Moderator- Hello, and welcome to public health live. It is the third Thursday breakfast broadcast. I will be your moderator. Before we get started, I would like to ask you to please fill out your online evaluation, as continuing education credits are available. Your feedback is helpful to plan future programs. We encourage you to let us know what topics are of interest to you, and how we can best serve your needs. We will take your questions throughout the hour by phone 800-452-0662. You may also send written questions by fax. Today's program is on palliative care, the guests are John Gillespie from Buffalo New York from the center for palliative care, and Dr. George. Lets get started by talking about what a definition for palliative care.

Dr. George- The outcome of palliative care is to address the quality of life of patients and their families. It is interdisciplinary care because we're looking at lots of issues, not only symptoms such as pain, nausea, short is a breath, but also financial concerns, other issues that can affect both patients and families. Very important is that palliative care can be done simultaneously with other measures, either to link in a patient's life, or that are curative.

Moderator- So, one does not preclude the other?

Dr. George- Exactly.

Moderator- Because I think often people think you can no longer take your treatment. Move that notion off the table. When did palliative care come into existence?

Dr. George- This may be the root of the connection, but the roots come primarily from terminally ill patients, especially cancer patients, in the early 1950's and 1960's. There were increasing studies done then. In England was where modern palliative care and will we would call hospice care developed, especially with dr. Cecily Saunders at St. Christopher's that look at education, patient care, and research. In the 1970's another doctor in Montreal established the term palliative care, in a unit in the Montreal. In 1974 there was a hospice which opened in new haven, credited as the first hospice in the U.S. You can see how palliative care and hospice get joined together that way. In the 1980's we have a Medicare hospice benefit, an official team mechanism for a particular type of palliative care called "hospice." But part of that Medicare benefit limited it to care a patient has in the last six months of life. The American medical board, that accredits cardiologists and other specialists, said that palliative care is a sub-specialty of medicine in its own right.

Moderator- I will go with the palliative care -- it is interesting how it came along side-by-side, and then begin to branch off. Dr. John Gillespie, you might have a little breather in the conversation. Because of this, is there confusion over the definition of palliative care?
Dr. George- Again, because of the connection with hospice which is palliative care during the last six months of life, but why should we limit those things that improved patients' quality of life, especially now we have studies that show patients chronic illness, not just terminal, have problems with pain and other symptoms. Their families are under stress, and the medical care system is more fragmented. Patients see more sub-specialists and less of their primary care physicians. Many no longer see their patients at the hospital. That is another disconnect. Unfortunately, this adds to a lot of miscommunication or lack of communication.

Moderator- Do you think that palliative care is under-used?

Dr. George and Dr. John- yes, yes.

Moderator- and with better knowledge you have the ability to serve more people? And making them more comfortable, better, easier to manage?

Dr. George- yes, as you will see, we have a growing number who have advanced chronic illness or living many years.

Moderator- would you say that you have a concern that because there is this misunderstanding, that people do not get into this, and at the think it means they're going to die within six months?

Dr. George- absolutely. Both physicians, nurses, and patients and families think of palliative care as -- oh no, because they think this is the end.

Moderator- What is the current vision for palliative care?

Dr. George- on the next slide, if we look to the left-hand side and say that is when the diagnosis is made, whether heart disease or cancer, and another frequent misunderstanding is we think of palliative care for cancer patients, but why not for people with heart failure and other chronic conditions? Even advanced renal disease. The best model would be that yes, let's do whatever we can to cure the disease to prolong a person's life, but at the same time in that portion of the slide, also start doing palliative care. Do not wait until the very end to address those issues of some control.

Moderator- so, at the very end, does palliative care and at death?

Dr. George- no, and at that time it would be working with hospice, and hospices that model of palliative care at the end of life. Families have services to help them with the year after the person's death.
Moderator- we will do a case study now. Let's begin by hearing a little about the patient.

Dr. George- this is a patient in the case study, in her upper 80s, she had many of the problems we see in the practices every day. Dementia, high blood pressure, arthritis, osteoporosis, but she was living and had been for years and an assistant living facility. In June 2008 she was sent to the emergency room because she was confused. This is a situation where problem developed, the primary-care doctor was not able to see the patient at the facility, and there was not a way to get the patient to the doctor's office, so she was sent to the emergency room -- as we do excellent medical care she had the big work up. That included neurology. Multiple medications, all good for a problem she had. When they did the carotid or ultrasound they showed a little blockage, so she was begun on a cholesterol medicine and aspirin. She returned to the assisted living facility, but then a little bit weaker. I think we see that patients with advanced illness, or hospitalization takes a little out of them. Then she returns to the hospital in September with having vomited some blood. At that time she was seen by a gastroenterologist and they did studies, she was seen by a lung specialist, and started on antibiotics and returned to the nursing home. With her first admission she was able to walk with the walker. Here she was much weaker. In November she returns to the hospital. At this time the poor thing is literally in a fetal position, just crawled up in a bed, not communicating. She has four large bed sores on her. You can see over a period of months the rapid deterioration. The major thing we did then was to sit down with her family. That is the major procedure. The family was very clear. This patient had already completed the health-care proxy earlier, before she had lost capacity. She had completed a living will. She had made it very clear that the most important thing for her was comfort, and it was to stay at that assisted living facility, that home. She did not want to keep on going back and forth to the hospital. We looked at her medications. For example, the cholesterol medicine was important, but at this stage -- why? It is not just stopping medicines. She had these very large sores, so we began around the clock pain management. We know that such patients cannot communicate pain easily. We began the medication.

Moderator- If she was not involved in palliative care, with the assumption about her pain and the need to manage it have come to the fore?

Dr. George- Much less likely. As well as looking at -- these are the medications -- importantly setting the goals first. That is a critical part of appearing to care. What are the goals for this patient while meeting with the family, and a fleet the patient. These wounds were a source of pain for her, and we let her eat, rather than putting in a feeding tube. We involved hospice, so the next thing something happened in the middle of the night -- a hospice nurse could visit, as opposed to sending a person to the emergency room.

Moderator- What did you think was going to happen with this patient?
Dr. George- I was convinced she would pass away comfortably at the assisted living facility within a couple of weeks, I was sure that one of those sores would cause an infection.

Moderator- What really happened?

Dr. George- We can show the slide, and this is a picture of her three months later. That is not her best smile. The better one is when her aide comes in. She lived another three months and had to come off of hospice. When I last checked on her she was still living in assisted living.

Moderator- do you think that because she was having paid to care, and you were tending to all of her needs, that made a difference?

Dr. George- Yes, clearly, if you look at that case we were doing traditional medical care which is good, but she was getting worse and worse. It is important for families and patients, that sometimes to get a pain medication is the best thing.

Moderator- She is still alive?

Dr. George- Yes, as of three months ago she is still alive.

Moderator- Clearly from this study we learned, as most medical practitioners know, that is not predictable. So what do we know?

Dr. George- If you go to the next slide, you can see patients who have cancer which is the top blue line, cancer tends to have a more predictable trajectory. Especially when a patient gets to that time where they're spending more than 50% of their waking hours either in a chair or bed because they are so tired, then generally we're looking at only a few months of life left. However, for non-cancer patients, and this is important for palliative care because it is hard to predict, -- it is more of coming into the hospital, having an episode -- sort of like a patient in the case study. They don't always return back to the same level. During one of the hospitalizations they will pass away, but it is much less predictable.

Moderator- that is not predictable. Let's look at one family's story.

Dolores- My name is at the Dolores Green. I have a husband who recently died. His name is Clifford Green. He began coming to the va after his last discharge from the service. When he became ill he continued his care there at the va hospital. He was at that hospital when he died. He had multiple Leoma and I took care of him for many years. It is a disease that is terminal. Patients are not cured of it. They can have a prolonged life with treatment.
Dolores- my husband was diagnosed approximately a year-and-a-half before he died. Receiving all his care at bva hospital they did offer various options to him. In the end, when he was re-hospitalized again, he did fall under palliative care in that unit. That is when I became in touch with the doctor in a palliative care team.

Nurse- palliative care is to try to help patients through the transition from an illness to beyond.

Dolores- the team was magnificent. The support they gave my husband and myself was unbelievable. I find that the va hospital in brooklyn, everyone I have come into contact with seems to be very upbeat, although they're working with seriously ill patients, although my husband knew he would not survive the disease that he had. He just said, well, this the path I must travel. Approximately a day and a half or so before he died, we knew that he was not going to make it. We were all able, the entire family and friends, to hold a vigil by his bedside. The palliative care team made such an effort to make us comfortable, to help us through this difficult period of time.

Nurse- one of the things we try to figure out is if there is a special event coming up. And you met him right before his 75th birthday. He just wanted to make it till his birthday. So, we talked to the head nurse who said she would arrange for the cake.

Mr. Green’s doctor- I think it is because of the emphasis we have gone recognizing what is important to patients and families. It is not just that they get the right treatment or chemotherapy, but we recognize them as human beings.

Dolores- after he died, Dr. Beal and the palliative of care team told me that at any time I could call them and I could speak to them are come in to see them, that just because he died it was not the end of our relationship.

Nurse- palliative care does not end of that. Just as the patient and family is the unit of care, after death we follow up with the family.

Dolores- there is no good death. You are always devastated when somebody you love dies. After 42 years of marriage it was very difficult. But, some of the very positive things that occurred was the fact that we knew he had a terminal disease. So, Clifford and I were able to discuss what was going on. We spoke very frankly about a lot of things. I knew after he died exactly what to do. I knew what undertaker he wanted, what type of church service he wanted.

Moderator- That is a very telling story that speaks to the point you have been making. Is there a growing need to provide palliative care to the population?
Dr. George- absolutely, because of we're looking at palliative care to help to address the needs of patients and families with advanced chronic illness, we're having more and more patients with multiple medical problems. Some of that has to do with the aging of the population. You can see the projections for people over the age of 85 doubling up to 10 million by 2013. In addition, 23% of Medicare patients have more than four chronic conditions. Those are the patients, who about 60% of all Medicare spending. For the physicians and nurses we see patients routinely with high blood pressure, high cholesterol, diabetes, arthritis. Those are four conditions right there, and to help treat them they are on five or 10 different medications.

Moderator- At what time should palliative care be considered an option?

Dr. George- I think we should be discussing those issues of suffering as early as possible. If we remember back to the slide showing the diagnosis of the serious illness, practically its maybe a first hospitalization for something like that. Certainly at chronic illness we should address bit of care.

Moderator- has this changed in recent years?

Dr. George- Absolutely. It has only been recognized as a specialty for the past few years.

Moderator- Let’s talk about the dollars and cents. How those paid to care benefit society as a whole?

Dr. George- we can talk specifically about money in the next slide, looking at the number of people and the growth of about 11% in Medicare hospital payments in 2008, close to three-quarters of Medicare budget spent on hospital care, and the amount spent during the last six months of life. More important than the numbers is the value. Are we getting the care that patients and families want, especially near the end of life. Were we getting the care for the elderly patients? Was that the care that she wanted with those repeated hospitalizations, or was it pain medications and other care? That is the value. There may be savings, but the most important thing is we're giving the care that patients and families want.

Moderator- why should a family or individual consider palliative care. It carries an option, as in check list? If you're taking the cliff notes to someone?

Dr. George- I would almost reversed that and ask, why not? If there is the connotation that makes them think oh, I am dying, then I can see what people would want to avoid that. But otherwise, if you can see you're at a state where we need to address these issues and live as long as possible, then there would be no reason not to.
Moderator- and someone might ask why wouldn't hospice care or another alternative be enough?

Dr. George- I think hospice would be an excellent choice and palliative care could lead into it in the patient who has a prognosis of less than six months. One of the difficulties and why hospice is under-utilized is because it is difficult to project that point.

Moderator- That makes this the perfect place to do the handoff. If you could talk a little bit about the home connections program? What is it?

Dr. John- Home connections was a program we began in the Buffalo. As George has been saying, one of the problems is not enough people get in to receive palliative care. We were looking to see if we could expand. As we have also talked about hospice for people whose physicians think they have less than six months, but its clearly only a small part of where palliative care could help. We were looking for a group of people who have significant chronic disease, have longer than six months to live, and to make this available to them. The importance it here is that we were concentrating well-beyond just cancer. We're talking about people with advanced heart disease, advanced pulmonary disease, chronic renal failure, kidney disease, and also people with dementia, all falling into this group we thought would benefit from palliative to care, but were not really receiving it.

Moderator- a much wider net?

Dr. John- Yes.

Moderator- What are the overall outcomes of a program like this?

Dr. John- When we started this, we were hoping, as George’s referring, that because they would get more coordinated care, that there would be a reduction in cost. A lot of times in those last years when you have a chronic disease, there are things done that do not really change your overall quality. They just get done because maybe there's a lack of communication, or often, the patient has not been an asked. One of the recurring themes here is always to empower the patient and empower the family so they really understand what is going on in can make some choices. So what we saw with the program is we have increased referral to hospice. These would have been unrecognized. They went in earlier which we feel is always a good outcome. We also saw we had less use of hospitalizations and emergency rooms and a huge bump in the number of those with advanced directives or health care proxies', and had them identified. Also, the proxy also knew what the person wanted which is not always the case. You have that story for you go and talk to the patient who has this kind disease, an illness, and you have a proxy? Yes, I do, they say. They might say it is their wife. You ask them if they know -- they do. The
husband says, of course. You look of a wife, and the wife says, I am also sure we ever discussed this. [laughter]

Moderator- you have written it in good times, and now there may be a change in what you really want.

Dr. John- that is the other thing. Not only do have to have the advance directives, but you should update them once in awhile because things do change. A person may want different things from year to year.

Moderator- what is the flow of patients through home connections, to and from other programs? How does someone find out about you and get involved?

Dr. John- we ran this program with local interests in Buffalo. They for helping us to identify people, and would identify as in the upcoming slide -- people would come in, and we had a case worker commanders to call them and tell them this was a program that was an add-on to the usual care, for free.

Moderator- for free?

Dr. John- yes, that always helps. So, once they were enrolled, what happened is about nine of 10 people thought it was a good idea. Initially, out of that, about three of those nine people were found to be hospice candidate. That was sort of a smooth transition for people who would not, that would not have happened. It would not have been recognized. We also saw over the ensuing next year about half of those people again move into hospice from palliative. It was a very nice transition -- you can have the palliative care, and at a certain point hospice becomes an alternative that you can sign on for. The other thing we're talking about, about 35% to 45% when we contacted them had advanced the directives, which is higher than the national average of about 20. By the end of the program over 90% had these advance directives. That is a huge issue for choice.

Moderator- is there cost savings?

Dr. John- the cost savings has been well-established by Medicare. They know anyone who goes into hospice, for every dollar spent there you saved a $1.52. If they were not in a hospice it would be costing almost 50% more. It has been well-documented. This is obviously for the continue to encourage the use from Medicare standpoint.

Moderator- There is also a physical cost and a savings there?
Dr. John- Yes, once people have been empowered to decide, first, would you like the and when this happens? Then they can make choices, they want to go to an emergency room, or continue to receive care where they are? Do they want a hospitalization? Going back to George’s example before, a lot of times, especially for older people, it is a downward step to go into the hospital. Not because the care is not excellent, but as with my mother, and the time she went into hospital she became very disoriented. It was a struggle to get back when she had left.

Moderator- There new studies out document in just that. Especially with seniors. Tell us a little more about cost savings. How are overall costs mitigated by bringing on paid to care or hospice early on?

Dr. John- Well, sometimes if people decide that it this time -- maybe they have had several rounds of chemotherapy. The look is not going to be a dramatic change to continue or not. Maybe then they make a decision that it is more appropriate to stop that, and moved into other measures for a high quality of time left. Some people would choose not necessarily to return to a hospital, but would prefer to have the rest of their treatment at home. There are often times when tests will not make a significant difference in treatment. The importance of this, the palliative had always been in conjunction with receiving their treatment. It is not stopping your treatment, but just an addition. Sometimes there will be decisions that you stop certain things which will have an effect on the overall cost. We have never had anyone not receive what they wanted. That level of the quality of their life goes up.

Moderator- We’re not talking about rationing here, but empowerment?

Dr. John- Exactly. If you were to ask families, they feel they have some control, rather than as out of control, I have nothing to say about what will happen to me.

Moderator- Does the patient’s use of have some connections any impact on visits to the emergency room. They make sure not to go there. Hospitalization rates also fall?

Dr. John- Sometimes I don't think it is that they're choosing not to, but because they become more empowered with what is going on, they recognize symptoms that might have had them go before. For example, some with congestive heart failure. Often that is just getting more short of breath. Then you have to go to the emergency room. With these types of programs because of the nurses and extra care givers, the member becomes aware that if they are little bit short of breath, they ought to call someone a little bit earlier. Then, often, and nurse might be about to go to the home and give them a medication that would prevent the need from going in. It is not that they're not getting a certain therapy by going to the emergency room, but that they have avoided that by getting better care. They have learned themselves how to take care of themselves better, and to avoid having to go to the emergency room.
Moderator- Yes, as you're comfortable with your own surroundings. What are the program outcomes for patients with advanced directives?

Dr. John- From the program standpoint, we do satisfaction surveys. The importance when you look at this, people give very high ratings to the care they received. The families also give very high ratings. There is more communication. The family members often do not know sometimes what the person wants. You have more communication. It gets much more organized. People read these programs very highly, as they do in a hospice. There is that understanding, being able to be part of the decision-making.

Moderator- Medicine in its totality can be threatening.

Dr. John- Yes, and when you have someone who is sick, your family member, the thought processes are not the highest. It takes time for people to walk through--- this is where we are. These are choices rather than directives.

Moderator- If you could, Dr. John Gillespie, give the viewers an example of time connections in action.

Dr. John- So, have a couple of them up here. Sometimes you have people with terminal illnesses. A lot of times they don't feel they have the control. They will recognize that they have a limited life span, and it will not be as long as they thought. For them, and they can participate as to what will happen, it makes a huge difference. Yes, this will happen, but then they can walk through it. As we saw in the first film there, the importance of being able to talk to other family members, and to make those choices and participate, instead of constantly feeling like you are a victim, that everything is falling downhill.

Moderator- Patients are saying that they are satisfied.

Dr. John- Yes, they are. It is the same thing. It is always the control thing. If you are not in control of anything -- and I am sure that has never happened to you, but -- [laughter] When you don't have control --

Moderator- It feels like hitting black ice.

Dr. John- Yes, rather than going across, seeing the exit on the other side, having a way to get there.
Dr. George- You used those "r" word and I will use the "h" word for hope. Talking to people with terminal or advanced chronic illness, when they do not feel in control, they feel hopeless. Conversely, feeling like you have some control over what is happening to you empowers you to feel hopeful. By giving them some choice you will strengthen their sense of hope which is so important.

Moderator- Yes, very important. How do the caregivers feel? We have been talking about those who are getting the care, but how do caregivers feel about the connections program? Do you do a survey?

Dr. John- I have an internal satisfaction. I think with caregivers it makes things a lot more important. You know--- they know that they have had the conversations, with their husband, father, brother -- that they want. That gets, it makes everything a lot easier, especially, I think one of the things you see that people talk about what they want for the funeral, what kind of service they want. Often you see when someone has died, you get into grieving. No one knows exactly what they want. There is continued frustration. But then when the person with the chronic illness has conveyed that -- this is what I want: And then another person says okay, this is what you want. That really simplifies things.

Moderator- You have started this, haven't you?

Dr. John- Yes. Surveys are very high. Over 90% of caregivers are exceptionally happy about how this worked. That is very good.

Moderator- And you don't have to argue with an uncle. You cannot be angry at the deceased. It has made life simple. These are the things that come up.

Dr. John- You see this all the time of large families where some of them are distant, and then when the mother or father has a chronic illness there is always what we should do -- or we should not. When it has been done beforehand, and someone brings up no, this is not what they wanted, then everyone acquiesces, it is so much -- From a physician standpoint, it certainly simplifies the role for the position, and external caregivers.

Moderator- What benefits do we see as individual payers, taxpayers, and as patients in having programs like home connections?

Dr. John- One, it is more effective use of everyone's funds to do this. Many studies show that with choice people make good choices, get great care, and have high quality at a lower cost. The second thing is that the satisfactions for the caregivers and member are all very high. Thirdly, as
you can see in those slide, we have increased referral to hospice which everyone has been in favor of been a decrease hospitalizations. Much greater use of advanced directives.

Moderator- Which works all the way around. You know, we usually think of palliative care for senior citizens. We tend not to think of it for your people, but that is not always the case. Let's take a look at another story now and how palliative care benefited a family on Long Island.

Mother- We had twins. Genevieve and James were born in 1996. As far as we knew, everything was fine. Then the children are born. James was taken from the delivery room. He was not breathing. They worked on him a bit. Then he began breathing. Genevieve was fine, no problem. They did not know what was wrong with James for about a month. We sensed there was something wrong. They gave him a blood transfusion. They could not do a brain scan because his breathing was erratic. They could not take the chance of disturbing him, so they finally did do the brain scan and determined his brain had not developed fully. When we found that about James, they suggested we put a d&r into effect. We discussed that before they had mentioned it to us. His quality of life would not really be quality of life. And the doctors were in there and James was rolling all over the crib. He was moving and turning. I was so excited, thinking well, he looked fabulous. The doctor who happened to be neurologists said, as I was on her what happened, she said -- I said I was hoping. She said there is no hope. He was transferred in November to St. Mary's. That is where we decided on the palliative care. They really just tried to keep him comfortable. The physicians were wonderful. To the physicians, you have to give parents time to breathe, to digest things. You know a lot earlier than parents know there's something wrong. We need to digest the information a little more. You have to walk around on eggshells a little bit to sense how they will handle it. Jimmy and I sensed early on that there was something off. James' cry was really strong. We really knew something, but we did not think it was as bad as it was.

Father- I work nights till 2:30 a.m. They did not give me a hard time. They remember your face. That was great. I enjoy the freedom that I had just going up been sitting there.

Mother- I think, first of all, to come to the decision is a process. Now this is all you're doing for your child. Many people are thinking, can you do this, that, what if you do this, see another doctor? But I think, just communicate to the caretakers that are helping you, and for us faith was an important part of our lives, still is. That got this through a lot of hard times. Also, doctors and nurses are not mind readers. You have to communicate to them what you do not like. If you don't want your child wakened for this or that. They really were good that way anyway. They are so experienced. It is like a calling for these people in palliative care. They are a special breed of people. It is so intimate. For physicians to tell parents, one step at a time. You cannot take in everything at once. It is too overwhelming. What is the next step? What am I doing tonight? Not what am I doing three weeks from now. What can do for my child today?
Moderator- A powerful story, one that we'll need to consider, that palliative care is for the chronically ill, the disease process, not the age of the person. It embraces an entire family. How does a primary-care physician fit into the end of a lie for the palliative care?

Dr. George- well, because so many models of how to take care of our aging, increasing chronically ill population has the primary care physician or a medical home model -- we want the palliative care team to be of support to the primary-care physician. Or the cardiologists. Many cardiologists are really the "primary care doctors" of those with congestive heart disease.

Moderator- Do the primaries ever feel a little pushed out? Do they always feel they have an equal place of the table?

Dr. John- I would say that can happen. But that is one of the growing pains of doing this, of where this will be helpful, rather than a take away. Anytime you bring in new programs it is never easy to do change. But I think over time you'll see that become a lot smoother. With this introduction, I could see -- I have seen where that has happened, but I think will be less and less as it goes along.

Moderator- It seems to me many people have a very good relationship with their primary or cardiologists, and if that position buys in, it is a smoother transition to palliative care.

Dr. George- Absolutely. It does not make sense to establish -- many palliative care teams are hospital-based. It does not make sense to establish a care plan based on the patient's and family's wishes -- not to have the physicians or caregivers out of the hospital not to be part of that. An important thing we do is to contact the patient's primary care giver or cardiologist to inform them of decisions made, and contact them before me with a patient. Exactly -- they have known the patient much longer than we have.

Moderator- They have the relationship.

Dr. John- Yes, this does not stop treatment. That is the important thing. There is not uniform acceptance, not only among patients, but also among physicians. Many physicians often think palliative care -- we will stop everything else. That is not what happens. The best slide was his first, that as soon as you're diagnosed people should start to think about the palliative as well as the curative side. Before it has only been -- there is no hope, so must be time for palliative care.

Moderator- A few more questions, the first I would remind you that we are taking questions throughout this hour by phone. Or, of course you can send a written questions in by fax. How does integrating palliative care effect of the primary-care provider?
D. George- We are hoping -- first, many palliative care physicians now, because the board certification just began in 2008, come from primary-care backgrounds. I am an internist. Many are family care physicians or internists. They have decided to say that this is an important thing the country needs and we need for our patients. Primary-care physicians have a lot on the plate. This is a study from the New England journal of medicine saying that the typical primary-care doctor with the usual patient mode, if that position called all the recommended preventive services and would take them 7 and a half hours, and then, if you look at the long-term services, an additional 10 hours. We're talking and 18-hour day with the typical patient, just following all the recommended services. Some of these discussions in the terms of setting goals, talking about the importance of advanced directives -- as you said, it is a process. As palliative care physicians, we are happy to be part of those conversations and help.

Moderator- That is what the next slide shows. And it has a quote on there as well.

Dr. George- Hope for the best, but be prepared for the worst. If we had three nutshells to bring back to the office -- hope for the best, but be prepared for the worst. It is not stopping treatment. Also, our patients with chronic illnesses, when we walked into the exam room we have 15 to 20 minutes. We're wondering about ldl, blood pressure -- the patient might be thinking something completely different. Let the patients decide. Ask the patient, what is the most important thing to you? If we want to partner with patients so that they agree with the plan of care, we have to make sure that we know what is important to them. Finally, try to at least bring up the subject of advance directives. We hope all goes well, but now that there have been tragic cases. Young women in excellent health who have been in the car accidents or other things. We should not wait until the end to do an advance directive.

Moderator- The twenties is the age where you think you will live forever and nothing will touch you. That is a particularly thorny conversation.

Dr. John- It is interesting. We were talking earlier about the younger generation. One of the things I always try to stress is, you like your civil liberties, then you want an advanced directive. When these tragic accidents happen, the state will step in. Many do not like that idea. Many times you can get to their sense of independence.

Moderator- Yes, and that is a good way to phrase it. We had a couple of questions phoned in. Somebody called to say, my sister had several lengthy hospitalization for cervical cancer. She continues to have great pain. How do we go about getting her the palliative care that she needs?

Dr. John- Well, the first thing is looking into seeing if there are palliative care councils in the area they're calling from. If that is not obvious, then a good thing would be to probably contact
hospice. Hospice is often connected with that and may have programs that the person may not know about. Those are two ways. Clearly, pain management is a big part of both of these.

Dr. George- There are actually two websites that list palliative care providers by region, and one is the American academy of hospice and of medicine. You can Google that. Or compassion and support, Compassionandsupport.org. Then you can search for a palliative care provider in your area.

Moderator- Sometimes it is difficult to question a doctor, not just the seniors with that sense. How do you open a dialogue with your own physician if they have not already addressed your pain issue, and they have not brought palliative care?

Dr. George- Again, it is that issue of letting the patients set the agenda. Bring someone in the room with you. I strongly encourage patients to do that. There is a lot of information. Have an advocate, whether it is a spouse, son or daughter, or friend. If we're talking about primary-care physicians, people have had a long relationship with the patient, hopefully they will accept that.

Dr. John- I’m sorry. I also think it is reasonable to tell people they should take control. Because, it is your life and you should have control over that. It is reasonable that if your physician is not doing that -- people are pretty busy, just state your case, your wish to do that. You will usually get a pretty reasonable response from them. If not, you have the choice of trying to find someplace where you might. When people give up control, that is not good. For patients, it is important to realize that it is them and their control.

Moderator- And it is a team. The physician helps to give that control and to share that control.

Dr. John- It works a lot better. You know that these are some of the options, sometimes difficult ones. It helps for the person to say I like one. And it is easier to say one is a good idea. Because sometimes between one and two there are significant differences. The other thing you often see, the control does not go excessively far -- people want guidance. Most people will not go out on the internet and decide which therapy that they want. They want help from their physician. But I think it is mutual, rather than -- this is what we're going to do. I am not advocating that a patient comes in to the doctor saying these are the three things I want to do. On the other hand, if there are conversations about that, it makes easier for the physician and patient.

Moderator- Yes.

Dr. George- And saying perhaps, these are the three things I want to talk about today. Have the patient bring the list. Granted, if it is 14 things, may not be able to get to those of many in 20 minutes. But maybe get to the top three things. And at the beginning of the visit, frequently
what happens is at the end of the visit, that is when we get the list. At the beginning say, please, I would like to reserve some time to talk about this.

Moderator- You both mentioned the palliative team. Who is on that team? Who comprises that team?

Dr. George- Because we are addressing so many issues, it is an interdisciplinary team. At many hospitals are counseled teams that include a nurse, social worker, pastoral care, the physician. Many times also there will be a pharmacist. It is an interdisciplinary team. Sometimes the suffering, discomfort the patient is having cannot be made better just by increasing pain medication. It may be the financial issues -- how to talk to my spouse about this, or my children? That is better done by a social worker or such.

Moderator- We have covered an awful lot of ground in this hour. Thank you to you both for joining us today. Please fill up your feedback on line. Continuing education credits are available. We are archiving our videos on two new ways. They give you a high-quality web version of this program. They will be up by early next week. Our standard archive will be up in about two weeks. The next broadcast is on March 18. I want to thank both doctors for their time and expertise. Thanks again for joining us on public health live.