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VOICEOVER:

Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Adam Striker, your editor and host here today with Dr. Sandra Sacks, Clinical Assistant Professor of Anesthesiology and Pain Medicine at the David Geffen School of Medicine UCLA. Dr. Sacks is also the Vice Chair of ASA's Committee on Palliative Care. She's contributed to *The Monitor*, including an article in the November 2020's feature section Embracing Opportunities in Palliative Care, and the article that she wrote was entitled *Anesthesiologists and Palliative Care Integrating Interventional Pain Expertise into Palliative Care Teams*.

Dr. Sacks, welcome to the show.

DR. SANDRA SACKS:

Thanks so much for having me. I'm really grateful and excited for this opportunity to share more about a subspecialty of anesthesiology that many people may not be familiar with.

DR. STRIKER:

Absolutely. And we're looking forward to the discussion. And before we dive into the meat of the discussion, do you mind telling us a little bit about yourself and how you came to be interested in palliative care?

DR. SACKS:

I took a bit of a non-traditional path. When I was a resident at Stanford, I really had no idea what I wanted to do after I graduated. I was one of those residents that really enjoyed every rotation that I went through. I thought I wanted to do peds anesthesia. I

was really interested in critical care. I was fascinated by the physiology with liver transplants and cardiac anesthesia. But I found myself coming back time and time again to the ICU and, you know, taking care of patients in the ICU was incredibly meaningful. But the hours are long and it's a, an environment that really makes you think about mortality.

I remember wanting to know so badly who this patient that I was taking care of and that I was spending so much time on. And I remember every time that families would visit, no matter how busy I was, I always made time at the end of my shift to go back and just chat with them and learn who they were, who the patient was, what the relationships were and what their stories were.

It was during one of my rotations in the ICU that I was introduced to palliative care. I didn't even know that it was a possibility to pursue a palliative care fellowship after anesthesia residency. But the more I learned about palliative care, the more that it seemed that it aligned with a lot of my own goals. So I went on to do a palliative care fellowship at Cedars, and after that it just made sense to do a pain fellowship. It went really hand in hand together. As palliative care providers, pain management is a huge part of what we do, and we have this added benefit as anesthesiologists that we're good with our hands and we like to do interventions. And it just made sense to do another fellowship after my palliative care fellowship so, so that I'm able to provide patients that I see this continuity of care of doing medication management, but also evaluating and doing the, any sort of interventions that they may need. And I got very lucky that UCLA was able to offer me a position that utilized all of my skill set in this unique niche of interventional cancer pain.

DR. STRIKER:

That's pretty interesting, especially with the addition of the second fellowship, was that something you just felt was a natural progression or did you have some encouragement to pursue that, the interventional pain fellowship afterward?

DR. SACKS:

It was something that I, I definitely just fell naturally as I was thinking about what the next step was. I think as during my palliative care fellowship, there was definitely times where these patients were limited to medications, but were, we were limited to further titrations because of side effects. And oftentimes they really needed an intervention. And, you know, as an anesthesia resident, yes, I did a chronic pain rotation, but never really thought too much about being a, an interventional pain doctor. But yeah, you know, after doing palliative care fellowship, it definitely just made sense that pain

management is such a big portion of what we do, that being able to offer the interventional piece would also be so helpful to these patients.

DR. STRIKER:

Well, historically, anesthesiologists haven't always been integrated into palliative care teams, at least not very well. Is that changing at all? And if it is, how has the integration of palliative care changed the practice of anesthesia?

DR. SACKS:

I would say that historically, anesthesiologists really haven't been integrated into palliative care teams because there may not have been a huge overlap. I think really the main overlap that we see is in the ICU when palliative care specialists are consulted, when there are conflicts between staff and family members or disagreements about medical futility, difficulties with communication barriers. But I think there's actually a huge need for well-trained palliative anesthesiologists, especially with our surgical population. As surgical patients are aging, are, we know that frail patients are at increased risk of perioperative complications. I think as anesthesiologists, we are the perioperative physicians and we're primed to be the leaders in this area where we can really walk with the patient from pre-op, inter-op and all the way through postop to be able to help support some of their palliative care needs.

I think a big part of it is really getting to know what patients want and what they expect from the surgery that they've consented for, what some of the perioperative outcomes that they're hoping for and even discussing what post-operative outcomes that they find unacceptable. Some patients may not want to be on prolonged ventilator dependence. And unless some of these things are clarified beforehand, I'd say that there's this concept of surgical buy-in for surgeons and even the surrogate decision makers may think that when patients are consenting to surgery, they're also consenting for any post-operative interventions and treatments that are necessary to prevent post-operative death. So I think there's a huge role for anesthesiologists to take part of this in the coming years as our patients get older and frailer and more complicated.

DR. STRIKER:

Now, is that role something that you feel the anesthesiologists or the specialty at-large should be more proactive in pursuing? Or is that something you feel that we as a specialty have been just sort of shut out or, or forgotten about.

DR. SACKS:

You know, when patients are referred to an anesthesia pre-op clinic, and we, we do risk assessments with a variety of tools. I think this is a great area where we can have some of these more meaningful conversations. I don't necessarily think that we're shut out from having played this role. I think that we just haven't stepped into this role in the past because we may not have felt that we were in the position to have some of these conversations. But we're assessing these patients and using risk calculators like a frailty index or post-op respiratory distress calculator or, you know, using a revised cardiac risk calculator. I think this is also a great place to break down what that all means to the patients and families and get a sense of what some of their expectations are, knowing that they may be at increased risk for complications. And being able to explain to the surgeons and, and post-op care teams that this is what the patient expects and what they're willing to do or not do in order to meet some of these expectations that they have.

DR. STRIKER:

Well, you've mentioned the ability to give patients a voice through your work. Can you talk a little bit about that?

DR. SACKS:

Of course. So palliative care, and I'm not sure how many people are familiar with it, the philosophy of it, but it really is to just provide an additional layer of support and to improve the quality of lives of patients and families who are suffering from severe illness. And there's really no agenda that we try to push on patients. Our goal is really just to make, to empower the patients to have their voices heard. And so we listen to what patients' goals, their values, their preferences are based on the current situation.

With the current modern age of medicine, patients are often seeing so many different specialists and there's so much complicated medical information that's being presented to, to them, we can help synthesize some of that information and help them make medical decisions that align with what they're hoping for.

DR. STRIKER:

You know, one of the keynote addresses at the ASA a couple of years ago, talked a lot about focusing on, and discussing with patients what the goals are to better serve them and figure out what interventions, what the medical processes we should undertake to, to help them. And probably as, as medical professionals in general, not just anesthesia,

we probably don't do that enough. And it sounds like that is very much up the alley of what you're doing and what the palliative care philosophy is.

DR. SACKS:

Yeah, absolutely. I think even in the pre-op clinic or even day of surgery, an easy thing for everyone to ask their patients is what are you hoping for? That also tells you what patients understanding of what the procedure that they're getting is. And maybe it doesn't necessarily align with what the surgeon wants or has told them. But I think we can gain a lot of insight into what patients' goals are. But just asking a simple question of what are you hoping for?

DR. STRIKER:

Well, let's talk a little bit about the complexity of palliative care and why that complexity requires a multidisciplinary team effort to drive better outcomes. And if you can maybe just talk a little bit about how anesthesia fits into that mix.

DR. SACKS:

Sure. So I like to introduce palliative care and define palliative care to patients as a three pronged approach. So the first part is that we're symptom experts. We have an extensive toolbox where we can help patients with their pain, nausea, loss of appetite, fatigue, a variety of symptoms. And we also provide psychosocial support to patients and their families. And this means that we need members that are beyond just nurses and doctors.

Palliative care teams are interdisciplinary, so they often include social workers, chaplains, sometimes nutritionists, music therapists. We have to remember that the overall goal of palliative care is to improve the lives of patients and their families and to help them really through this time of difficulty and, and coping with psychosocial distress.

And finally, the third piece is that we're communication experts. So we're the bridge between the doctors, patients, families and their, all their multiple care teams. I think that anesthesiologists fit into the mix naturally. We already think of ourselves as the perioperative physician. We're good at managing symptoms and we have a strong understanding of surgical care. We might not think about this a lot, but there aren't very many physicians that actually step beyond the doors of the pre-op holding area into an OR that's not an anesthesiologist or a surgeon. And we're very well positioned to be able to provide this type of specialized medical care to patients because we understand

both the perioperative side, but also we can help advocate for patients with the specialized palliative care side.

DR. STRIKER:

What are some of the peripheral benefits of providing palliative care to patients?

DR. SACKS:

I think patients and families definitely feel more supported and they know that having a team on their side to make their voice heard is very empowering. I think it's very comforting for them to know that there's not really an agenda, but really, that we are just trying to make their voice heard and trying to synthesize all the complex information so that they can make the best decisions that work for themselves and their families.

You know, there's a landmark study in 2010 from Teml et al that showed that patients with metastatic non-small cell lung cancer that were enrolled in early outpatient palliative care lived longer. It's not been replicated, but we have to remember that how heterogeneous palliative care is, and that's just one small population with a single type of diagnosis. But more importantly than longevity, there's been multiple studies that showed improved quality of life, decreased health care utilization and cost, and improved satisfaction from patients and their families. And I think that's what's most important.

DR. STRIKER:

Well, I was wondering if you could tell us the story of a single patient you've worked with or a case study to exemplify how palliative care plays out at the patient level specifically?

DR. SACKS:

I remember this case well. It was in the beginning of when I started my current position as a junior faculty. She was in her 70s and was diagnosed with metastatic pancreatic cancer. She was extremely sensitive to opioids, but had severe pain. And I remember talking to her about her goals and one of her big goals was making it to the birth of her grandson. And so we did a celiac plexus block. She was able to come off of all her opioids. She even traveled to Maui and was able to renew her vows with her husband of 50 years and attend the birth of her grandson.

Eventually, after four months, the pain came back. Additional imaging showed that the disease had progressed. We repeated the celiac plexus block at that time, but she didn't quite get the same benefit as she did before. And it didn't cover all of her pain because of the progression of disease. She was still very sensitive to opioids. We weren't able to use very high doses, so we decided to do an intrathecal pain pump. And with that, she was able to live a really good remaining of her life with good quality of life. She had a lot of meaningful moments with her family, with very minimal symptoms of nausea, constipation, very little drowsiness.

And throughout all of this, UCLA, we have an innovative oncology service that provides support groups and psychosocial care to patients and families who are affected by cancer. And I could just tell just from, from seeing the patient and her family time and time again how appreciative they were to have this team approach to taking care of them and having this holistic approach to their care. And they definitely were very grateful that we were in constant communication with everybody on their team and keeping them in the center of our care.

DR. STRIKER:

That's a wonderful story. And what a great example of just how a team approach engaging with a patient and discussing their goals can, can make such a difference and an impact on the patient.

Well, do you envision palliative care becoming more necessary as more people live longer, you know, obviously, with a range of health conditions? And what are some thoughts or predictions regarding how palliative care will evolve, especially with anesthesia?

DR. SACKS:

I definitely think palliative care will, the needs are going to be increasing tremendously. Patients as they age and become more frail are going to have more needs for just symptom control. But also, as I mentioned earlier, that there's a real risk for some of these patients to lose decision-making capacity after surgeries and for us to elucidate what some of their goals are before surgery. And some of that conversation are so important to, to be had. I think as anesthesiologists, we're primed to be leaders in this area of what we call, you know, a palliative care, peri-surgical home where we can really follow these patients from the pre-op clinic and taking care of them with the multimodal management that everyone already does so well and also in the post-operative area where we can really help patients navigate and make their voice heard.

Pro, providing this comprehensive care to this complex group of patients that have very high palliative care needs.

DR. STRIKER:

Well, palliative care has become a subspecialty of anesthesiology. And as, as you pointed out, you weren't even sure you could do that initially. And I believe ACGME has even expanded their clinical competency in interpersonal and communication skills for anesthesia residents to include primary palliative care milestones. So given all that, what characteristics or strengths are necessary for someone to be successful in palliative anesthesia care?

DR. SACKS:

I think it's definitely very important for the anesthesiologists who may be considering palliative care to be very empathetic, a good listener. They have to be very driven to want to advocate for patients and their families, and they have to be very patient. So I would say that the, the biggest difference between palliative care and OR anesthesia is that the pace is often much slower. So we have to have time to sit down with these patients and really listen to some of their concerns and what they're hoping for with all of the other complicated things that are going around them.

But also, I think a strength that is very important that we don't always think about is resilience. This field is not easy. I've lost a lot of patients in the short time that I've been doing this, and it's definitely very important to be able to recognize signs of compassion fatigue in yourself, have a good wellness practice so that you're taking care of yourself while also providing such good care to patients and their families, trying to get through really hard times during their life.

DR. STRIKER:

Let's talk about what you think is the biggest misconception about palliative care.

DR. SACKS:

Yeah, I, I think there's two big ones that come to the top of my mind. One is people have this misconception that palliative care is synonymous with end of life care. And to be honest, I think that's a very common misconception with all physicians, not just anesthesiologists. And I'd say that because our, our paths so rarely cross. And when they do, it's in the ICU when patients are dying, that's probably why people have that misconception. But palliative care really can be implemented at any time along a

patient's trajectory of a serious illness. And it's not based on prognosis or code status at all.

And the other one is that palliative care can only be implemented when curative treatment ends. And that's not true either. A lot of times palliative care is implemented at the time of diagnosis or whenever symptoms come on. So when symptoms are severe and patients have high palliative care needs or when they have a new diagnosis and they have a lot of psychosocial distress and need help with coping with a new diagnosis or metastatic spread, palliative care can be implemented and it has nothing to do, again, with prognosis or code status.

DR. STRIKER:

Well, I, I certainly think that those are, are myths that probably are fairly well propagated. I mean, for a long time, when I heard palliative care, I instantly just went to assuming that prognosis wasn't very good or that's end of life. And so I, I think that's probably one of the most important points we've covered so far in this discussion.

DR. SACKS:

Yeah, definitely, I think it's a big misconception out there. And even in the general public, there's been surveys put out to the general public in 2011 and also 2019 by the Center to Advance Palliative Care, and I would say that 70% of the people that they surveyed also didn't really know what palliative care was or had heard that it was related to end of life or hospice care. I think the most important part is educating health care providers first, because the general public usually learns what palliative care is through a physician and are referred to palliative care specialists from physicians. So that's definitely a misconception I think it's important to clear up.

DR. STRIKER:

Well, do you have any advice to anesthesiologists and anesthesia residents or students that are interested in palliative care? So the first part, anesthesiologist that are in practice, is there advice you have for them in any way related to palliative care that you, you think we should know?

DR. SACKS:

You know, I bet a lot of people, I think I would say everyone who practices clinical anesthesiology is already practicing primary palliative care, whether they know it or not. As anesthesiologists, we see patients for the first time in one of the most vulnerable

moments in their lives when they're getting ready for surgery. And there's a lot of techniques that we use to help ease their anxiety and to comfort them. And that's actually practicing primary palliative care. The multimodal pain management and nausea management that everyone already does intra-operatively and post-operatively, that's primary palliative care. And people, when you pass by family members in the pre-op area, you see them in the cafeteria and you just ask how they're doing. That's, that's also doing palliative care. So just recognizing that you're already practicing primary palliative care and take ownership of that.

Now, I think if you want to people want to take it a step further, maybe asking them on the day of what, what are you hoping for from the surgery and maybe exploring some of these perioperative outcomes that they're expecting or hoping for or maybe some post-operative outcomes that they find absolutely unacceptable? I think hearing what's going on through the patient's mind and then just as importantly, being that patient's voice and passing that meaningful conversation on to the surgeons or ICU team post-ops, then that could be an incredibly important and meaningful step for people who want to take primary palliative care to the next level.

DR. STRIKER:

And then what advice for any anesthesia residents or students who think that, you know what, I, I actually might have a really strong interest in this or this is interesting. This could be something I could really sink my teeth into. What advice do you have for them as they go through their rotations and their coursework of how they should pursue that?

DR. SACKS:

I would say that the palliative care is so broad and heterogeneous that there are so many opportunities for it to overlap with anesthesiology no matter what you choose to do. So there are people out there that do ICU and palliative care. For me, I do pain and palliative care. There are people who do private practice or just clinical anesthesiology and palliative care, and there's a lot of different pathways that intersect.

I would encourage them to see if they can actually do a palliative care rotation at their home institution with palliative care, which is usually run by the internal medicine department. The division of palliative care in many institutions falls under the department of internal medicine. But I did one during my residency and just know that it is definitely a possible fellowship. It is a definite possibility to pursue palliative care after residency. And of course, anyone who's interested in palliative care as a fellowship after anesthesia residency is more than welcome to talk to me. I'd be more than happy to chat with them.

DR. STRIKER:

Perfect. Well, thanks so much, Dr. Sacks, for all the information. And thank you for a fascinating discussion about palliative care and, and for joining us today.

DR. SACKS:

Thank you.

DR. STRIKER:

Well, thanks, everyone, for joining us on another episode of Central Line. To read the palliative care articles featured in the November 2020 ASA Monitor issue, please go online to [asamonitor.org](http://asamonitor.org) and please tune in again for another episode of Central Line. Thanks again. Bye.

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