

Dr. McPherson:

Hello, this is Dr. Lynn McPherson, and welcome to Palliative Care Chat, the podcast brought to you by the Online Master of Science and Graduate Certificate Program at the University of Maryland. I am delighted to welcome our guest today, Dr. Red Hoffman, who is an acute care surgeon and, interestingly, a hospice provider from Asheville, North Carolina. Welcome, Dr. Hoffman. How are you?

Dr. Hoffman:

I'm great. Thanks so much for having me on the program, Lynn.

Dr. McPherson:

Oh, we're super excited to have you. So what a background, acute care surgeon and hospice provider. Can you tell us a little bit about your background and how you ended up here?

Dr. Hoffman:

Sure. So my story, I like to say I took the road less traveled. I actually started my professional career as a naturopath and a yoga teacher, and sometime in my naturopathic training, I was in India studying homeopathic medicine and spent some time in the operating room and realized I made a terrible mistake, I think I want to be a surgeon. And so I came back to the states and finished my naturopathic training, and worked for two years while I was applying to medical school, and I got very lucky because I was living in Portland, Oregon, and then I got to go to medical school in Portland, Oregon. And Oregon is the birthplace of Death with Dignity and also OHSU, where I went to medical school was the birthplace of the POLST form, and so palliative care was really integrated into my medical education from the very beginning.

Dr. McPherson:

You are fortunate, yeah.

Dr. Hoffman:

Yeah, it was great. So I went to medical school knowing that I was interested in surgery and then was introduced to palliative care and ended up really wanting to combine the two, and of course I didn't ... well, not of course, but I didn't have much mentorship around that in general surgery residency. Where I went, we didn't even have a palliative care program and so I saw a lot of suffering, but I had learned a lot of primary palliative care skills from the palliative care team at OHSU. I spent a month with them in my fourth year of medical school, and so I used those skills throughout my training. And then I spent a month with Dr. Stacie Pinderhughes in Phoenix, Arizona during my general surgery residency and learned so much more, but I realized that in order to really, I guess, be legitimate in the eyes of my colleagues, that I was going to need to end up pursuing fellowship training as well.

Dr. Hoffman:

And so I completed a fellowship in surgical critical care and then did another fellowship in hospice and palliative medicine, and I just got so lucky. Where I completed my hospice and palliative medicine fellowship in Asheville, North Carolina, they were actually hiring acute care surgeons and so I got to stay on, and I just feel very blessed because I was very integrated into the hospital already, felt loved and supported by the palliative medicine team, and then got to continue doing work in the hospice where I had actually trained during my hospice rotations.

Dr. McPherson:

That's amazing. That's so amazing. So given that your nickname is Red, you're kind of a red herring, I think, with this crossroads of acute care surgeon and hospice provider. Are you an [inaudible 00:03:09] in the country or what?

Dr. Hoffman:

Well, I think that there are 80 surgeons in the country that are currently board certified in hospice and palliative medicine, and everyone combines those two very differently. So I have some colleagues who don't even practice surgery anymore and just do hospice and palliative medicine. I have several colleagues who really have this great half and half, they have a professorship in the department of internal medicine and then another in the department of surgery and split their time between two departments, and I don't know of anyone else who does hospice, though there may very well be. That's just kind of how my interests ended up lying and that was the needs of the community right now.

Dr. McPherson:

I'm always amazed by ... I mean certainly it's understandable why an oncologist, for example, would be interested in hospice or palliative care. It's kind of an extension of what they do through supportive care, but I'm always amazed, we've already had one trauma surgeon graduate our program and we have several more trauma because in our master's program. I'm always surprised at how many emergency physicians are in our program. So what's the scoop? I mean, do surgeons learn about palliative care during their training?

Dr. Hoffman:

Well one, I always want to give a great plug to Dr. Balfour Mount, who's the urologic oncologist. So he was the surgeon who coined the term palliative care, so I like to say that palliative care, that's in our blood. And also when you look back into the history of hospice in this country, many of the first hospice programs in the '70s were actually run by surgeons. So I think that we actually have a great understanding of suffering and a great need to kind of cure that suffering, but also the knowledge that sometimes the cure is not surgery. Sometimes the cure is more supportive care that's offered by hospice and palliative medicine, but certainly I think Dr. Balfour Mount kind of set the stage for us, showing us how you can bring a surgeon's mindset into this world of palliative medicine. And it's very fascinating, on my podcast when I talked to kind of the old guard of surgical palliative care doctors like Dr. Jeff Dunn or Dr. Bob Milch and I got to interview Dr. Balfour Mont as well, they all have the same DNA. They speak like surgeons and palliative care providers at the same time, and it's really fascinating that all of them use the same exact language.

Dr. McPherson:

I actually have a picture of myself with Dr. Balfour Mount, which I treasure.

Dr. Hoffman:

He is just ... I don't even think ... he was my first guest on my podcast and I don't even think I realized how lucky I was. I wish I could go back and talk to him now a year later. I mean, he is just a pure gem. It was just such a joy to talk to him.

Dr. McPherson:

Yeah, you couldn't get any higher than that, so it was all downhill from then on.

Dr. Hoffman:

I know.

Dr. McPherson:

Oh my goodness, and I am proud to be down at the bottom of the hill, because he is the father of the palliative care movement, absolutely.

Dr. Hoffman:

Yes, yes.

Dr. McPherson:

So when you consider your practice ... I mean I know that half of you is surgery and half of you is hospice ... do you, to any degree, integrate your knowledge and skills of hospice and palliative care into your surgical practice?

Dr. Hoffman:

Sure. So first of all, I do need to correct that actually almost a hundred percent of me is acute care surgery, and then I just do hospice on the side. So I get to pick up say two shifts a month. The majority of what I do is I feel like I use my primary palliative care skills every day on service. I spend some time on the trauma service, sometimes on the emergency general surgery service, and then some time in the neurotrauma ICU, and so of course, depending on the day and what the patient list looks like, and also depending on what my emotional mindset is of the day, that kind of dictates how much primary palliative care I may use, but I certainly have a lot of goals of care discussions with patients, a lot of code status discussions, particularly when I'm taking these high risk surgical, particularly geriatric surgical patients into the operating room.

Dr. Hoffman:

I always make sure that I clarify their code status before we're going, and even try to get into the nitty gritty about, "Well, if I can't get you off the ventilator, would you want a tracheostomy?" Because I'm always thinking ahead, what is this going to look like? And I always tell the family that it is such a blessing when the patient can be a part of these discussions, so that if the patient is still conscious and able to communicate, we should take that time to have them set some of their goals or some of their limits beforehand. I'm a big fan in the emergency department of trying to get early admission to hospice. So if someone comes in and it's very obvious that they may be in the last stages of their life and that their goals are aligned with hospice, that trying to avoid a ... it's easy to say, "Well let's just admit them to medicine overnight and consult palliative care tomorrow."

Dr. Hoffman:

Well, if their goals are already clear and they meet hospice criteria, we do not need to be using the overworked and overstretched palliative care team. We can be using our own primary palliative care skills and work with our case manager to get these people right into hospice. And then lastly, especially with some of these traumatic injuries, trying to just bring some of that love and support to these families of dying patients that may be actively dying in our emergency department. And I'm a big fan

that you can still have ... I don't want to say ... sometimes that word, a good death, I don't know, because sometimes there's no such thing as a good death in some of these situations, but that you can still kind of try to make some legacy for the family, even in the worst case scenario, and you can still do that in the emergency department. It just takes some time and some forethought.

Dr. McPherson:

Yeah. I suspect that you are a very atypical surgeon, because surgeons are not reputed for being touchy feely and having a lot of kumbaya kind of discussions with patients and families. I mean do you kind of feel like sometimes you're a little different from your colleagues?

Dr. Hoffman:

I feel ... I'd say for the vast majority of surgeons, yeah, I may be somewhat atypical, but it's very interesting that the majority of my partners ... I have 12 partners ... are amazing communicators and I think we all think about these things a lot. So it might just be where I work, or it might just be the field of acute care surgery when we're dealing with so many sick patients, many of whom die despite everything that we do. So it may be more about that, because I do know that there's certainly surgeons who will fight to the end, though I will say, sometimes you want your oncologist or your transplant surgeon to fight to the end. So I think there's a role for everyone, but yeah, I think I tend to be probably more open about my emotions and probably try easier than a lot of my colleagues, and certainly some of that is just because who I am, and then some of that is just that hospice and palliative medicine training and really just being comfortable with holding space for whatever's going on with the patient and their family and then just kind of being moved by that space sometimes, which I think is completely appropriate.

Dr. McPherson:

Well that's the kind of doctor I would like, certainly, so I appreciate that you've got that skillset. Do you think that medical schools are doing enough to teach medical students about palliative care, and specifically in surgical fellowships, do you think they are including enough palliative care?

Dr. Hoffman:

So I think my training in medical school is probably atypical because of where I went, although it's very interesting, because I was just looking at the AAMC conference that's coming up, and one of the speakers is Dr. Timothy Quill, talking about physician assisted suicide or whatever word you want to use. So I think it's a topic that more and more people are talking about. In surgical residency at OHSU in Portland, Oregon, actually all of the surgical residents a month with one of the surgeons, Dr. Tim Siegel, who's also a palliative care provider. So that's the only surgical residency in the country that I know where the students get a whole month. I think, again, that this is something that we are continuing to talk about more and more. So I think that things are moving in the right direction, but it would be my goal to have every surgical resident spend a month with the palliative care team, because it's incredible to me that even doing my surgical critical care fellowship, I didn't spend any time with the palliative care team. You would think if you're going to spend your life doing ICU care, you would spend some time with the palliative care team. So it's not even integrated on the fellowship level yet. So there's definitely a lot of work to do.

Dr. McPherson:

Absolutely. It's interesting, you mentioned primary palliative care skills. I'm actually very, very interested in that and I'm going to be developing a [inaudible 00:12:48] massive open online course teaching

primary palliative care skills to anybody who was inclined to sign up. What would you say is the primary palliative care skillset, and especially as it pertains to surgeons?

Dr. Hoffman:

Sure. It's so funny when I use that term, because I interviewed Diane Meyer and she hates that term.

Dr. McPherson:

Does she?

Dr. Hoffman:

So I'm always like oh, maybe I shouldn't be using it. Yeah, I forgot what she said instead, but she did not like that. But anyway, when I think of primary palliative care skills, I think of knowing how to have a good goals of care discussion conversation, knowing how to discuss code status, knowing how to run a family meeting, having some basic understanding of symptom management, so pain, constipation, nausea, and then lastly, having just a basic understanding of how hospice works, who's eligible, and I guess maybe the first beginning understanding of how you get someone there, and then the difference between home hospice and inpatient hospice. So those five skills I think could go a real long way with patients and their families.

Dr. McPherson:

And it wouldn't be that hard to teach. I think I agree with you, everyone, whatever you call it, whether you call these basic and trustable professional acts that all healthcare providers should possess, I think it's very important. So important.

Dr. Hoffman:

Yeah, and what's amazing to me is I feel like I learned so much in that one month elective with the palliative care team, as a medical student that carried me through all of residency. So it really doesn't take that long. If you spend just a little bit of time watching someone else do these skills, yeah, you might not be perfect and you might not get all the nuance, but you'll have enough, and then you just practice, and the practice makes it better and better.

Dr. McPherson:

Absolutely, and I'm sure that you have been ... certainly patients, maybe families have spoken to you about the spiritual side of things in medicine, and not all physicians are comfortable with that. What are your thoughts on that?

Dr. Hoffman:

Well, I just feel like ... I mean we're all spirit. In the end, we're all going back to that same place. So for me ... well, it's very interesting because I live in the South and I'm Jewish. I don't really practice. I think I'm more kind of spiritual, but I have found that in the South, most of the patients are Christian and a lot of Southern Baptist, and I've just kind of ... so I have found myself kind of using their language, and to me, it's all the same. I mean it really resonates in the same place in my heart, and so I have found myself saying God bless a lot, which is something I wouldn't necessarily have said, and just kind of using that stuff and finding common ground there. And to me it feels very natural.

Dr. Hoffman:

It doesn't feel like I'm putting on airs. I'm not pretending to be someone I'm not. It's just trying to reach them where they're at and to provide them comfort, and that's all I really want to do. I think there's such a role for that and I think there's so much fear when you're in the hospital or when your family member's in the hospital, and I think that spirituality or religion, whatever you want to call, brings so much comfort to patients' hearts and their family's hearts and I want to be a part of bringing that comfort to them.

Dr. McPherson:

Absolutely. It's very humanizing. Are you ever involved in performing what I guess I would refer to as a palliative surgical procedure? Or is that not -

Dr. Hoffman:

Yeah, so I think that's something really important to talk about, because when we talk about this surgical palliative care movement, I think a lot of people think it's surgery, and really Jeff Dunn, who I call him, Dr. Jeff Dunn, the father of the surgical palliative care movement, when I asked him to define surgical palliative care, he says that surgical palliative care is the attention to suffering in all of its manifestations of the patient and the family under surgical care. And he said that palliative surgery is just one part of that. So we're still providing good symptom management and we're still doing goals of care discussion, and we're still attending to their spirit, but yes, we do do some palliative surgeries. And so the one that I probably do the most often is a venting G-tube for someone who has an obstructing mass that we're not going to be operating on. And I actually just did that a couple of weeks ago, and it just makes you feel so good, because really the patient had failed third line chemotherapy. I mean she was done. She just wanted to go home and we got her home the next day, and so to me, that's such a great use of my surgical skills.

Dr. McPherson:

Yeah, and I know your role is not primarily in the emergency room, but I am always surprised by how many physicians and nurses who work in the emergency department end up in our master's program. So what is your thought about people who work in the emergency department possessing some palliative care chops? What do you think about that?

Dr. Hoffman:

Yeah. Well I think there's a lot of suffering that goes on in the emergency department. I mean people come to the emergency department because they are desperate, and so I think when you see that suffering ... and also, they don't have a lot of time with their patients, because unfortunately emergency medicine physicians are just ... the metrics they are held to are almost dehumanizing for them, nevermind the patient. And so I don't think that they really get say that same kind of feeling that I get to get with my patients because I can take a long time with them or I can go back at night and spend time with them. They don't have that. So I can understand them, seeing this suffering and not getting to minister to their patients because they don't have time, I can see them going elsewhere to look for that training to figure out how to fit that into their world.

Dr. McPherson:

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Yeah, that's awesome. That's amazing. So Dr. Hoffman, is there anything else you'd like to share with our listeners? You have such an interesting background.

Dr. Hoffman:

I would just say that I feel very strongly that one, because palliative care is such an interdisciplinary team sport, that really anyone in medicine who's interested in this kind of work, there's a place for you. There is a place for you. You don't have to be a doctor to be doing this kind of work. I mean I talk to like my nursing colleagues and my respiratory therapist colleagues, everyone has a place in bringing some joy and some kind of ease of suffering to patients and their families, and so I would just really encourage everyone to kind of find your role in this world and just make it work for you. And then the other thing is too, because I kind of followed the non-traditional path going into surgical palliative care, if you want something, just figure it out and go for it. Believe me, there's someone else in the world doing it or someone else who will support you doing it. You can make it happen for yourself.

Dr. McPherson:

Wow. You're amazing. I think I want to be you when I grew up. That's just awesome.

Dr. Hoffman:

All right, and then I'll be you. It will be great.

Dr. McPherson:

There we go. Well, thank you again, Dr. Hoffman. This has been amazing. This is Dr. Lynn McPherson, and this presentation is copyright 2020, University of Maryland. For more information on our completely online Master of Science and Graduate Certificate Program in palliative care, or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.