring.

Dr. Laura Morrison is an Associate Professor of Medicine at Yale School of Medicine and an Attending Physician on the Palliative Care Consultation Service at Smilow Cancer Hospital. If you have questions, the address is cancer-answers@yale.edu and past editions of the program are available in audio and written form at YaleCancerCenter.org. I am Bruce Barber reminding you to tune in each week to learn more about the fight against cancer. You are on WNPR, Connecticut's public media source for news and ideas.