Podcast Transcript

Holistic Approaches in Palliative Care

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Guest: Melissa Dorris, MSN, RN, CHPN

Melissa Dorris is a compassionate and dedicated hospice care leader with over 25 years of experience in hospice and palliative care. A Certified Hospice and Palliative Nurse (CHPN) for the past 8 years, she brings a deep understanding of both clinical practice and leadership in end-of-life care. Throughout her career, Melissa has served in a variety of roles, including home health aide, case manager, team manager, director of nursing, hospice residence administrator, and Director of Inpatient Hospice Units. Her extensive experience and commitment to excellence have made her a trusted leader in the field. Melissa currently serves as the Hospice House Director, where she continues to advocate for high-quality, patient-centered care. Outside of her professional role, Melissa enjoys spending quality time with her children and grandchildren, finding joy and balance in family life.

Host: Candace Pierce: DNP, MSN, RN, CNE

Dr. Candace Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. PIERCE: strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

Transcript

Candace Pierce: Hello, I am Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. So welcome to our podcast on holistic approaches to palliative care. And joining us for this discussion is Melissa Dorris. Melissa, thank you so much for joining us today.

Melissa Dorris: Thank you, I'm happy to be here.

PIERCE: Can you share just a little bit about your background in palliative care and what really made you pursue this area?

DORRIS: So I actually started in hospice care in 2000 as an aide. And then when I went to nursing school and graduated, I did work in acute care. And then because I had done hospice before, I wanted to do that also as an RN. So I started as an RN in hospice in 2005. So this marks my 20th year. And I've gotten a really great opportunity to do hospice, inpatient and outpatient, as well as palliative care, outpatient and inpatient consulting as well.

PIERCE: Yeah, you have so much knowledge. Twenty years. Is that what you just said? Oh my goodness. Well, first of all, congratulations. Twenty years is a long time, but your dedication to our profession and to your patients—I just want to commend you for that. Wow. So through this episode, I really want to explore the holistic practices in palliative care. But, you know, trying to focus on the physical, the emotional, and the spiritual well-being of the patient—so really the patient as a whole. And really my goal is going to be, hopefully, we can just provide healthcare professionals with some insights and strategies they can use to enhance the quality of life for their patients who are receiving care.

Now, I have seen that there's been growth within hospice and palliative care in the US, especially over the last decade, where the number of patients that are looking for treatment in this area has increased by almost 60%. Are you seeing this trend and do you think it reflects like a... is there a growing recognition of what can be offered and maybe an understanding of what palliative care and hospice is?

DORRIS: Yes, absolutely. I mean, hospice was introduced into the United States back in the 70s, but it didn't become part of the Medicare benefit until the 80s. And so I have seen an uptick, and I think a definite positive to that has been, you know, now we have the internet, social media. We've had a president who received hospice care—a former president—for over a year, and that has received a lot of recognition. And also, they are starting to offer some reimbursement for palliative care through the Medicare benefit, which we didn't see in the last 10 or 20 years. But there's still a whole lot more education that needs to be done. Patients are electing hospice still in the last weeks to days of their life when palliative care is most beneficial for six months or more.

PIERCE: Yes. And I did see when I was looking through things for this podcast that actually a lot of the patients that are in these types of programs are starting to be Medicaid, Medicare—is it Medicare that falls under? They're starting... that is, they are underneath Medicare versus private insurance.

DORRIS: Right, we are seeing, I mean, in the last few years, I have seen an uptick in younger patients. So, yeah, it depends on the state, but there are still some states that Medicaid does not cover hospice care. And because the reimbursement for palliative care is so low, you don't find a lot of outpatient palliative care options. Some home health agencies are partnering with larger commercial insurance companies to offer some palliative care in the community. And there are still many hospital systems that don't have a palliative care component, especially in the smaller hospital systems or rural areas. So that is definitely a disadvantage if you don't live in a big urban or metropolitan area. There are still commercial insurance plans that don't cover hospice, or they have

very few hospice agencies that they contract with. So that makes it a little harder for those patients to access the care.

PIERCE: And then when you were talking, I was thinking about the rural versus those that are in the city. It's almost, if we have that—the desert area—where it comes to healthcare, then you're probably not going to find what you need for palliative care, hospice care either.

DORRIS: Yeah, I mean, there is a growth and again, it's all state specific—what their rules and regulations are on opening a hospice. So there are hospices that cover rural areas, but it makes it a little bit more difficult as far as depending on how far the patient is from the office, what the response time is of the hospice if they need something versus a routine visit. And that can certainly impact the care.

PIERCE: Yeah, let's back up just a little bit. Can you help—what is holistic palliative care and how does that differ from traditional palliative care approaches that are used?

DORRIS: So if you think about just traditional palliative care, for instance, if you had a cancer treatment center or an oncology clinic, I just use cancer because it's the easiest to decipher, they may have a nurse that talks about or helps with palliative care. But when you're looking at a holistic approach, when we have to look at the whole patient, you must have a social worker and a chaplain so that we can focus on the physical needs of the patient, their emotional needs, and their spiritual needs. Because all of those different factors can impact the palliation of their symptoms. And so that's how.

PIERCE: Right. It seems like that's what you're taught in nursing school too. You know, we're taught to look at the patient as a whole. And so—but when we got out of nursing school, and you probably have seen this too, twenty-five years—I just love that so much. I'm getting close to that, not quite there yet, but I'm getting close.

But when we came out of school, I didn't really see where we treated a patient as a whole. You know, it was, this is their diagnosis or their disease process, and this is their treatment. And you didn't—and still, even today in some areas of healthcare, I still don't see where we're looking at the patient as a whole person, a whole being.

And so just hearing like this holistic palliative care versus the traditional, it just takes me back to that. We should have always been looking at patients regardless of where they are in their healthcare continuum—you know, from healthy to sick to being born to dying. We should not have already been doing this?

DORRIS: Yeah, I think you see that a lot in an acute care setting. I've worked as a nurse at the bedside in acute care and we're so focused on whatever reason they came into the hospital. We don't know what happens to them when they leave. And then you see patients that keep returning to the hospital. And is it just a physical need or are they really needing help on their spiritual journey, or are they having psychosocial issues that maybe we failed to notice, or we just didn't have the time to address those issues? And I think that a lot of times that's why patients frequently return to the hospital.

PIERCE: They don't have all of their needs met, and they don't know how to meet their needs, and they probably don't know what their needs are. They just know they need something. Now, is there a difference between the term palliative care and hospice, or are they intertwined? Because I know when I think of hospice, I think of the clinic down the road that has, you know, hospice on it, and, you know, that's the name of it and, we're going to call in hospice. But is there a difference between those terms, or are they intertwined?

DORRIS: So I think sometimes we like to intertwine with them, but there is some separation. So definitely in hospice, we palliate symptoms. But in palliative care, when you're talking about palliative care, patients are still pursuing curative treatments. And so palliative care is meant to help with whatever symptoms they're experiencing. And if it is a true palliative care program, they are looking at their psychosocial needs and their spiritual needs.

So when I like to explain what the difference is, I kind of talk about hospice as being a bridge. So they can start in palliative care, and then if they make a decision to forego any curative treatments or if those curative treatments are no longer effective and they just want to focus on their comfort and their symptom management, then they can cross over to hospice.

Where it is still holistic, we still have an interdisciplinary team with a social worker and a spiritual care provider. But now we are no longer focusing on treatment, we are just focusing on palliating their symptoms. And so I hear it talked about synonymously, but it really is, there is a significant difference.

PIERCE: Now, when you were talking about insurance earlier, one of the things that I hear when people are debating on, am I going to call and set up hospice, they are debating on, do I want to give up the treatments, to try the curative treatments? So when it goes to insurance, are there insurances that will pay for that palliative care while they're seeking curative treatments?

DORRIS: So with Medicare, because hospice bills their Medicare Part A, which is also their hospital coverage, for whatever diagnosis they were brought on to hospice for, they will not dual pay. So the patient has to understand that once they choose hospice, all of those curative-type treatments are going to stop.

When they are on palliative care, they can still continue their treatments. Medicaid varies from state to state, and I can't even say that I would begin to know what that would entail. For commercial insurances, it really depends on their plan and how it's carved out, what that benefit looks like. So again, that would be very individual based on their healthcare plan. The only caveat to that would be pediatrics. Pediatric hospice or pediatric palliative care is on a whole different level where they may cover a lot more than they would for an adult.

PIERCE: Right, and those are hard decisions to make too. Do you think that maybe that's why so many don't actually come to hospice until weeks before their death?

DORRIS: I believe that, and I also believe that there are still a lot of physicians and providers that need continued education. I mean, if I was given a diagnosis, I would want to weigh all of my options, and I would want all of the information so I could make an informed decision.

But I think that there are times where patients are offered options, and they are told this could extend your life five years, or this could extend your life for two or three more years, but they don't really understand the gravity of the treatment and what that is going to do to their body, what that is going to do to them, not just physically, but emotionally, financially, and spiritually, depending on where they are in their spiritual journey.

So I think that all of those factors combine. And there are still a lot of misconceptions that hospice means death and that the minute you choose hospice that you have given up. We have made great strides. Speaking about death and dying is still a pink elephant in the room that nobody wants to talk about.

PIERCE: Absolutely. Yes, it really is. But I was also thinking, when you were talking about needing education, also needing education by what you just pointed out. There is a difference between palliative care and hospice. And if you receive this diagnosis, then we should be able to look at: here are the treatment options we have, but we also want to offer you palliative care to go along with it, not because we are saying you are going to die from this diagnosis, but to help you through the treatments and the symptom management and the way that your life is about to change, potentially, through this time. So, because I didn't realize that there was a difference between palliative care offerings and what hospice also offered.

DORRIS: Right. So working with palliative care in an inpatient setting, we had a team, we had a social worker and a chaplain, as well as a physician and nurse practitioners. And so we could palliate their symptoms, whatever symptoms they were having, but also help them work through whatever, you know, psychosocial issues that they were having and offer them all the information that they needed so that they could make an informed decision, not necessarily about their treatment plan, because that is not what our intent is, but just to offer them options and let them know that it is okay, that it is not them giving up if the treatments are no longer effective. I mean, unfortunately, we cannot always beat the disease, and it is not a reflection of our mental strength or our physical strength. Sometimes we just cannot.

PIERCE: Absolutely. So when I was preparing to meet with you today, I looked at some statistics around palliative care. And I really did search palliative care. And what I found was that there was a 40% improvement in patient-reported quality of life and a 30% reduction in symptom burden.

I just think if we understand how helpful this is and we were able to help our patients — it might be our parents, you never know — help our patients understand that these approaches are worth it, that we're looking at you as the whole person and not just the disease process or the symptom progression. Those are some pretty good statistics and a reason why we should be offering and making sure they understand what palliative care is. Now, what role does pain management play when we're looking at it from that holistic point of view?

DORRIS: I don't have the exact statistic, but most people don't even seek medical care until they're having pain or discomfort. There are times when by the time they start seeking medical treatment, their disease is already very progressive. But if you are in constant pain, not only does it affect your physical well-being, it also affects you emotionally and spiritually. I'm not a chaplain or have any education or training, but I have seen patients really suffer with their spiritual pain. It is a very real thing. You know, depending on what their cultural background or their belief system is, maybe at

one time they believed in God, but now they haven't been living their best life. They feel that this pain is there. They need to feel pain in order to pay for whatever wrongs that they've done in their life. And I don't know about you, but if I'm hurting, I'm not sleeping well. I'm not able to eat. I might be irritable, which then affects personal relationships. And then again, all of those things compounded can certainly impact your quality of life.

A lot of people that are going through treatment still want to continue to work. But if you're in severe pain, you're not able to do that. And then that takes away from their personal identity, their independence, and all of those things. So it does play a significant role in their overall well-being and quality of life.

PIERCE: Absolutely. And when I was looking at it, I saw that for hospice, it says it's for hospice, but I feel like this probably would be true for palliative care too. It says pain management is a cornerstone because that focus is on quality of life, on comfort during that journey, whether this is the end of your life journey. But it's a cornerstone. What would you say?

DORRIS: Yes, and what I've seen is this, most especially in an acute care setting, we live in a very difficult time right now as far as the opioid epidemic going on in our country. And therefore there's a lot of fear with physicians or providers on prescribing adequate pain medication, for obvious reasons. So when palliative care comes in, I know we did this in the hospital when I did inpatient palliative care, our physicians were well trained at doing very thorough pain assessments and deciphering what type of pain the patient was experiencing so that they could prescribe them the correct medication.

You know, there's some pain where an opioid is not effective. So no matter how much opioid you give them, it's not going to take care of that specific type of pain. And so that is where I feel it's the most beneficial when we talk about the cornerstone, because that is ideally what we're trying to do. We may not be able to bring their pain level down to zero, but we want to bring it down to a level that's tolerable so that they have better quality of life and can visit with their family or can go and do the things that they want to continue doing that bring them joy.

PIERCE: Absolutely. Would you say when you were talking about that fear of prescribing, but also, I see the fear of patients taking medication as well. If we are in the palliative care, or even if we're in hospice, I don't know if you want to differentiate between the two in this question, but should we be worried about addiction while we're trying to treat them at this point in their life?

DORRIS: That is a huge myth and that is a... it does become a barrier both in palliative and hospice care. You know, the gold standard tends to be morphine, and morphine has a very negative reputation. And so that's part of what we do, at least from the nursing side, is educating the family and the patient. We're not worried about addiction when acute pain or chronic pain is being treated appropriately. Addiction is a psychological need for that drug, but when we are treating acute or chronic pain, the chances of addiction are very minimal and it's not even something that we're thinking about because our focus is starting them on the lowest dose possible so that we have room to titrate it if needed.

But we also want them to be as awake and alert as possible, although there are times when that isn't possible, especially if they're adjusting. And so we just do a lot of education about that. We're

starting at a low dose and we're not going to increase it unless it's needed. And if that medication isn't effective, there are other choices that we have to ensure that they get the best pain management possible.

PIERCE: Right. When you started talking about morphine, I also know that there is some... I don't know that I would necessarily call them myths, I don't know how you want to address it. But for example, my grandmother, she had leukemia, and she was in a lot of pain. She was at the end of her journey with leukemia. And my brother and I, both being in healthcare and healthcare professionals, we made the decision to give her morphine.

PIERCE: Knowing that she was going to pass away, and she knew that as well. But we made the decision to go ahead, and she was in a lot of pain. She agreed to take it because she knew what was going to happen, and we also knew. But I hear a lot of people also referring to, "Well, they gave my parent morphine and then they died. And so they gave them too much." And what are your thoughts behind that? The education that needs to be given?

PIERCE: Our goal is not death and giving the morphine. Our goal was to relieve your pain, and if this happens, this happens.

DORRIS: Mm-hmm. So a lot, I mean, I hear that all the time. And also from nurses that are administering the medication. They don't want to give it because they're afraid that dose is going to end that person's life. The truth is, with morphine, you have to give very large amounts in order to suppress the respiratory effort. And we use morphine for pain. We can use it for air hunger. We can use it for extreme anxiety to kind of help them to relax.

If you have a patient that has been in constant pain or high levels of pain for a very long time, a lot of times what happens is we get their pain managed and they're actually able to relax. And then that kind of can allow them to enter into the dying process. But the morphine is not what caused their death. We start with a dose as low as five milligrams, which might be equivalent to a Norco, which people are really comfortable taking, Percocet or taking Lortabs or taking Norco. Morphine is, those are much more potent or much stronger, and that's why we start at such a small dose.

And so it's just that constant reassurance. You know, if they don't need it, we're not going to give it. We're only going to give it, you know, if they really need it. And so that is a constant education and reassurance that that small dose of morphine didn't cause their death. They were already... their disease is what caused their death. No matter what we tried to do, we weren't going to be able to prevent that.

PIERCE: We were just trying to help them transition more comfortably. Yeah, which is how me and my brother were explaining it to our family as well, that this is not to... this is just to help her to be comfortable through this night. So I know we talked about morphine and other pain management with medications, but what about non-pharmacological methods for helping with managing pain?

DORRIS: I educate nurses all the time that, you know, we can't just go straight to medication. Medication can be helpful. But I always like to ask questions, talk to the patient. When you're feeling stressed or you're feeling uncomfortable, what helps you to relax? What do you do for you?

And so some of those non-pharmacological interventions could be guided imagery, meditation. I've seen music therapy be very effective. It's actually the most beautiful thing to watch as the music therapists come in and play music.

You can do aromatherapy for some people. For some people, aromatherapy can actually exacerbate their symptoms if they're having nausea or if they're really in tune to some smells. But it can be effective, especially in patients with Alzheimer's or dementia diagnoses. They get agitated, and you can introduce an aroma that was familiar to them, aftershave or a certain type of lotion, something that kind of brings them back to a time that they can recall. So I've seen that be very effective.

Massage therapy, you know, depending on where that pain is, can help them to relax. I know if we've ever experienced stubbing our toe or some acute pain, every muscle tenses up because we're, you know, trying to address that one area. So all of those complementary therapies can be very beneficial if that's something that the patient is receptive to and has responded positively to in the past.

PIERCE: Repositioning, I was going to say that. I like to start with repositioning and then go from there. Yeah. Keep going. Yeah.

DORRIS: Yeah, repositioning. And sometimes, you know, if they're able or we have a safe way to get them out of bed into a chair, or maybe they need to get out of the four-walled room that they're in so they can feel the sun on their face or they can feel the fresh air. So I think that there's a lot of different ways that we can help alleviate some of that pain, but we have to talk to the patient and ask them if that's something that they would like to do.

PIERCE: Right, because I like how you said talk to the patient. To me, allowing... empowering, I guess is more the right word that I want to say, is empowering the patients to really participate in their own comfort. What does bring you relief? What doesn't bring you relief?

And helping them to participate in it because, you know, as that nurse, you're not always going to be in the room with them or available to them, since this type of care is usually in their home rather than in a hospital setting. And we do have some where it's more of like kind of a nursing home rehab type setting, but a lot of palliative care and hospice takes place in the home. So helping them to be able to participate, and the family members as well being able to participate.

DORRIS: Absolutely. And whoever they deem their family to be. Yes, absolutely.

PIERCE: Right. I have a lot of family friends that are family. Yes. Who are always standing by you. So I completely understand. And that's... oh, I want to ask you about that too. Since you brought that up, in a hospital it's usually family, has to be family. But is there more freedom in palliative care and hospice care for family friends who are like family to participate in the care with the patient?

DORRIS: Absolutely. Really the only time it has to be a family member is when we're talking about consent forms or legal documents. Who has the legal authority to sign for that patient if they're unable to sign for themselves.

But when it comes to their home, we are a guest. We're a guest in their home. And in any nursing environment, always, if there's someone else in the room, you always ask, is it okay if I speak to you about what's going on with you in front of whoever's in the room? But yes, their family unit, whatever that means, if it's a pet, you know, children, friends, whoever that is for them that's their person or their significant other or their support, we absolutely want to include them in the discussions and in their plan of care because that's what's important to the patient.

PIERCE: Absolutely. I love that aspect of it. That, to me, really speaks to that holistic care that we're talking about, being able to involve so many people into their care. Now, what are the benefits of incorporating mindfulness and meditation practices?

DORRIS: Well, our brain is a very powerful thing. It's a very powerful organ. And it's kind of cliche, but mind over matter. So there's a lot of things. If we're feeling anxious, if we're feeling uncomfortable, if we're feeling scared, if we can help the person be aware of what those triggers are and what can we do to help them calm themselves.

Yeah, so mindfulness being, educating them, continuing to speak to them even if they can't communicate back to you, I think is really important. But also allowing patients their time to be with themselves. Sometimes they don't want someone hovering over them. They just need to be alone in their thoughts or just have some quiet time to reflect. And so yeah, I think that's very important, whatever meditation or mindfulness means to that person.

PIERCE: Right. And I think that this is just, I have not worked in hospice care or palliative care at all, other than, you know, my background is ICU. And so I've worked with a lot of people who have passed away. And we have transitioned our care sometimes to more of a palliative approach, but they were within, you know, hours to a very short amount of days before they were going to pass. But it seems like, I would think from my own thoughts, that anxiety is that high in the patients that you work with at this point.

DORRIS: Absolutely. I mean, you know, everybody handles stress differently. Some people are more emotional. Some people will hold a lot of those feelings in. A lot of people are very open about, "I'm feeling anxious, fear, fear of the unknown." And part of what you have to do in hospice care, and I can't use it with men because men don't have babies, but if I'm talking to a patient or a family member that has experienced pregnancy, part of what we need to do is educate these patients and families on what's going to happen to their body. What does this process look like?

And the more that we educate and talk them through "this is what you can expect," I think that that does help alleviate a lot of that anxiety. Because if you're constantly wondering, "Am I going to sleep all the time? Am I going to have pain all the time? Who's going to take care of my pet when I pass?" So kind of helping them work through all of those things that are causing them anxiety can certainly help alleviate some of that. There are medications that we can use, but it doesn't mean it's going to alleviate the problem. It may just palliate it for a moment.

And one of the beautiful things about hospice and palliative care that I love is having a whole team to support. So if I do have a patient that's experiencing a lot of anxiety or having a lot of problems, I will incorporate my social worker.

DORRIS: Right. The social worker is that's what they do. They can help them talk about coping mechanisms or talk through some of those fears. If some of that anxiety is caused from a spiritual aspect, I will incorporate our chaplain to kind of help them work through those things that are causing them anxiety.

And I think that that is the wonderful thing about working with an interdisciplinary team. I can't be a nurse, social worker, chaplain. I love having a team that I can reach out to. And so when those anxiety levels get high, it's always helpful to figure out what is the cause of the anxiety and then we can, you know, help make it better based on that.

PIERCE: And you have a whole team in your hands, basically, to help you with addressing those emotional and psychological needs that that patient may experience. Because I know every journey is different for, you know, for the patient. None of them are the same. When it comes to nutrition and dietary interventions, how do you support the well-being of the patient through this palliative care and/or hospice?

DORRIS: So again, education. Probably the best example that I could use and that I've used with my patients that I've cared for that have had a cancer diagnosis, let's say if they have a tumor or whatever the cancer is that they're experiencing, if you eat a hundred calories, the cancer is going to take probably 60 to 90 of those calories. And so a lot of times they lose their appetite or they're starting to have trouble swallowing.

So what I try to do is, first of all, let them have whatever they want, whatever brings them joy. Tastes will change with treatment. So maybe their favorite thing was ice cream, but now due to medications that they're taking or chemotherapy or radiation, those taste buds have changed. And maybe now they like Brussels sprouts where they never ate those before.

So just try to talk to them and see. You know, also educating the family that there are going to be times when their loved one's appetite is going to decrease. We don't want to force them, but we can make small meals that are more meaningful or more robust, giving them advice on maybe what to add so they don't have to eat large meals. They can eat small meals and get more calories in just those little bits or little portions that they're taking. Culture can play a big role in nutrition, and so how am I going to know what their culture is except to ask? What's important to you? What kind of foods do they eat? Maybe there are dietary restrictions based on whatever their cultural background is. So being in tune with that.

But just consistently educating, especially toward the end of a person's life. They may stop eating and drinking because they're having swallowing issues. And so when you go for at least 24 to 48 hours without any food, your body kind of goes into ketosis, which can actually be very... can cause a sedating effect. And I think, well, I know, that that's our body's natural way of kind of protecting itself and making that process a little bit easier.

But if I don't educate the family ahead of time that that could happen, it can create a lot of issues, increased anxiety, and a lot of fear. "I'm letting my loved one starve to death." You know, food is, we can't live without it. And so just addressing those fears in a kind, and I can be very kind, but I have to be, I don't want to use the word direct, but I have to be very firm and truthful with them. And so that is the best way that those interventions can support them.

I'm also advocating, right? Because I've had patients tell me, "My daughter keeps forcing me and I'm just not hungry," or "I'm feeling nauseous," or "You know, the smell is making me sick to my stomach." So I'll be the bad guy and tell the daughter that, you know. I'll advocate for the patient if that's what they want, and I'm okay with that.

PIERCE: Yeah. Now, one of the things that I struggled with when my grandmother was passing away was fluids. For me, I wasn't as concerned about her eating, but there was just something that bothered me from a healthcare perspective. I don't know. I just, I said, you can just leave her fluids going in. That was my only request, was, can you just please just leave her fluids going at a low rate? There was just something about it for me with dehydration. I don't know what it was. I'm not sure, but I just had trouble with letting her dehydrate, I guess.

DORRIS: That's a common fear. We experience that a lot. And again, it all comes down to gently but firmly educating the family member. You know, if we have patients on a tube feeding, there's going to come a time where they're no longer going to be able to absorb that feeding, and it can actually cause them more discomfort — diarrhea, vomiting, and excessive swelling which then can impede their breathing. So that's with tube-fed patients that are getting a feeding burst that way. With IV fluids, the best way that I try to explain that is, there's a reason that they're not wanting to swallow. Either they're not feeling the thirst or the hunger that we would normally feel because their body is starting to shut down. If we keep introducing fluids as their organs start to fail, they're not going to be able to absorb them efficiently. And that's when you run into a lot of fluid, edema, that third spacing, because their body just isn't able to absorb it. They start having that congestion and the breathing difficulties.

We can actually cause them more discomfort by introducing artificial nutrition or hydration than by just allowing the body to kind of take its natural course. Which again, we are concerned in an acute care setting about dehydration, but when you're talking about someone who's getting towards the end of their life, as those organs start to shut down, dehydration again can be a very sedating effect. And it's the body's natural way of preparing them to transition.

PIERCE: Just hearing you, you as you talk through this, it just, it doesn't sound as scary as what it did before. Before, just, you know, listening to you where you're like, hey, that's the body's protective mechanism. That's a way for it to not be as hard on the patient and their body as they're transitioning. And so just hearing that just makes me feel more at ease myself now than I did, you know, before. So I think that you are probably so amazing. I know just listening to you, you are amazing at educating not just the patient, but the families and just alleviating some of that stress and anxiety that they're feeling.

Because I know at the end of the day, it's how we still want to save. We still want to save our family member. We still want to make sure that they're taken care of. And so we look at it from a living perspective where we have to have food, we have to have water, we have to have all of these things. And you're kind of knocking on our door saying, hey, that's what we need, but that's not what they need. Not right now.

DORRIS: Right. And you know, I try to validate families' feelings. Like, our natural human emotion is to be selfish, right? We don't want to lose the person, this person that we love, because that's a

normal response. But by continuing certain treatments or continuing certain interventions, we're going to cause them more discomfort, and we don't want to do that either.

So I think a lot of times just validating feelings, acknowledging the care that they're providing. Sometimes there's a lot of guilt there from the family. You're doing all the best things, you're doing all the right things, and this decision that you've made to forego treatment or to stop treatment is actually the most kind and loving thing that you could ever do. And this time that you've been given to spend with your loved one is a gift. If they had passed, you know, in a traumatic or tragic way, we didn't get that opportunity or that time. And so now we have this time, and it's a gift.

PIERCE: That's a really good way of looking at it. I'm curious, earlier you were talking about some, their background as far as their culture and their beliefs. Have you run into different cultures and beliefs that other healthcare professionals should be made aware of? Like, what are some of the things that you have seen?

DORRIS: I mean, it can vary. When I worked in New York City, I worked with a hospice that had a very large Jewish population, and there is a sect of Hasidic Jews that follow a very strict pathway when it comes to healthcare and health decisions. And so I have to ask questions or I'm not going to know. And I think that people appreciate that, especially when you're discussing what their culture is. And so we would have to follow certain things before we could stop a treatment or give a medication. I've had, not very often, but I've had a few patients that were Buddhist. And as their loved one was starting to transition and could no longer swallow safely or take in a lot of food, they would continue to feed them or continue to force feed them. And here I am, I'm trying to educate about the dangers of that. So I had to ask, what is it about your faith or your religion? Why is this important? And basically in their faith, Buddhists believe in reincarnation. And so if they don't feed this body, they won't be able to reincarnate safely into their new vessel.

PIERCE: So how do you navigate that?

DORRIS: I just have to, I can educate, but I have to meet them where they are on their journey. And I have to be supportive of that and put my own thoughts or feelings or beliefs to the side, because it's not about me, it's about them. And so, I just continue to ask questions so that I could also educate myself. It's kind of hard to watch because you know what's going to happen, but at the same time you have to be respectful. Again, I'm a guest in their home, and so that's all I can do is be supportive and offer education and knowledge.

PIERCE: Yeah. Have you seen any others?

DORRIS: Don't get very many Native Americans in hospice, but not so much during the caring process, but their death customs. They would have to be laid a certain way. They would have to be cared for a certain way at the time of death. Muslim patients, their death customs were very significant. You know, at some Jewish faiths, you have to open a window when they pass so that the spirit can pass on. They can only, in the Muslim faith, they want an Imam to come and do their post-mortem care. And so I wouldn't know those things if I didn't ask. And so it could be that maybe it has nothing to do with religion, but it could be just something cultural within that family.

And so I always made sure that I asked, when your loved one passes, what is something that I need to know so that I can honor your wishes. I've had someone ask me as simple as, when the funeral home comes, please don't cover their face when you bring them out to the hearse. Let them feel the sunshine one last time, so if I can honor that, I'm going to do it.

But I think the biggest thing that I could say to any healthcare provider, you have to ask the questions. Talk to them, ask them those difficult questions because they may feel like they're going to insult you or make you upset if they ask for a certain thing, so I just make sure to ask lots of questions over time.

PIERCE: It's part of that holistic care where you're taking care of them emotionally, mentally, spiritually, physically. So it should be taken into consideration when we're, and we should be using a holistic approach to care for all of our patients. Yeah, what are some challenges to implementing holistic approaches in palliative care, and how can we overcome those challenges?

DORRIS: I think the first thing would be, where is the care being provided, right? If it's in an acute care hospital setting that doesn't have... maybe they don't have a spiritual care program. They may have social workers, but they're more on a case management. So they're just trying to do discharge planning. Especially for the nurse, and I've worked in acute care, we don't have the time to sit and hold hands. Yes, time constraints. And so if a patient is receiving palliative care, let's say from a home health agency that has a palliative care component, again, they may not have all of the disciplines. So that barrier is you're seeing that nurse once a week or maybe you're doing a telehealth visit with a healthcare provider for 30 minutes or an hour just to address. So I think that some of those barriers are going to be availability. Can the hospital system or that home health agency, can they afford it? Do they have the funding to provide these services? Where you live could be a barrier, right? If you have to travel 50, 60 miles to go to a palliative care clinic, you may not have the financial means to do that or even the physical strength to make those trips. There's also family that is a barrier. A patient may want one thing, but the family is pushing them to do something else. To be very frank, a lot of times it's not the patient that is the issue, it's the family. That can be a huge barrier.

PIERCE: Yeah, I can see that. The resource constraints, the time constraints, the training and the comfort level of the staff that are trying to take care of this patient. You mentioned the cultural beliefs versus our own personal beliefs. And then another thing that I picked up when you were talking is fragmentation of care. The care breakdown between home and rural settings and metropolitan settings. Lack of sharing what's happening throughout the healthcare team, which fragments the care that the patient's receiving. Earlier you talked about insurances, so looking at reimbursement and policy limitations as well. Yeah, and how do we overcome?

PIERCE: That's a lot to overcome.

DORRIS: We have to continue. It is. We have to continue to educate, and we have to continue to lobby our legislation to make changes in reimbursement and the importance of palliative care and hospice in healthcare. And I think that that's the key to it: continued education, constantly learning and educating.

PIERCE: Yes, education is a big one for healthcare professionals, but also for people who make laws and people who run insurance companies. You know, money is another issue, which goes back to the reimbursement issues and the education. And so I just see how it all plays into each other. But it has been positive to see that the options for palliative care and hospice care have grown over time and that more people are starting to see the benefit of it and starting to use it. So I think that's a positive.

DORRIS: It is absolutely a positive.

PIERCE: Yes. Well, Melissa, as we wrap up our conversation, is there anything that you want to emphasize or maybe that we just didn't get to discuss, you want to make sure that we talk about?

DORRIS: I think the biggest message is that if you yourself or you have a loved one that's received a diagnosis, just don't. Get the education. You don't need a doctor's order to call a hospice or a palliative care provider and just ask for information. You're not obligated. But at least you can have that information to make an informed decision and know what options are available to you in the event that you want to stop treatment or your treatments are no longer effective. That's the biggest. Don't be closed-minded. Just listen so that you can make the best decision possible.

PIERCE: Thank you so much. And I think it's important for us as healthcare professionals that you made a really big point today that there is a difference between palliative care and hospice care. And we need to understand the difference, and we need to understand what a holistic approach to care means, to care for the whole person and not just their symptoms, to address their physical, their emotional, spiritual, and social needs.

Because you mentioned social a few times, to really support their quality of life during this really vulnerable moment for them. So when I think of holistic care, I think it builds trust. I think it honors all of our diverse values, and it helps patients really just to feel seen and heard, even during this vulnerable moment. And I think for me, and I know that I can sense it from you, I think that that brings a deeper meaning to our work. It reminds us why compassionate, patient-centered care really does matter, even at the end of life.

DORRIS: It is a privilege to care for someone at the end of their life. And it has just as much meaning as bringing a new baby. It is an honor and a privilege to care for patients at the end of their life, for sure.

PIERCE: I think that you're amazing. Thank you so much for sharing your knowledge with me and our listeners. It was such a pleasure to learn from you.

DORRIS: Thank you.

PIERCE: To our listeners, thank you for joining us, and I encourage you to explore many of the courses that we have available on EliteLearning.com to help you continue to grow in your careers and earn CEs.