

DR. JACOB

Hello. My name is Dr. Jacob Strand. I'm a physician in the palliative care section of the division of General Internal Medicine here at the Mayo Clinic in Rochester, Minnesota. I'm talking today about an article I recently published with my colleagues, Dr. Mihir Kamdar and Dr. Elise Carey, entitled "Top 10 Things Palliative Care Clinician Wished Everyone Knew About Early Palliative Care."

STRAND:

Palliative care is a medical sub-specialty focused on the aggressive symptom management of patients facing serious illness, as well as psychosocial spiritual support of patients and their families in addition to helping clinicians and patients work together for complex advanced care planning in the face of such serious illnesses. Palliative care is a interdisciplinary team of physicians, nurses, pharmacists, nurse practitioners, physician's assistants, social workers, and chaplains with a single goal providing the best possible support and care for patients facing a serious illness.

Palliative care was built out of the hospice movement and because of this, there often are malingering concerns about what palliative care has to offer or when the right time to integrate palliative care into the care of patients. One of the things that we find patients and clinicians ask us most frequently is what does palliative care have to offer.

Many studies have recently been published showing the wide degree of benefits for patients facing a serious illness or life-threatening illness when they are able to see palliative care early in the course of their disease. We know that patients experience their illness in a number of different ways.

Now certainly, there are many aspects of palliative care, such as close patient communication, exquisite detail to symptom control, and psychosocial support that really are in the realm of all clinicians. What palliative care is able to do is offer sub-specialty expertise for complex symptom management issues as well as complex psychosocial and spiritual distress amongst patients facing a serious illness.

Implications for patients are many. Patients facing a serious illness such as cancer or end stage renal disease or ALS often suffer from things such as pain, nausea, vomiting, depression, anxiety as well as asking very appropriate questions about what does this mean for me, for my family, and what does the future hold.

Palliative care clinicians and teams can work with patients' primary providers to help address these in a comprehensive format. For patients facing cancer, palliative care has often been acquainted with end-of-life care. This is because palliative care grew out of the hospice movement, where patient's involvement in hospice really was limited to a terminal prognosis of less than six months.

Fortunately, palliative care has grown in the past number of years to really encompass caring for a patient throughout the course of their serious illness. With regards to patients with cancer, we now have very good data to suggest that early involvement of palliative care in patients with metastatic disease at diagnosis actually provides improvement in quality of life, as well as potentially a survival benefit.

Palliative care certainly doesn't replace the care of the patients' oncology team, but rather works in concert with them, helping to focus on aggressive management of symptoms, support for patients and their families as they go through chemotherapy, surgery or radiation, or whatever the course may be for them.

For patients who are experiencing other life-threatening diseases, such as end stage renal disease, severe heart failure, chronic obstructive pulmonary disease, or COPD, palliative care can also be an incredibly important aspect of their care. Pain, shortness of breath, fatigue, depression, and anxiety are all underreported and underdiagnosed in these populations.

We know that even in patients who have COPD or congestive heart failure, the focus is often on dysthymia, and rightly so, as this is a very debilitating symptom. But over 50% of these patients also have significant pain symptoms, which can be treated in many of the same ways.

Palliative care clinicians and their teams are experts in identifying these symptoms as well as bringing a whole team atmosphere working with the patients' primary care providers to make sure that these symptoms are expertly managed. Early and aggressive management of non-pain symptoms in patients facing a serious illness can also have significant benefits for patients' caregivers.

We know that people who are taking care of a family member or another loved one with a serious illness also suffers significant symptoms such as anxiety and depression. Making sure that there is a team approach to help patients and their families manage such difficult situations, both symptoms as well as the psychosocial and spiritual distress that can come along with them, can provide that support and reduce the overall burden on patients and their caregivers.

As a palliative care clinician, one of the questions I often get asked is, is my patient ready for palliative care? Conversely, one of the barriers to palliative care involvement is that we don't want to take away their help. This is an important question, as all patients and all caregivers as well as the clinicians who take care of them in the hospitals and outpatient setting want to do everything they can to support a patient's help as they face that serious illness through treatment and beyond.

Fortunately, what we have found over several years of study is that palliative care does not take away hope. Palliative care does not cause anxiety, and early involvement of palliative care does not cause patients to be more depressed. What we have actually seen in a number of well-designed studies is that early palliative care involvement can actually decrease a patient's anxiety, can decrease their experience of depression, and can help improve their hope.

Given that one of the biggest barriers to palliative care is the concern that patients may not be ready for palliative care or may be concerned that when doctors and other referring clinicians are talking about palliative care that what they're really talking about is end-of-life care. What we know from large public opinion surveys is that the vast majority of patients and their family members don't really understand what palliative care is. This presents a tremendous opportunity for us as clinicians, for us as other health care providers, and for patients who have had experience with palliative care to educate our family members, our friends, our coworkers about the benefits that palliative care can provide.

It's care that is and must be provided concurrently with a patient's disease-modifying treatment such as chemotherapy, heart failure medications, or dialysis. In doing so, we can provide the patient with the best holistic interdisciplinary care. When patients and their family members are informed that this care can be provided at any age or any stage of disease, well over 90% of patients and their family members want that for themselves, for the hospitals they frequent, and for their own family members.

Given that many aspects of palliative care, such as patient-centered communication, expert symptom management, and family support are part of the normal practice of many specialties and sub-specialties. Certainly, skills such as those are really important for any clinician taking care of a patient with serious illness. And this will only increase as the number of patients facing chronic serious illnesses increase over the coming years.

While palliative care provides sub-specialty expertise for patients with difficult-to-control symptoms, common reasons that consult palliative care include difficult-to-control pain, pain existing with other symptoms such as nausea, vomiting, shortness of breath or anxiety, the presence of difficult-to-control symptoms such as refractory dysthymia. Patients with significant difficulty in coping with a serious illness or refractory depression or anxiety, conflicts between patients, their family members, or even between patients and clinicians, ethical concerns about which treatments most closely mirror the patient's goals and values.

Patients who have repeated admissions into the hospital for the same serious illness. Answering no to the question, would I be surprised if my patient passed away in the next year? It's model of care is focused on reducing symptom burden as well as providing psychosocial, spiritual, and emotional support for patients and their families facing a serious illness.

Rather than merely end-of-life care, palliative care can be delivered at any point in a patient's serious illness. It can be provided concurrently with active disease-modifying therapies given that the overall goal was improving a patient's quality of life. Our goal is to work collaboratively with other providers, helping to make care more efficient and focused on improving patient symptoms, quality of life and the experience of their disease.

SPEAKER:

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