**Timothy Elder**:

And then can you just confirm that I have your verbal consent to record?

**Respondent**:

You have my consent to record.

**Timothy Elder**:

Excellent. So what I want to ask you about today is about your experiences working with your colleagues in other areas of medicine as a palliative care clinician and your processes for training fellows and working with their colleagues in a cordial and productive way. And the place that I want to begin is if you can recall a recent case in which you felt that your involvement made a big difference in the outcome of the case.

**Respondent**:

It made a difference because of the interactions with the colleagues or just it doesn’t matter.

**Timothy Elder**:

Just a case in which you felt that being involved was important and it would have been different otherwise.

**Respondent**:

Yeah, let’s see. Someone I was just thinking about. There’s a gentleman who I see who has ALS. It’s all video visits. He has a home care team, like community visiting nurses that are really committed to him. He’s got like a family that helps give a lot of care because he can’t use his arms or legs really and has some trouble with his breathing. And he doesn’t really like talking about not beating this. He’s like a coach and like he’s just that’s who he is. Even though that is not biomedically, that is not anything that people are entertaining or things possible. He’s been followed by the ALS clinic and a neurologist. And I think that our involvement has allowed him to tolerate talking about the future and about what he would or wouldn’t tolerate. And even though it doesn’t change, he hasn’t changed what he’s still going to go through pretty aggressive stuff at this point. And his family has a good sense of when enough is enough and they have confidence that that’s actually what he wants so that they could have less burden I think later. And I was thinking, you know, we basically like talked about having the conversation, negotiated when we might have a conversation, had a conversation, translated into paperwork that would be appropriate to have like a serious illness conversation. And then this most recent visit, I had given them all the people like his family and stuff, his sons who haven’t even been part of the discussion, asked them to kind of review the paperwork, the values and goals that patient told us about and just make sure we had it right and that people didn’t have questions. And I was kind of thinking, man, you know, like we’ve had enough time to really, really like nail this down. And I don’t have yet an outcome of how it will go. But I think when you look at this high quality end of life care and having planning documents and discussions, this guy’s had it and maybe give him some time before he actually dies that he could actually start to make different decisions if quality declines in such a way that it’s not going to get him what he wants.

**Timothy Elder**:

And how did you become involved in caring for this particular person?

**Respondent**:

How did we get involved? You know, he was referred to our outpatient clinic. I don’t know who referred him, to be honest. I don’t know if it was the ALS team or if it was a self-referral.

**Timothy Elder**:

And do you recall, you know, after the referral was made, what you were asked to specifically address?

**Respondent**:

No, the way I got involved is that a fellow saw him with someone else. And then she came into my clinic and she was like, he’s really hard. He won’t talk about any of the advanced care planning stuff. And I just can’t get him to talk about it. And he’s like pretty dogmatic about what he wants. And I can’t make him fix, I can’t make him change. And so I don’t know what he originally came in for, but she was trying to do a lot of advanced care planning work. And then she graduated. And so I took on his care and had been supporting her in it. So I’ve kind of been involved since then.

**Timothy Elder**:

Now, do you recall what specifically was he dogmatic about?

**Respondent**:

Wanting to go through CPR because his wife, he provided CPR to his wife and she was dying of a different type of illness. And he believes that he wishes he could have done it better so he could have gotten her back for longer. He wants to make sure he goes through CPR so that he can be around longer. Even though his quality of life is, he struggles a lot with where his quality of life is. So framing that it’s going to, surviving something like that would mean his quality of life would decline even further. It’s still hard for him to say, sure, let’s skip it. He doesn’t really do skipping. He’s the kind of guy, he said he told me if you tell me I can’t do it, that’s going to make me make sure I do it. I’m going to show you that you’re wrong. Interesting. He’s kind of a stoic, stubborn guy.

**Timothy Elder**:

And so over the course of your involvement with him, it sounds like you brought this case up in response to my question about making a big impact. And so do you remember if there was a moment in which you felt that you had made a lot of progress? Or was there, can you tell me a little bit more about maybe how you were able to get through this dogmatic perspective you had?

**Respondent**:

So the success in my mind, the reason why he comes up is because he has many people touching his care. And usually this comes up in the hospital. He would get admitted, he’d be very sick, and then we’d try and sit down. We’d hear from the home care agency that would tell us one thing and then his family would tell us another thing. And then we wouldn’t get much information from him and we’d have to try and sort out because he’s very sick. I feel like everyone’s on the same page because we’ve been able to talk about it. We’ve kind of should have prevented that crazy thing that happens. And what’s more is that people actually understand why he’s choosing what he is. And it does actually make sense. He’s not just being irrational and emotional about it. It’s the thing where you say, I know that you’re right. I’m probably not going to get, but I think it’s really important to have tried it to see what’s possible. That’s a part of what I want to be able to do. And I’m willing to tolerate a pretty poor quality of life to get more time because time is really important to me. And so in everyone hearing that, it was less like, I don’t know, he was just kind of he was fixed on it, but we should definitely switch things around. It was kind of like, no, we want to we now know how to try and respect what is important. And we also have kind of an off ramp. Like we know he sets he set limits of when he couldn’t communicate with them anymore. That’s not a time he wants to live anymore. So it was kind of I think there was some relief. It seems like his family was able to tell him they wished they don’t want to see him suffer. And they’d like him to then not go through aggressive life support because they worry it’ll make him suffer. And he said that he didn’t he didn’t see it as suffering. He saw this kind of fighting. And so I feel like we’ve kind of helped get everyone to a good place that at the end of all this, they’ll look back and go, you know, it went for as bad a situation as he was dealt. It went really well.

**Timothy Elder**:

Now, you mentioned so getting people on the same page and specifically you mentioned sort of the family. But was there members of the care team that needed that same kind of coordination in terms of getting on the same page about why?

**Respondent**:

Yeah, the home care agency really wanted to push for hospice because they felt like he was had symptoms and that he wasn’t going to get better and he was only going to get worse. And they could provide him more support, more types of people if he was on hospice. So we had to have kind of a one on one discussion to talk it through. And although the concept was interesting, the like practical pieces, they were really clear is like he probably wouldn’t qualify. He’s got expensive equipment we couldn’t pay for, you know, and then talking it through, they kind of, I think, came to some realization that maybe we could just have kind of like a good advanced care plan so that everyone knew what to do and that we knew the timing of hospice, which would ultimately be when he decides he doesn’t want to be supported, his respiratory status wouldn’t be supported artificially anymore. And that would probably be the right time. But so it required meeting with them separately. They had that distress around that. And they seem like they’ve really come to a better place of being able to have like a voice in the conversation. I think before they were a little worried that they didn’t know how to insert themselves. And it was all him, but they were able to kind of figure out how they could name concerns and challenges and work how we could be doing that together as a team. Because I would try and hold space for that for them to build. And I mean, the patient really wants them as part of his team. He wants them speaking. It’s just I think they’re afraid to bring up stuff that might be contrary to what he says he wants. And I think by my mentoring and modeling, they feel like now they can do it because he can tolerate it. He’s willing to talk about people saying, we just worry about you and we don’t want you to be stuck on a machine that you can’t, you know, he’ll be able to say back, he’ll cry a little bit and say, no, I hear that. I don’t want that either. But I think I can try and get through it, you know, and they’ll be like, all right, let’s give it a go. Let’s get behind you. You know, like that’s something to fight for. And we know what when we have to fight for something different, you know, also his neurologist is a lovely man, but doesn’t do this. He doesn’t talk about the future. And it talks more about just how you’re doing now and what do we need to do is very practical. And so there has been some impact of trying to think about how to use medications creatively in ways that might not be exactly evidence based. This gentleman gets he can use his fingers more when he has more steroids on board. And that helps him because he can call for help by hitting a button or even use the controller to change the TV on his own without having to call. So there’s a sense of self agency. And but steroids aren’t a normal part of his regimen. So I’ve been trying to work with his neurologist to maybe help the neurologist see that we could use steroids more often and try and mitigate the long term risks of being on a steroid. He’s kind of coming around, but hasn’t fully yet. Yeah. Yeah. And so you mentioned that originally you became involved in this case because a fellow was having some issues in that you provided them support while they were still in the program. And I wanted to hear more about what specifically that kind of support looked like.

**Timothy Elder**:

How were you mentoring them to address the needs of this patient?

**Respondent**:

The way our fellowship is structured, both on the inpatient and outpatient side, is that the fellows effectively have three different levels of independence that they gain over the course of the year, depending on their demonstrated confidence. And the first level is probably more focused on being able to track and understand conversations. The “he said, she said”, and watching different faculty and the techniques and then trying out some of the techniques they’re learning about or wanting to grow in. But they’re running smaller chunks usually in terms of the communication stuff. They’re more independent with managing symptoms, seeing patients on their own doing assessments. And then in the second phase, like the second four months or so, we want them to now be at a place where they’re running all the conversations, but they have a coach or a faculty member with them in the room all the time so that someone can help them understand. If things didn’t go the way they were expecting, there’s someone who was actually paying attention to what was happening. It’s hard to talk and know what was happening. And so this fellow was in kind of that phase of the fellowship when she was sharing this patient with me. So I was joining all of her visits with him. And then they get to the last phase where they are supposed to be doing more independent visits without a faculty member there so that they can practice how to track, have the conversation and track what happened so they can go back to a faculty member and say, I said this and they said this and I said this and they said this. What happened? Why did they get so upset? And we could actually have enough information to talk about it. And then during that phase, they’ll ask for faculty to come join them when they’re dealing with situations where they feel over their head. So they get a lot of, I mean, mentoring all the way along the way, but it’s supposed to be mentoring that kind of shifts from lots of hands on to like learning how to do it yourself and figure out where you’re running in the gaps and get help.

**Timothy Elder**:

And so at what stage was this fellow when they were reaching out to you?

**Respondent**:

She was somewhere in between that second and third. This was a guy she wanted me to see anyways. And there were some communication encounters I wasn’t going into with her because they seemed straightforward enough for what she felt her skill was. But when I said, which of your three or four patients could I see today that I could like join you so that I could just get to see your skills? She was like, you should join this guy. I really don’t. And actually, would you mind running it so I could kind of see how you handle this? That’s kind of how the first encounter with him went. Did you have any encounters with them where they were taking the lead and you supervised and aided that way? Yeah, she after that, after one of the first visits where I took a crack at, she ran most of it. And then I jumped in and tried to talk about code status. And we ran into some stuff and I tried some things. And then she basically was running most of those meetings. And then I would kind of take on a part. She would try and run with it like in the second and third meeting. She tried to run with the work. I had done the meetings before and sometimes was successful. And sometimes I would have to step in again and try and help move the conversation towards a productive place because I had cognitive maps. I had patterns that I knew were going to work out with this guy that she didn’t know yet because she hadn’t run into lots of guys like this. So I want to switch gears here a little bit and still talking about sort of recent cases and notable cases.

**Timothy Elder**:

I want to ask if you can recall a case either notable or recent in which it made you change or it made you consider changing how you approach teaching your fellows how to effectively work with their colleagues.

**Respondent**:

Not one readily coming to mind. That’s probably just because I still get my brain clicking. Let’s see there was well this yeah so there’s a person who I again there was a patient who I’ve kind of taken on management but was managed by a fellow before. This is the normal paradigm when people graduate. And what I’ve run into recently in taking care of the patient on my own is that the patient recently shared we’re helping they have like a long term chronic serious illness multiple myeloma and they even helping with symptoms. We’ve been doing a lot of different stuff. So I carried that on and the when the family sat down they said we were just wondering like who like what happens with this like how do you decide who’s running with the symptoms you know I was like what do you mean. They’re like well because last time we like saw you and then we saw the oncologist right after and they said no one listens to me when we told them about what our conversation was about the symptoms, because they had a different idea of what to do. And I was like oh and I started realizing I wonder if I wonder like why Jesus seems like I might be stepping in it like I’m doing stuff that the oncologist isn’t wanting help with. And so I did then have a conversation with the oncologist and it was clear that they actually they want to help with certain areas of symptom management but not other areas. So I relinquish that but it made me think you know I oftentimes I’m teaching the fellows you know we teach them about consult etiquette we’re talking about this idea and like it’s it’s very frequent for me to say you know they’re going to consult you for certain reasons. But ultimately it’s up to you to decide what you think is going to be best to do for that patient. And then you’re going to you’re going to you’re going to provide that care. But this made me realize just how it can be destructive to a relationship with a colleague and certainly also impact that that destructive relationship can impact how your patient views you or their oncologist. If you don’t have an explicit discussion about what what you’re there to help with sometimes. And so it made me think about it made me kind of have to think a little bit more about when to do that. It’s happened with like there are folks that get transplants for hematologic malignancies. And those attendings are really clear they don’t want us talking about goals of care and like we respect that because they’re like you’re not coming to see the patient if you talk about that we’re not going to work. But we do have symptoms and we’re like fine because sometimes that their own changes when things you know hit the wall whatever so we just get in the door. But I hadn’t thought about it for symptoms. Usually that’s not the situation. So it made me think a little bit more about maybe being talking with the fellows about what have we talked with the oncologist about if they ask for pain. Did we ask them whether they want help with nausea and how do we negotiate that when we think we might be doing a better job than they’re doing. And yet they want to be the ones managing it.

**Timothy Elder**:

Are there anything is there anything else that is kind of in your mind that you’re considering changing.

**Respondent**:

About how we supervise fellows.

**Timothy Elder**:

About how you specifically address the need to effectively communicate with their colleagues and work with them.

**Respondent**:

No I haven’t I haven’t thought about any. And we’ve had some other areas that we’re focusing on that’s taken priority because of national surveys not looking so good. So we’re focusing on those things instead. But their ideas I have if we were to if we were to improve if we were to put effort into that it’d be some great opportunities. What are the other things that are kind of taking priority over or these. We have just some there’s some we don’t do well with teaching about patient safety and adverse event analysis like doing root cause analysis on patient safety. And that’s a requirement for all graduate medical education training programs even if it’s not really a part of your field of practice as much. We’re having to try and beef that up. We are having to try and work on how much independence we try and assure people get at the beginning of the year so that it’s a little bit more flexible because some people come in and they don’t really. Like having to watch more than doing and it causes a lot of angst and distress for them. People are really love it they’re like this is a great opportunity for me to watch and learn and other people are like this is making me feel like I’m just like I feel terrible and like no one trusts me and I’m not allowed to do anything. And so we’re trying to think about how to. Come up with something that’s a reasonable middle ground that people with certain competencies might be able to move. Pass that quicker but more based on learning styles. So that’s relatively complex.

**Timothy Elder**:

If you have a, if you have time I was hoping to get to one more question.

**Respondent**:

Yeah.

**Timothy Elder**:

So I wanted to ask how the emotions of particularly how do emotions, particularly of your colleagues influence how you contribute to managing the cases that you’re, you’re called to address.

**Respondent**:

Well, their emotions, sometimes get in the way of what feels like the most rational plan or communicating particular information that you think might be really helpful for someone to be more prepared for the future. So I might want to prepare someone that they’re ready. And oftentimes emotions from other clinicians get in the way because they’re like we’re not certain that’s the future and I don’t know if I want to, that’s a big news and I’m not. God knows you never know I mean I’ve had people say God knows you know I’m like, whatever. Yeah, sure. God knows but still like we can prepare them for what God might do you know, but they get, I don’t think it’s like I don’t think it’s an attitude, I don’t think it’s like an intro thing like they don’t see the point and why you might I think it’s an emotion cue that they just are like, I don’t want to cause someone great suffering is what it feels like to tell them something about a future that we don’t actually know yet So I think that frequently gets in the way of being able to prepare people for what’s to come. And then when we’re when the shit hits the fan and it’s late now everyone’s fine telling them because now it’s worth it. But unfortunately they lost their gap, like they don’t have a chance then to change the way they make decisions based on it. What might have happened and they’re less prepared and emotions take time to process so they don’t get that processing time. So sometimes you have to work with your colleagues to help them feel more comfortable with their own emotions, and that it’s fast is really tough stuff it’s

**Timothy Elder**:

Is there a recent case that comes to mind that kind of typifies typifies that?

**Respondent**:

I think you’ve won right off the top of my head here. Happened a lot as an inpatient. That was years ago and there’s not a particular case that’s hitting on the outpatient side. There are I don’t know that it hasn’t been as big of an issue in our oncology center. They don’t really. They’re, they’re pretty good with being able to try and share either share prognosis they’re the ones that are sharing the tough stuff, and then we’re like lightning it or they have no problem sharing additional information there is one there’s like an oncologist or You ask them to share Clearer news because it’s their role and they are because I know that if I share something, they might not share the same thing and I don’t want to have discrepant news so I asked them to share and they just don’t tend to do it. There are other times when they seem like they’re much there. They’re okay sharing whatever news, the bad news. So I know they can do it. It just seems like sometimes they feel hesitant to do it when there’s less or T. Like in the prostate cancer realm, for example.

**Timothy Elder**:

And so how do you train your, your fellows to address this sort of this aspect of the work.

**Respondent**:

If it’s a patient, they have, then we kind of talk through how to intentionally message oncologist order, or we join them for a conversation they might have with the oncologist and talk it through. If we’re seeing people in person down the cancer center, we would be able to be by their side, which is a lot of the time and would be able to step in to help manage some of that angst from the oncologist. But we don’t have a formal, we do have during our retreat, like our regional retreat we practice this kind of framework that’s designed to try and help them prep for, like before going into a family meeting or when you’re going to have to deliver news, trying to prep about who’s going to share what and what you’re going to share and what the priorities are so that you’re on the same page. And so it’s that same skill set we asked them to kind of think through the prime bit.

**Timothy Elder**:

Gotcha.

**Respondent**:

But I don’t know that all faculty know it, you know, like the only people that go to the retreat know it and we don’t, it’s not disseminated knowledge that everyone’s had because it’s not part of all training programs so a little tricky terms of disseminating.

**Timothy Elder**:

Great, so that’s the end of my formal questions. But I always at the end, give the opportunity to the person to whom I’m speaking to ask me any questions about this, the interview that they have or the research that we’re doing or to, you know, provide their perspective on anything that I might not have asked about that they feel is important.

**Respondent**:

No, great questions really made me think. Yeah, that’s good.

**Timothy Elder**:

Cool. Well, I appreciate you taking time to talk to me today.