Ruth Adewuya, MD - host:

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Ruth Adewuya, MD - host:

This episode is part of the COVID-19 mini series Addressing Up-to-date Insights on COVID-19. In today's conversation, I am joined by Dr. Grant Smith. He's a Clinical Assistant Professor of Medicine in the Division of Primary Care and Population Health at Stanford University. In addition to providing direct patient care, he is passionate about increasing access to palliative care.

Ruth Adewuya, MD - host:

I'm also joined by Dr. Brook Calton, Associate Professor of medicine in the UCSF division of Palliative Medicine. Dr. Calton is an outpatient palliative care physician and the Director of Home-Based Palliative Care for UCSF. Much of her academic work focuses on telemedicine research and preparing trainees and clinicians to provide the best possible care by telemedicine. Thank you both for chatting with me today.

Grant Smith, MD:

Thank you so much, Ruth, for having us. We're super excited to be here.

Ruth Adewuya, MD - host:

Well, Grant, can you begin by telling us a little bit about palliative care pre-COVID and what were some of the challenges even before the pandemic?

Grant Smith, MD:

Yeah. You know, pre-COVID, it has been a really exciting time to be in palliative care. Over the last several years, palliative care has really grown enormously. We know that actually the prevalence of palliative care teams has tripled in hospitals that have 50 beds or more. So the growth has been a lot in patient palliative care, but outpatient and community-based palliative care is also growing sort of right along with inpatient teams. I think some of the other exciting things happening in palliative care pre-COVID is that the evidence base for our services is really growing a lot. And especially our early involvement in cases.

Grant Smith, MD:

More and more is being shown that we've helped out patients. We help manage their symptoms better. We help caregivers and loved ones with their wellbeing. And there's even some pretty exciting data out there suggesting improved survival, especially when we're involved early on. So those are some of the exciting things that have been happening pre-COVID.

Grant Smith, MD:

When I think about our challenges, I think one of the major challenges that we faced pre-COVID is really a lack of awareness and knowledge about palliative care. And I think that is true both among our clinician colleagues and also among patients, caregivers and the general population. You know when I think about that maybe even beyond just awareness is actually there's some pretty tightly held misconceptions about palliative care that we would love to address.

Ruth Adewuya, MD - host:

Yes. What are some of those myths?

Grant Smith, MD:

The most common is really that palliative care is synonymous with hospice and end-of-life care and that's not true. Maybe just to clarify for all of our listeners, palliative care is really an approach to care and it's a medical specialty that's for people who are living with what we would call a serious illness. We really focus on relieving symptoms and trying to relieve stress of an illness. And our whole goal is to improve quality of life, both for patients and those who are closest to them.

Grant Smith, MD:

We work as an interdisciplinary team. So it's doctors, nurses, chaplains, social workers, and we all work together alongside patients' other doctors. So patients still have their oncologist, cardiologist, primary care doctor. And we're another layer or really sometimes an essential layer of support to patients. And our services can be provided really based on the needs of the patient, not on a particular prognosis or even a particular diagnosis.

Ruth Adewuya, MD - host:

Thank you so much for pointing out the fact that there are some myths around palliative care and how it's not only for the general public, but also within the health system, and with clinicians and colleagues. So I'm glad that you brought that up. In the course of this conversation if other myths come up, we'd love to highlight that, and we can do a little bit of myth-busting of what palliative care is.

Ruth Adewuya, MD - host:

It sounds like pre-COVID already, a lot of innovation was happening. You mentioned a lot of evidence around the importance of palliative care in the continuum of patient care. If we switch gears to then COVID hit and as COVID began to fill up some of those hospital beds last spring, what was the initial impact on palliative care, both for those suffering from COVID, but also those suffering from other terminal illnesses? And either one of you can start.

Grant Smith, MD:

Maybe I can start and Brook, please chime in too. But certainly just as the hospital became busier, our teams got busier as well. But I think some of the main impact that happened was that the intensity of our work really increased. And I think like all of us have experienced even the healthiest, most resilient of us have faced new challenges that we maybe never had to face before. And both in our inpatient and outpatient work, I think part of our job is really to walk alongside our patients and to sit with that stress and distress that comes, and to help hold that for our patients to some extent.

Grant Smith, MD:

And I think when I think about the inpatient side, some of that stress and distress came from the separation between patients and their families because of the visitor policy. And I think practically some of those things is that we often recommend a lot of non-pharmacologic techniques to manage symptoms, pain, anxiety. Using things like distraction like watch a movie with your loved one, or talk about what you're going to do when you get out of the hospital, those types of things. And that's still all possible with an iPad and video calls, but it's a little bit different. It's not exactly the same. So we've

certainly tried to work with our interdisciplinary team members to try to help facilitate video calls and iPad chats as much as possible, but it's not quite the same.

Grant Smith, MD:

I think the other way that that separation played out was for some of our sickest patients and especially for patients who were sick with COVID. Because unfortunately this illness took people who probably before getting COVID thought of themselves as not sick. Maybe they had a comorbidity, but they probably didn't think of themselves as like seriously ill or being released sick. And then they find themselves in an ICU on a ventilator critically ill. And I think that separation even with video calls, it's very different to be bedside with your loved one and seeing them in that situation.

Grant Smith, MD:

And so that disconnect and that contrast between who that person is outside and before COVID and where they are right now is a pretty big gap, and leads to some very difficult and heart-wrenching conversations. And I think that's where palliative care, our expertise is really good at that. That's what we do. That's sort of a perspective from the inpatient and maybe Brook can say a little bit more about outpatient.

Brook Calton, MD:

Yeah. So I practice primarily in the outpatient setting at UCSF so that's really what I'm most familiar with. And what I can tell you is that we have a pretty robust outpatient palliative care practice seeing patients in clinic, but essentially now all by video visits. And I think we're going to talk more about that in a little bit. We have been busier than ever before in our clinics. And I think there's potentially lots of different reasons for that, but I think one of them potentially is just that our patients have been, as everyone has been facing more isolation and looking for ways to connect and that support that we're able to provide.

Brook Calton, MD:

I think the other things that we've noticed in the outpatient setting is just the really difficult decisions that our patients who are seriously ill and very much at risk for difficult outcomes when it comes to COVID that they're having to make. They're having to really weigh risk in a different way. And so I think we know for all sorts of people, but especially for patients with serious illnesses and especially early in the pandemic, people were much more concerned about going to the emergency room being hospitalized because of the risk of COVID on top of the risk of them being hospitalized potentially with serious illness or even at the end of their life, and not being able to have family with them in the hospital. So that's just an incredibly rough decision to have to make.

Brook Calton, MD:

The other thing that I've noticed. And that is still persisting now is just how people are weighing risk when it comes to how they spend their time over Thanksgiving. If you had 25 more Thanksgivings to look forward to then like, yeah, maybe you would skip this one with your family. But if you knew that this might be one of your last Thanksgivings, that risk calculation is much different in terms of the desire to make it a special time and to be with family or friends. Something that we as palliative care clinicians don't have the perfect answer to, but I know we're spending a lot of time talking about with our patients and their families.

Ruth Adewuya, MD - host:

Grant had mentioned earlier the role of palliative care teams and kind of where palliative care teams can step in even pre-COVID, and even during COVID. I'm curious to hear from you, Brook, what the role of palliative care teams have been to provide an added layer of support for families who can't be present? And then I think on the flip side, also curious about support for staff to prevent burnout.

Brook Calton, MD:

Thank you for that question. I think many of us in palliative care see our role, just like you said, to support patients and families and to support colleagues. I'll flip a little bit and talk about the inpatient setting because I do some time there and just say that I think one of the ways that we've been able to be helpful is really supporting families who can't be present because of COVID. So really practical things that make a big difference like taking the extra time to coordinate a Zoom call so that a family member could spend time with their loved one who's hospitalized who is not able to be in the hospital because of visitor restrictions goes a long way.

Brook Calton, MD:

Other things like our chaplain in our hospital palliative care program will ask for pictures from family. They'll email them to her and then our chaplain will go and post them in our patient's room. I think it can be really meaningful both for our patients and their family. Or finding out what our patient's favorite music is and playing some of that when we're in the room with them. I think that the other thing that we always try to do in palliative care is really to be able to understand what our patient was like when they were not as sick and in the hospital.

Brook Calton, MD:

And so we do spend a lot of time with our patients' families, especially if our patient is not able to talk to us at that time in the hospital. Just to really spend time to dig into like, what is life like before this illness, before this hospitalization and what brings your loved one joy? And we really can bring that information into future conversations around goals of care, advanced care planning I think in a meaningful way that can have a big impact.

Ruth Adewuya, MD - host:

Grant, anything to add?

Grant Smith, MD:

I just wanted to share a really interesting thing that was able to happen earlier in the pandemic. And this was back when New York and Seattle were being hit particularly hard with COVID and other places relatively we're not as busy. In palliative care, we're sort of uniquely positioned because we can provide a lot of support and help over a phone and Zoom. So there were faculty at UCSF and Stanford and all over the country that actually helps support our palliative care colleagues in those cities by calling families to update them or even doing early goals of care discussions. So I just think that's a really amazing thing that happened.

Grant Smith, MD:

And the other thing I might just add to what Brook said is similar to what I mentioned before. I think we all in healthcare faced unprecedented challenges and stress with this. And as a field, we sit with serious

illness and deal with what can be impossible feeling situations on a daily basis. So all of us take a lot of time to think about what are the mental frameworks, the practical things we do in our own personal lives to sort of fill our cup back up when it gets emptied throughout the day.

Grant Smith, MD:

And so I know a lot of us have been trying to share some of those frameworks and techniques with our colleagues as we go through our day. And one of those I can think of when I was just on service last week and thinking about cases that are really difficult, and all of us have those cases that for whatever reason pull at our heartstrings. Maybe they're your similar age, gender, life stage, whatever it is. But sometimes we talk about putting on our emotional raincoats and you don't want to do that all the time, but sometimes you need to do that and just let those things wash off of you so that you can continue to go about your day.

Grant Smith, MD:

And certainly you need to process those things in a deep way at some point, but that is a tool that is okay to use and we would definitely recommend. And knowing that you may bear witness to a lot of stress and distress, you don't always have to take all of that on yourself and internalize that. So it takes a lot of work. We have to work on this a lot, but we try to share those ideas and frameworks with our colleagues to help get through this, and we've all needed it during this pandemic.

Ruth Adewuya, MD - host:

Maybe towards the end of our conversation, I might ask you for some additional tips that you have for clinicians as we navigate this seemingly endless era of COVID. But it's a great segue into my next question for you, which was telehealth and technology. You mentioned how palliative care teams have been able to support other teams across the nation with utilizing technology.

Ruth Adewuya, MD - host:

So how has telehealth and technology influenced palliative care and has it relieved some of the challenges that you mentioned earlier, or has it increased isolation?

Grant Smith, MD:

I'll talk about I think some of the really positive things we've seen from telehealth. I do think that it has increased access for some people. In places like UCSF and Stanford, we're a referral center. So our patients come from three, four or more hours drive away. Back when it was all in-person visits, some people just couldn't make it. So now we're having almost zero no-shows and people are coming to their visit. So I think that's been a really great thing that's happened for access.

Grant Smith, MD:

I think the other thing that I know Brook and I really enjoy about video visits is that you get to peek into someone's home and their life at home. Very clearly you see who's around them, who's joining you for the visit. And that's really nice. I've got to see their dogs. Lots of patients have met my dog. I had one patient who I met them and they had this whole wall of trophies behind them. I was like, "What are those trophies from?" And I found out that they show horses and that's like a huge part of their life. I had no idea it was going on.

Grant Smith, MD:

So I think sometimes telehealth has really made a nice connection between providers and their patients. And I also think that patients are just more relaxed and chill. They're in their home. They haven't spent time driving across the city or up and down the 101 and have to pay for parking and all that. They're at home on their couch in their pajamas. So you know if you're going to have a difficult conversation, I much rather folks be relaxed and in their comfort zone than in my clinic, to be honest. So I think there's been some real wins, but as you mentioned, some challenges too.

Ruth Adewuya, MD - host:

Yeah. So what have been some of those challenges? Because I imagine that having those difficult conversations via video or mobile phone and spotty internet or whatever else, situations could be an issue as well.

Brook Calton, MD:

Yeah. I can take that one, Ruth. I think in terms of challenges of telemedicine particularly as it relates to the patients that we take care of and some of the difficult conversations that we have. I think that from a communication perspective, we know that there are definitely skills that we use on the in-person side that then translate over video quite well. We also know that or at least we think based on some data that we have, including a study that we just recently published at UCSF of our patients and caregivers that most patients and caregivers feel really comfortable having discussions over video, difficult discussions over video. Maybe with the exception of breaking bad news in the survey that we did, where there were more patients and caregivers that preferred to have that conversation in person. So there seems to be comfort on behalf of our patients and their families.

Brook Calton, MD:

In terms of clinicians, we were just recently completing a focus group of our palliative medicine and geriatric fellows to understand their educational needs when it comes to telemedicine. And midyear, they're still definitely reporting that they want more help and training and guidance, and observation and feedback on serious illness conversations in particular, and especially responding to emotion.

Brook Calton, MD:

So we have all these ways of responding to the emotion in the room when we're in person with people and it can often feel quite intimate, or maybe you use a light touch. It's easier to see if someone's angry or if someone is sad, or someone is crying. And obviously all those things are more challenging over video. So I think that that's a big challenge is how to do those things in a meaningful and respectful and compassionate way by video.

Brook Calton, MD:

So simple things that we encourage clinicians to do is if you can't tell how someone is feeling based on their facial expression, because maybe they're looking down or maybe the lighting isn't great, just to ask, can you tell me how you're feeling right now is a really good first step. And then those verbal responses to emotion because facial expressions that you may have are going to be more difficult by video too, and you can't touch someone's knee are even more important. So even something just as simple as naming what you think is going on like, "I can see how sad this is making you" I think can go a far way.

Brook Calton, MD:

The final thing I will say is that while I think telemedicine has been really helpful for us as palliative care clinicians in the outpatient setting, because we can sit at our home and see people and we don't have to commute that there is I think a different level of attention that it takes to see patients throughout the day by video. And that's regardless of if you're a palliative care clinician or a primary care doctor or a cardiologist, it just takes a very different amount of attention. And so I think to the point that you made, Ruth, earlier being really intentional about how you plan your day and how you take breaks and trying to preserve that time, even just to get up and stretch or walk outside for a moment.

Brook Calton, MD:

One of our colleagues before she let someone in from their waiting room, she just takes a big deep breath to kind of center herself. I think those things are even more important. And as we continue in this pandemic and we continue doing telemedicine, I'd imagine that how we support ourselves as clinicians is going to evolve as well.

Ruth Adewuya, MD - host:

Yeah, absolutely. And I think now that we are at a full year since the first COVID surge, well almost. I guess depending on where you count and how you count it, how has palliative care changed and how has it evolved over this time? For example, has your advice to patients changed in that time as well? How do you handle those conversations?

Brook Calton, MD:

I think that our advice has changed in terms of especially how to advise someone around COVID. I mean, I think initially the first couple months of the pandemic, there were lots and lots of conversations about how we can avoid you going to the hospital with all means possible, right? We were worried that if you spent more time in the hospital setting that we were worried about our patients contracting COVID, and our patients really didn't want to go either.

Brook Calton, MD:

I think in terms of that advice, I have now changed my tune. I think that actually other than being in your home socially distanced, given the safeguards and testing that we're doing in our hospitals that it's actually one of the safer places to be. And so I've changed my tune and encourage my patients when they're hesitant, but they need a procedure or they need to go get an X-ray or they need to get labs, or they need to go to the emergency room. We should do this now or there's a chance that we're going to let this time go by and you're going to be sicker down the road, and that's going to be worse.

Ruth Adewuya, MD - host:

Grant, any thoughts on that question as well?

Grant Smith, MD:

Yeah, I might add that one of the things that changed is how we talk about advanced healthcare planning. And I think really COVID has brought to the forefront of people's minds this idea that you could develop what I would call a sudden serious illness. Or people I think are more aware of the idea that you could become so sick that you couldn't speak for yourself, and might need someone to step in

and make decisions for you. So I just think the public consciousness of the idea of possible serious illness and planning ahead. There's been a lot of New York Times articles, a lot of news programs about this.

Grant Smith, MD:

So in some ways, that's made our job a little bit easier in broaching some of those conversations. We sort of feel like everyone can benefit from advanced healthcare planning. And this is a really good example to bring up when you're trying to say like, "Why would I think about this now?" Well, I really hope this doesn't happen, but you've certainly seen that this can happen and it can come out of the blue. So that's been, I think, a way that we've changed some of our advice and how we talk about advanced care planning at least in palliative care.

Ruth Adewuya, MD - host:

And so, Brook, looking ahead, both in the short-term and the long-term. In your opinion, what do you think we need to do to make some lasting improvements to palliative care?

Brook Calton, MD:

Yeah, this is a very big question. I feel like we could have nine podcasts about this question. I think a couple of things to mention. I think that one of the challenges that we hadn't highlighted earlier of palliative care programs is even though palliative care is growing, it's still access. And it's still about how we fund our programs. And that's really challenging because we very much believe in a interprofessional model in palliative care of doctors and nurses and social workers and chaplains and pharmacists, but not all of those clinicians can bill for visits. So the fee-for-service model and palliative care doesn't work that well.

Brook Calton, MD:

And so I think that in terms of how to create lasting change, we you have a very good opportunity now and I expect it to continue where value-based care is even more important in sort of moving outside of the fee-for-service model is gradually happening where we can really impact the value of people's care and get them the care that they want. And then hopefully be reimbursed so that our whole team can be supported.

Brook Calton, MD:

And my hope is that that will help create access in places where there is not palliative care specialty access. So places that are more rural outside of urban academic medical centers. The Southeastern part of the US is really lacking in palliative care services. So my hope is that it's going to help. Nevertheless, we still are never going to have enough palliative care specialists to meet the need, especially as baby boomers age and patients are luckily living longer with lots of different, serious illnesses as medical technology advances.

Brook Calton, MD:

So I think that another really important improvement or thing to think about is who needs what type of care and when it comes to palliative care? There may be people that really need specialty palliative care with a whole interprofessional team. There may be people that need a piece of that care and there may be people that need to stick with their primary care doctor who really has some additional training in

symptom management and communication so that they can help them along in their journey of serious illness.

Brook Calton, MD:

So I think putting some good attention and ideally funding as well into preparing our whole workforce to care for patients with serious illness in the best way possible I think is something that is in our future and really, really important.

Ruth Adewuya, MD - host:

And Grant, I know you're passionate about access as well to palliative care. So I imagined that you agree with that as one of the short-term and long-term goals for improving, right?

Grant Smith, MD:

Yes, very much. I have many ideas and responses to your question, but I do very much agree with what Brook said. And going back to the challenge of misconceptions about palliative care, I do think that that is a really important next step for our field and us as medicine and colleagues to be able to be aware, have some basic knowledge about palliative care. And really importantly to be able to explain that to our patients so that they're not fearful. We have a lot of work to do as palliative care providers on that as well, but we need the help of everyone because patients trust their primary care doctors and their other specialists too.

Grant Smith, MD:

And piggybacking off Brook a little bit too. We also know that as a field, there are populations that we have not successfully engaged in palliative care, and that's going to take some work to find the right language, to have culturally appropriate materials, and certainly to have a workforce that reflects the diversity of our communities. We have some pretty serious work to do on those fronts, but we're excited that we are a growing field. We think there's a ton of opportunity and we have a lot of hope for the future of our field.

Ruth Adewuya, MD - host:

I want to throw out one more question to both of you. Both of you have indicated that there's this lack of awareness, lack of knowledge around palliative care. And so if you were to synthesize that, what is one thing that you would want clinicians to know about palliative care? I'll start with you Grant and then maybe go to Brook. If you want people to walk away with one thing around palliative care, what is it?

Grant Smith, MD:

I think really that palliative care can be for patients of any age and at any stage of a course of an illness. That's really, I think our biggest barrier is that people think immediately end-of-life care. And we're not that. We're much, much, much more and really focus on making life as good as it can be for as long as it can be.

Ruth Adewuya, MD - host:

Great. Brook?

Brook Calton, MD:

I think mine is pretty similar, but what I would say is that to think of palliative care as something that can be done very much alongside other care, cancer care, heart failure care, even curative care. We're an extra layer of support. We can help people get through tough times, both emotionally and physically in terms of specialized symptom management. That palliative care is not something that you go to. Some people will use this word like they're on palliative care or they go to palliative care, or they're not ready to be on palliative care.

Brook Calton, MD:

We don't think of it that way at all. Our goal is to partner with clinicians and partner with patients and families so that people can have the best quality of life possible. And you know, one of the reasons that I like working in the outpatient setting so much is that I get to see some handful of my patients get better. Especially in oncology, I have patients who we manage their pain and their neuropathy and their nausea related to their chemotherapy treatment and they got better, and they got cured of their cancer, or they're in a long-term remission. And that's super rewarding as a palliative care clinician and I think what we always hope for when that's possible.

Ruth Adewuya, MD - host:

Thank you both for that. And I know I said that was my last question, but one more. What would your advice be for clinicians who have been on the frontline and are having to navigate the complexity of dealing with the COVID crisis? What are some measures or strategies that you can advise them to utilize in their day-to-day? I'll start with Brook this time and go to Grant.

Brook Calton, MD:

I don't think any of us are experts on this although as palliative care clinicians, we do think a lot about it. And generally I hope we're pretty good. Although there are high rates of burnout in palliative care too just to point that out, which is concerning. I think one of the main things which is simpler said than done is just trying to pay attention to how you're feeling from day-to-day. Especially I'll speak for physicians. We've gone through years and years of medical training and we sort of have this it's like, "I could just keep going if I put my head down and do the work, I'll just do it."

Brook Calton, MD:

And we all went through residency and that's what we did, but that doesn't work when it comes to a worldwide pandemic. And it doesn't really work when you're taking care of patients outside of a pandemic either. And so just really trying to pay attention to sort of what you're experiencing, how you're feeling day-to-day, and then figuring out a few activities. It may not be 10 things because you can't do 10 things because you're busy in the hospital taking care of patients with COVID.

Brook Calton, MD:

And also a lot of our coping strategies like meeting up with friends or going to a movie we can't do right now anyways, but just like what are a few things that can be restorative for you? And rather than waiting to sort of finish this marathon that's never actually going to end. Doing those now a little bit every day to help sustain you.

Ruth Adewuya, MD - host:

Great, thank you for that. Grant, how about on your end?

Grant Smith, MD:

I just had to think of some mental tricks to help me kind of get through. And I think the idea of self-compassion is one that I tried to think about and a mantra I sometimes tell myself. I'm a young clinician. I sometimes just remind myself like, "I am enough." I am enough for this case, for this pandemic, for this day. I am enough. And I think I just hold on to that and try to remember that as best I can.

Ruth Adewuya, MD - host:

Fantastic. Thank you both so much for your time and for sharing your insights with me today on this topic. I think it's a key topic that we should continue to talk about. And it sounds like lots of innovations has been happening pre-COVID and even within COVID there are still some innovations happening. And so I look forward to the advancement of this specialty area. And again, just thank you for your time and chatting with me today.

Grant Smith, MD:

Thank you. This was great. I really appreciate you having us on.

Ruth Adewuya, MD - host:

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