

The inSocialWork Podcast Series Presents:

Palliative and Hospice Care: Knowing the Difference

With Dr. Rebecca Calabrese and Amber Hultgren

Hosted by Peter Sobota

Peter Sobota. [00:00:02] And a comedian once said, I'm not afraid of death. I just don't want to be there when it happens. From the University of Buffalo School of Social Work, welcome back to the In Social Work Podcast. I'm Peter Sabado. Good as always to have you along, everybody. All kidding aside, our lives are full of transitions and serious illnesses and the end of life are no different today. Today our guest, Dr. Rebecca Kalil Bryce and Amber Holmgren, a physician and social worker who are there when it happens. Talk with us about their partnership with parents and families as they work through serious illnesses and end of life. No conversation. These two are complete without discussion, of course, of life, love, compassion, hope and resilience. And you'll hear about how that can all play out. They will describe the distinction between palliative care and hospice, what they do to assist people in this process, and the myths and misperceptions that often accompany their work. Dr. Calabrese and Ms. Hultgren will tell us what goes on in these settings and talk about the unique skill sets a multidisciplinary team brings to the work and how these skill sets work together. Dr. Rebecca Calabrese is the medical director for Home Connections and Hospice and Palliative Care in Buffalo. She is board certified in both palliative care and internal medicine. Amber Hultgren L.M.S.W., is a medical social worker with hospice and palliative care buffalo, where she works with chronically and terminally ill patients and their families. She's also a UB School of Social Work graduate. Hi, Rebecca and Amber and welcome to In Social Work.

Amber Hultgren [00:01:52] Hello. Hi. Thank you for having us.

Peter S. [00:01:55] Oh, no, no, no. We're glad to have you. And thanks for agreeing to. Come on. So I have been thinking about this, and I'm anticipating a discussion that will include a lot of compassion and love and resilience and hope. And more than anything, I hope we're going to talk about life. But. Of course, you can't really have any of that. You can't even have that conversation without considering, you know, loss and fear, pain and death. You know, they're kind of part of the same package, if you will. So I'm going to ask both of you how you came to this work, because I always think that's kind of interesting. But before I do that, could we lay out the playing field, if you will, and just get a couple of terms that I'm probably pretty sure you're going to use and get these clear from the very beginning. So I'd like to ask you to make the distinction very clear between palliative care and hospice care. Would you start by laying out the difference between the two.

Amber Hultgren [00:03:04] And where you want to go first? Sure. So this is Amber, one of the social workers. Palliative care is a really broad approach to care is simply put, it's symptom management. So when somebody has a chronic or serious illness, there might be physical symptoms, emotional symptoms, other types of effects that happen in their life. And the goal of palliative care is to alleviate the burden of those symptoms. Hospice is a very specific subset of palliative care, and it's what most people think of when they think of palliative care. Hospice is a Medicare benefit. It is for people with what's considered a terminal illness. So all hospice is palliative care, but not all palliative care is hospice.

Peter S. [00:03:56] Okay. Yeah. Rebecca, would you maybe elaborate on that a little bit? Because it sounds to me like the main difference is hospice is for people who are in the end stage of their lives.

Rebecca Calabrese [00:04:10] That is the main difference. I'm Rebecca Calabrese. I am a physician and I am the medical director for Palliative Care Buffalo. And I, I, I think Amber put it very well that palliative care and heart disease are not the same thing, but they're very interrelated. And I think that I think it's important to note that people oftentimes mistakenly use the two terms kind of they basically the two terms as if they were the same thing. And it's not just the general population that does that. It's physicians, too. And I certainly came to palliative care late in my career, and I definitely remember interchanging those terms until the more the the more recent part of my career. Palliative care, in essence, means is, as Amber said, relief of symptoms. It means relief of suffering. And it's a specialty. I think that's an important thing to know, that it's a specialty. The physicians train for the social workers train for the nurses train for which is geared toward centering care around the patient, relieving their suffering, supporting the patient, supporting their caregivers, and discussing the future of their illness with them, their wishes, their hopes, their their goals of care. It really does. So it's very, very comprehensive. It can include medicines. It can include prescriptions that it may not. It depends on what the patient needs. And palliative care can, as Amber said, be given in any stage of a patient's illness. And typically, some of the the the illnesses that we see in people who are enrolled in palliative care, things like cancer, like stage three for cancer, congestive heart failure, which is the heart now working on kidney failure, liver failure, some sort of organ failure. COPD also called that's an old that's kind of a newer term for what used to be called emphysema, which is essentially lung failure. These are these are conditions that are not curable, but people can live with them for a long time. And they need some support. They need some symptom management because they want to live comfortably for as long as they have to live. And as Amber said, the palliative care hospice is a specific, specific type of palliative care where it's it's a it's a patient who has has to be deemed by two physicians. These are Medicare sort of rules. And the patient has to be deemed at six or six months or less to live. So it is at the end of their life, but cannot be given with curative treatment. People who enroll in hospice usually will give up things like chemotherapy, dialysis, sometimes radiation, and basically a hospice will completely assume their care. Both palliative care and hospice can be delivered in over many settings. Hospitals are a setting. Most, most. Hospice is aimed at delivering care at the home. Our palliative care program is definitely a home-based palliative care program, but I have been involved in some robust hospital programs and outpatient clinic programs as well. So it's a pretty diverse field. I hope it didn't take. I hope I didn't take too much time to explain that.

Peter S. [00:07:37] No, no, not at all. And I wanted to start there for all the reasons you just said, and many of which I think I'm certainly that I can get myself into thinking that way. So. All right. So now I want to find out, you know, I think a lot of people are going to listen to all that and go, what are you people thinking? You're doing this every day. So I'm really interested in how did the two of you end up where you are today, doing this kind of work in this kind of setting? And how did that happen? Is there a method or a journey that got each of you there?

Amber Hultgren [00:08:19] Yeah. So, Amber, here, I will start at age seven.

Peter S. [00:08:26] My it's an hour-long podcast.

Amber Hultgren [00:08:28] And so my, my grandfather died when I was seven years old. He had lung cancer and very few memories of him. But I do remember being able to say goodbye to him actually in our home, and that's because he was home with hospice towards the end of his illness. And then around the same time, my grandmother, his wife, was diagnosed with Alzheimer's. So we stepped in. We being my mother, not actually me. I was a kid. But we stepped in as her caregivers and took care of her for the next eight years. So I spent most of my childhood in this realm of watching a caregiver, seeing what it looked like. So by 16, I was like, Yep, I got to help. I got to do something here. It took me a little while to figure it out. A degree in human development ending with social work. And I ended with hospice, which turns out was the end goal was to be in palliative care and hospice. So here I am.

Peter S. [00:09:32] Yeah. Thanks.

Rebecca Calabrese [00:09:33] I didn't know that.

Peter S. [00:09:34] Yeah. Wow.

Rebecca Calabrese [00:09:35] This actually is pretty incredible. Yeah. Yeah, I'm glad for my type-A personality, so.

Rebecca Calabrese [00:09:45] How about you, Rebecca?

Rebecca Calabrese [00:09:46] I can't remember what I was thinking when I was seven. It wasn't. It wasn't that. I think not. I know it's not about my career, for sure, but that's pretty incredible. But I. I wanted to go to medical school. I can't remember wanting to do anything else except maybe being a veterinarian, but I decided I wanted to go to medical school long before I went to college and went to medical school eventually and got residency. I was in New York City, got a residency in internal medicine and really kind of after I graduated from residency, I really almost I felt like I kind of lost my way. I didn't know what I wanted to do. I think I still wanted to be a doctor, but I didn't know if I like, you know, I didn't really like the office setting that much. I did start a private practice right away and that was it. I liked my patients. I loved the relationship I had with them, but it just there was just a business side to it and a regulation side, which I was not particularly good at. And then I did some stuff with obesity medicine with a hospital in New York, and that hospital closed. And yes, and I actually had lived to see a couple of hospitals, really big, prestigious hospitals, because of the way medicine is evolving, just closed down because they couldn't support themselves, which was just a slap in the face to a lot of doctors, I think, and eventually ended up back where I trained at Beth Israel Medical Center doing hospital medicine. And I and I really liked it. I really thought that was it. I found my calling. I became the associate director. I loved the people I worked with. And then wife sort of inadvertently gave me another direction. My mother became ill and I sort of knew that was happening and I didn't know what to do about it because I could hear it in her voice and I could see it on her face. And she didn't know. And she and I could tell she didn't want to go see a doctor. So eventually she ended up in the emergency room and she was diagnosed with very advanced ovarian cancer. And my I said, I'm going back to Buffalo. It's I need to this isn't going to be long. And I need her to know that I was there at the end of her life and that I supported her and my family. And off we went. My husband, my two children were very supportive. My children were like three. So they couldn't didn't have a day. But my husband was very supportive, and I got a job as a hospitalist here. And anyway, my mother sort of went through this journey where she did chemotherapy and surgery and was in and out of the hospital and never really felt very good. Stopped her own

chemotherapy because she was feeling so crummy. Never, just never seemed to be herself until she accepted hospice. And when she accepted hospice and drew the last few months of her life, they were such an amazing support to my family and they were an amazing support to my dad. And I finally felt like for the last couple of months of her life, I got her back. My mother, who I knew back, and I thought to myself, this is it. This is what I want to do. I want to be. Helpful at the fore during this journey that people have. And I. At the you know, after 20 years or so in medicine, I decided to go back into training for a year. And here I am.

Peter S. [00:13:10] I have to say, I'm not surprised, but it doesn't change, I think, the impact of those stories. I think that's how I always start with that, because I think almost everybody who we have on and even myself, the journey who makes a lot more sense when you look at it backwards. Right. It all seems to fit. So thank you both for doing that. So let me start and by the way, a lot of questions based on some of the things you said, but I'll do this first. So you've alluded to this, but what kind of setting do the two of you work in? And more importantly, what goes on there? What you what do you folks do?

Amber Hultgren [00:13:51] Well, I'll say it's the wild, wild west now. So we're in we're in people's homes. So and whether their home is a home or an apartment or an assisted living, where wherever they may live. And so it's so interesting working in people's homes. You're not in an office, you're not in a hospital. It's not your setting. It's theirs.

Peter S. [00:14:15] It's their home feel.

Amber Hultgren [00:14:17] Yeah. You walk into that house with it doesn't matter. You are there literally meeting people where they're at physically and emotionally. So I think it's it's probably my favorite thing in the world to work in because you are you are in a person's environment. You learn so much more about them. You get such a better picture of what's going on. And you are really, really humbled sometimes because you're a guest in their home.

Peter S. [00:14:45] So yeah. Thanks. That that yeah.

Amber Hultgren [00:14:50] Rebecca I agree. I think so. I've worked in, you know, I worked in the hospital setting for, I would say, the majority of my career. And the, the, the way that you can relate to a patient in their home is just so different in the way you relate to them. In the hospital. In the hospital, they're they're scared. I mean, not there aren't too many people that aren't scared in a hospital. They're usually cold. Probably somebody hasn't fed them in a few days. They don't have their supports around them. I, you know, in COVID, they couldn't even have visitors. And then having this transition of going into the home where, as Amber said, you meet them where they are and whatever agenda you have. I have very definite ideas of how a visit is going to go in the home and and that you know, I it goes better when you don't because it goes much better if you walk into the home and ask them what what you can do for them, which I have learned to do. And still, you know, I'm type-A as well. I'm a control freak. I definitely want to control the visit and my time. And I have this busy day and, you know, I've got my whole day planned out. But when you go into people's homes, you literally never know exactly what you're going to get. And you have to be okay with dogs and you have to be okay with cats, which I love. You know, we all we are big animal lovers where we work. And sometimes you have to be okay with kids and you have to you have to be okay with whatever is going on in that house at the time.

Peter S. [00:16:29] Yeah. And you know, I obviously this is an audio recording, but you can't see me laughing because I used to do home visits in the beginning of my social work career. And you were bringing back great memories because I used to have a plan to I'm not terribly tidy, but but I used to have a plan and I had many places to go. And I have this distinct memory, especially of going over to visit home visits on the west side of Buffalo. And and people would make me eat the cookies they made and they would make me and I would have to sit at the table with them before we could get them to what my business was. We had we had a visit for a little bit and it was. I learned I learned to relax and I learned how meaningful and how grateful I was that they even did that for me. I just thought, that's a nice way to treat a guest. So. So this is going to be a very weird question. I hope it comes out in the way that I intended or in a way you can understand it, but. If there was no such thing as palliative care or hospice. What? What would be happening to people. What would the world look like?

Rebecca Calabrese [00:17:56] Hey, can I. It's Rebecca. Can I go for it? So this is Rebecca. Everyone, this is. This is a weird question. It's very.

Rebecca Calabrese [00:18:04] Thank you. I'm good. That's my specialty. It was, say.

Rebecca Calabrese [00:18:09] Not a very dystopian feel to it, to me, you know, just like what would happen if there was no Internet. So I.

Rebecca Calabrese [00:18:19] The first people would talk with each other.

Rebecca Calabrese [00:18:21] The first thing I think is there would be more people dying in hospitals. I like to think that we've had a positive impact as as palliative care and hospice. So I think of the the positive impact that we we really try and get to the crux of how people want to live with their illness and how maybe it would work if their time were running short and support them in that goal and respect them and that goal. So I would like to think. That because there's hospice and palliative care that more people are dying, living and dying in a way that is concordant with their goals and respecting them. I but then I thought of this very sort of, well, unintended consequence. What if there was no palliative care in hospice? What if people had to do this themselves? Would communities come together and and sort of fill in this gap? And, you know, I just started letting my mind wonder, would there be this this sort of, you know, would there be more community-based care? Would would neighbors be helping their neighbors a little more? You know, I and then I thought, no, because if that was happening, we probably wouldn't have this field. So that was my circular thinking.

Peter S. [00:19:39] Mm hmm. No, I. I like that you said that because I would like to think that, you know, we have professionalized so many things that people in the past did on their own or with the support of their neighbors and their family. So I understand the thinking, but I do think there is something very unique to what you do. And I think I share. You know, a certain kind of resignation that I think people would be dying in hospitals. I agree. And that's not always great. Amber, did you want to.

Amber Hultgren [00:20:16] Yeah, I you know, my first thought was that was definitely the same thing, right? People would not have the support that they need to endure illness and eventually die the way that they want to. And I think about what it's like to do either a palliative care or a hospice admission. And you walk into this home and maybe it's a new diagnosis, maybe it's an old diagnosis that's just gotten more severe and people are overwhelmed. They don't know what to do. There's no roadmap. Every person, every

illness, every family and friends support system is different. So they can't just Google, how do I do this? So I think that. Looking at. What we're able to do in terms of just helping people have a guide, a lifeline, to call and say, how on earth do I handle? This situation is such a huge value that we provide. And so I, I don't like to think about what that would look like for families without having that ability to call and say, you know. Mom's acting this way and that's new. Or, you know, we all want to do a family. How do we how do we navigate any of these situations? So I think people would be. Without a really necessary support, without palliative care. And if I could add something, just thinking back to when I was in training many years ago, I didn't. I didn't. No one taught us to stop. Like when to say to a family we might be doing more harm than good with everything that we're doing to your web. Wanted to talk to a patient like that, especially. I mean, there was you know, I trained during the HIV year where there were no protease inhibitors. There was you know, we we just didn't ask a patient if they were okay with what they were what we were doing to them in the hospital. And now I think with palliative care, that conversation is is not only has been brought up, but that conversation has actually been encouraged and to some degree normalized, I think, in hospitals. Is is this what you want, you know, or do you want something else? You know? And and I think the patients are allowed to now sort of be more in charge of speaking up about care. They don't want care. They want and care they don't want.

Peter S. [00:22:58] Mm hmm. Yeah. If I could follow up with you, Rebecca, because as you were talking, I thought about something. Physicians are trained. To heal and to preserve life. And so I would imagine it's not unthinkable that many physicians. Perceive palliative care and hospice. Almost like as a failure. Of. The natural extension of their profession. Now, I don't see it that way. But I wonder. You know, our physicians trained to have the difficult conversations. Like you mentioned, you didn't know when to stop and you began to think critically about your interventions and wonder out loud, are my interventions actually making things worse than better?

Rebecca Calabrese [00:24:02] Yeah. Nat Honestly, that thought that you're saying that I had, where are my interventions making it worse? You can fast forward years to my bike that I didn't think about that during my training. I didn't even that like, you know, is bad for the patient. I'm like, I didn't think about that. I just thought, okay, this is going to, you know, extend their life by, you know, minutes, hours, whatever. And it was it was, you know, looking back on it now, it seems like such hubris on our, you know. I yeah I think there are physicians do feel that that it is a failure if if a patient gives up. And I think we hear that. Yes. Not giving.

Peter S. [00:24:41] Up. Mm hmm.

Rebecca Calabrese [00:24:42] And I mean, I always say, what is giving up mean to you? I hear you saying give up. What? Why do you think you're giving up or what? Let's explore that or say more. I usually say say more about that. Yeah, because it makes it just breaks my heart to hear somebody say that because they want to change their care trajectory, you know, to one more in line with staying at home, quality comfort, being with their loved ones, if somehow that's giving up. And, you know, the patients sometimes they get their they get pressure from their loved ones that they're giving up friends, loved ones. But yes, definitely, I've seen them get pressure from physicians that if you don't take this treatment, you're going to die. Or you're giving up and that's a bad thing. And then they get it. And some people just go on with things, but it wouldn't be their choice. They're doing it for other people.

Peter S. [00:25:32] Exactly. Yeah. Thanks. Yeah. Thanks for even entertaining. I thought. Actually, I have one for you too, Amber. If, if, if you don't mind, because I had a similar kind of thought as well and and Rebecca kind of touched on this. Are there are there common? Or typical family or caregiver responses. When people are considering being engaged with palliative care or especially hospice. I mean, I know that's not a fair question because I'm asking for the greatest hits almost, but I would imagine that there are things that happen in patterns.

Amber Hultgren [00:26:15] So yeah, I see that actually in large a large part of my role is kind of breaking down those, those fears, this stigma around the idea of palliative care, which is why I have my prepared speeches. Simply put, palliative care means symptom management. It doesn't mean that it's not the same as hospice, but it I've actually had I've actually been in homes where when people maybe are being discharged from our program because they're medically stable or people who don't necessarily need our program anymore, they're like, you know what? I'm kind of relieved because it is a it is a scary word, palliative care. But if you ask me, it's just really the best approach to care because it's patient and family focused. It's it looks at not just how do I present in an office or in a hospital, but what's going on every single day when I'm at home trying to live my life. So. So, yeah, I do hear a lot of fear around the word palliative and like a sigh of relief when people aren't palliative. So we're still working on that. And it may mean different things to different settings, too. I mean, to be to call a specialist in a trauma intensive care unit is a very different visit than seeing someone at home who, you know, maybe just got out of the hospital or is undergoing physical therapy. It's it's a very different conversation. It's almost a different specialty at that point when, you know, when you're if you're going and talking to somebody who had gone to work, you know, a family that of a loved one who had gone to work the day before and then went skiing and crashed into a tree and is never going to wake up. And that's what you're going to talk to them about versus going into someone's home or it's where it's nice and peaceful when they're in their dog is there. It's it's very different.

Peter S. [00:28:17] Yeah. I don't know if I'm saying this correctly, but you can graduate, if you will, successfully from palliative care. I mean, I don't know if that's the way to put it, but does that happen?

Rebecca Calabrese [00:28:31] Yes. Yeah. We we have often have people who have their goals met, which means, you know, on some occasions we have patients with cancer who go into remission, which is always super exciting for the team. But even somebody who has a chronic illness, a heart failure or COPD, as Dr. Kaleri said, is chronic obstructive pulmonary disease. So let's say they'd have been having a lot of hospitalizations and we came in as palliative care to help work with them, work with their doctors, try and get things better managed. And they've had several months where, yes, they have underlying disease, but they're. Not having these exacerbations things are fairly stable then yes, people can can graduate from palliative care.

Peter S.[00:29:27] Maybe not the best word choice, but yeah. Thanks. The and now it's flip it the other way now. I mean, even I know this is that many people begin contact with your services for palliative care. And then of course, things progressed to the point where hospice becomes the the new option. I wonder what that's I mean, it's going to seem like a silly question, but. I can only imagine what that's like because one of the ways people cope is with faith and hope and things are going to get better and then they don't. So in terms of impending death, what are the unique challenges there? I just wonder, you know,

what is that like on your end and what do you see? Are there unique challenges during this transition?

Rebecca Calabrese [00:30:21] Well, again, I think it depends on that. It's so individualized. It's very there are people who want hospice and aren't ready for hospice. As per the Medicare guidelines, they jump to more than six, even if they have a chronic illness. They just have more than six months to live or even a year to live. And we we keep an eye on those patients, but it's challenging to tell them that. For all intents and purposes, they want to. They want to. I don't want to go to the doctor anymore. I don't want to go to the hospital. And I'm done. I just want to stay home, be comfortable. Why can't I have hospice? And the challenge is explaining to them the Medicare benefits. I think the other side of that is when you actually when one when we actually see a patient who is ready for hospice, who could really benefit from hospice, and that the dying process is happening to the treatments that they're getting, maybe are a more burden than a benefit or just aren't helping. And having that conversation to sort of be open and honest with them about that when they're not quite ready for it or that that's very challenging. And because that kind of comes off like you have an agenda. Which which you know. You do. I do. I guess when I go in and I'm and I'm trying to make, you know, get people to see that maybe hospice might be the best thing, especially if it's recommended by the primary care, by by us, by even the oncologist. So trying to have that discussion without appearing that you're not having an agenda, which for all intents and purposes, I guess there is an agenda. Does that make sense? You know.

Peter S. [00:32:08] Yeah. Oh, yeah.

Rebecca Calabrese [00:32:09] Trying to meet a patient where they are, even if where they are is and where they think they are.

Peter S. [00:32:16] Yeah.

Rebecca Calabrese [00:32:16] Yeah, it's, it's, it's embarrassing. And they're hard conversations to happen.

Peter S. [00:32:20] Yeah, well, and I would think it would be an experience that just kind of fraught with mixed feelings and ambivalence for the patient, the family, and even for you, the professionals. With what you would hoped was going to occur and what is occurring. So both of you have been talking about what you do and and kind of the nuts and bolts of this. But what I really like about this is the this kind of notion of different disciplines kind of working together. And I don't know if they're I honestly don't know if there are other disciplines involved in this. But for the two of you, in your own opinion, what skill sets. Do you bring to the table based on your your training? And then even more importantly, I think or more. I think my bigger interest and beyond that is even, you know, how did the two of you then work together? You know what? How how does that all come together to, you know, serve the whole person? So there were two questions there. Sorry. Yeah, let's let's do the first 1/1. What, what are the unique skillsets, I guess.

Amber Hultgren [00:33:36] So, so I will start, you know, my title is Medical Social Workers. So, you know, there is a certain understanding of of different illnesses and health that I have to have. But ultimately, my role is is as an advocate for the patient and their family is to help guide them in some of the non-medical components of their care. You know, how do I get somebody here overnight so that mom's not alone or, you know, how how do I cope with this anxiety without medication? So there's there's a whole piece of

medical care that is not, in fact, medical. And and we have a team that's comprised of social workers, nurses, nurse practitioners and and our our physician. So we are largely a medical program, but we all have to acknowledge that there's so much more that goes into dealing with illness. Of course, the the buzzword being the the social determinants of health. But, you know, we're we're all involved in that together as a team.

Rebecca Calabrese Yeah, I think. Yeah. There's a lot of overlap between, you know, but, but there's, I mean, I'm, I'm a physician. I had a right to, you know, I had to do a fellowship. I had to take a yearlong fellowship. I had to take a test. I had to be board certified in this. Um, and I can't keep track of all of the services and. Social determinants, the things that people the things in the community that people can get to help support them. I simply can't keep track of that. I really rely on Amber and our other social workers, too, to be able to help me with that. Sometimes we have nurses in our program, too. We have some nurse managers. I, I don't think that my job is as important at this point as the rest of the team, because that that's who the patients remember are Amber and whoever. They're nurses and the doctors. They don't oftentimes remember me from another doctor. So that's that's how we kind of work together. I feel like I'm almost ancillary in the palliative care field.

Peter S. [00:36:06] Yeah, that's interesting. Social workers often claim that they are the ancillary in places like schools and hospitals. So it's interesting to hear that perspective. And, you know, I before interrupted to speak with you both today. I went to. The website of of your place. And as I just read the kind of descriptions of what you do and your philosophy, it it fit really well with this kind of bio, psycho social, emotional, spiritual thing that we preach in schools of social work all over the place. So it makes perfect sense that you have different disciplines to the table here and and working together, obviously, to, to serve patients. All right, so we're getting close to the end of our time, so. I was going to ask you, do the two of you ever is there tension or is there is there things that you would disagree about based on your different training? But I guess I just asked that. I did. I was I did it. And then I did.

Amber Hultgren [00:37:20] Yeah, I don't think so. Not yet. So every single person, every single person on my team has heard me say yes, but it's their right to make bad decisions. You know, we have different approaches and viewpoints, but we have team meetings. We as social workers, nurses, physicians, nurse practitioners. Talk about what's going on. So our viewpoints are sometimes different. Like I said, there's there's the occasional like, wait, wait, no, that's, you know, from there. From their perspective, this is what they have the right to decide. And maybe we don't agree with them. But the fact of the matter is that we we need each other. We do joint visits all the time. And I myself and a nurse. A nurse and Dr. Calabrese. Myself and Dr. Calabrese, we work together because as we talked about earlier, when you walk into somebody's house, you don't know what it is they're going to need. So, you know, if I walk in thinking I'm going to fill out some kind of benefit application, but they're horribly nauseated. I need somebody there to help address that. And likewise, if somebody is prescribing a mad but they can't afford their co-pays, they're going to need my help to navigate that as well. So we we rely on each other.

Peter S. [00:38:44] Yeah. And that really I didn't mean the question as a pejorative when are poking around for trouble. But, you know, there are different orientations based on different levels and types of training. And but I see that as a good thing. I mean, I think that would be, you know, the right questions get asked based on that, the differing

perspectives. And it's obviously a credit to the at least minimally the two of you that you have a respectful, respectful working relationship. Good.

Rebecca Calabrese [00:39:14] You know, having worked in hospitals. There is I mean, it doesn't always there isn't there isn't always a congeniality between yes. Between and even between doctors, but between the social workers, discharge planners. I mean, it's just such a high stress, high stakes environment. But I don't I don't think anybody who goes into palliative care, I think one of the reasons that they actually choose it as sort of a specialty is they're ready to give that up. They really want a more collegial, collaborative environment where, again, the patient is really in the center. And, you know, and I'm not going to say we never do. It's not that we disagree. It's just somebody might say, well, I think they need this if it's a medicine. And I'll say, no, that's not the right medicine. And no one ever, you know, they they they different my expertise. I defer to members expertise. I defer to the nurses expertise.

Peter S. [00:40:18] It's yeah, yeah, perfect. All right. So now, now I want to ask any more questions that I said I was going to ask. And so how about this as we near the end and you have hinted at this along the way, but I want to give you a like a distinct opportunity for for both of you what myths or misperceptions about either palliative care or hospice or both would you like to use this opportunity to set straight? And I do do things exist. Like that.

Amber Hultgren [00:40:55] There are lots of conceptions misconceptions, rather, out there about both palliative and hospice care. My. The biggest one that I can say is that it's really not about dying. It's, you know, whatever time I have, how do I want to spend it? How do I want to live it? It's about living well with an illness, with the understanding that none of us have unlimited time on this earth. So I think it's it's so much more about how can we enhance and not about what are we taking away, because it's somebody is older or somebody is at the end of their life. It's definitely the other way around.

Peter S. [00:41:43] Yeah, it's interesting. It's almost an extension of what I would call a how like a broad segment of society views death as something separate and distinct from living. I think that's what I was kind of hinting at at the very beginning. And then that plays out in in these services being death. And that's not it at all. Rebecca, are there any misperceptions or myths that you would like to set straight here?

Rebecca Calabrese [00:42:16] I think just to echo and emphasize what Amber was saying, the palliative care people think it's it's the end. And I'm doing air quotes. It's yeah, it's the end. It's end of life. And this is not just patients. This is doctors, too, you know? Oh, my patient isn't ready for palliative care. You know, they're not they're not hospice yet or they're not at the end of life yet. So that's one big mess. And the second method, I think it might be sort of important to touch on here is that oftentimes palliative care physicians will use medications to help symptoms, pain medications, medications for breathing medications, for nausea medications while a patient is on chemotherapy. So they're at their strongest to be able to tolerate the chemotherapy. And oftentimes patients and families think that the meds will hasten their death. And oh, yeah. So palliative care and even hospice medications are used for symptom management and not to hasten death. There's actually a lot of literature that shows that the medications used don't hasten death and really do help people with their symptoms and help them with a better quality of life.

Peter S. [00:43:31] Yeah. Great. Okay. This'll be your last chance here. If you have. You have a megaphone and a microphone here. Whether you would. Whether you're thinking about physicians, social workers, patients. You have a chance to. It kind of call out to

people here and and kind of ask them to consider something about this work that you hold near and dear. What what would you want people to kind of take away from the conversation and and who or what would you like to call people out for?

Rebecca Calabrese [00:44:06] I'll go first. So for me, I think the message that I would scream from the hilltops is that palliative care is not scary. Whether that's for patients and families to understand that it's a supportive service. It's it's an approach to looking at your total self and wellbeing. Or whether that's for other other disciplines, other physician, social workers. It's funny because even going through social work school, when I said I wanted to do hospice and palliative care, people were like, Oh, that's. That's really sad. And I'm like, Yeah, your social worker is like, You're probably not going into a super happy environment yourselves. So I think there's just something to be said for, you know, looking at.

Amber Hultgren [00:44:56] That.

Amber Hultgren [00:44:56] Illness and death, like you said, is part of living. It's one of the only universal human experiences that we have. We all endure, whether it's our own or the one of a loved one's illness and and end of life issues at some point. So it really is just part of the human experience, and it's not as scary as some people think it is. It's remarkable. It's a system of support. It really is. It's a medical specialty that does support patients and puts them into the center of care. And this has been the philosophy of the palliative care medical specialty for, you know, since its inception. And I think other specialties, especially primary care and third party payers, are coming to realize that now and putting systems in place. But palliative care has always been about that support. And as and I think Amber said it perfectly, it's not scary. It's not it doesn't have to be scary. It can be very supportive, very hopeful and very healing in a way.

Peter S. [00:46:10] Yeah. Well, you know, thank you both so much. I mean, I mean, it was really nice to hear the voices of the people who do the work, you know, remove the mystery from from the process. Right. That many people are so afraid of. And and clearly, your, you know, your passion for the work and the way you evaluate, I'm sure I'm sure it's out into the care that you provide. Thanks so much for joining us. It was a real pleasure to talk with you both.

Amber Hultgren [00:46:42] Thank you.

Rebecca Calabrese Thank you very much for having us.

Peter S. [00:46:45] The folks who embrace life in the moment and comprise the in social work production team, our director and website manager, the blissful Steve Sterman, our Swiss Army Knife of production assistants, Kate Bears. And I'm Peter Sabatier. It's possible that this podcast corresponds with the conclusion of our graduate production assistants. TIME With our podcast, Kate Bears has graduated, gone back to Michigan with her husband and son, and will be starting her post MSW career with a new job. Listeners need to know that Kate was instrumental in bringing this podcast to life each month, far more than a production assistant. Her fingerprints are on every show we've done in the past two years. It wouldn't be the same without her. We will miss Kate a lot, but we are certain that she will continue to do terrific work in her career as a social worker. So with gratitude and love, Kate, thank you for all of your work, creativity and contributions to our podcast and school power to you in your new phase of your life. Thanks for listening, everybody.