



Every weekday at 8:00 a.m., the members of the palliative-care team crowd into a conference room to discuss their patients. They begin with a poem or some other reading that helps them leave behind, at least for the moment, whatever had been on their minds as they made their way to work. "What we want to do is come together and focus on those we serve," says Donna Soltura, the team's social work coordinator (at the end of the table, in front of the bookcase). "Alone, none of us would be as good at this as I think we are together."

SIMPLY PRESENT

Palliative care is sometimes thought of as an alternative to receiving treatment—in effect, preparing to die. It's true that the doctors, nurses, and other staff members on DHMC's palliative-care team deal with death as part of their daily routine. But it's quickly apparent when observing them at work that their real gift is for helping patients and their families to live.

While some palliative-care patients are close to death, others have many years ahead of them. But all have serious illnesses that affect their health and complicate their ability to get through each day. The issues raised by the palliative-care team in their conversations with these patients and their families can be uncomfortable: physical disability, emotional well-being, family dynamics, finances, and, of course, death. But they do raise them, gently, time after time. Evidence from clinical trials shows that these efforts are effective—that palliative care can both improve patients' quality of life and, in some instances, even prolong their lives.

But the methodologies of palliative care do contrast with much of modern medicine. Unlike other specialties, what palliative care has to offer is not the promise of a cure but the ability, and willingness, to talk and to listen. As Dr. Ira Byock, the director of the program, wrote in his book *Dying Well*, "While I may bring clinical skills and years of experience to the task, ultimately I am simply present, offering to help."

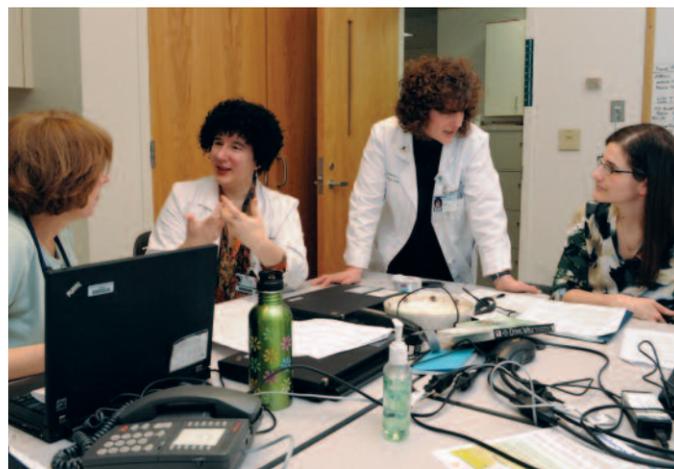
All the patients pictured on these pages gave permission for their images and stories to be shared.

Often confused with hospice care, palliative care is, at its core, about caring.

About caring for the patient, not just the patient's disease. About simply being present for patients, as Ira Byock, the nationally prominent director of the DHMC palliative-care program, puts it. Here's a look at just what that means.

**Text by Amos Esty
Photographs by Jon Gilbert Fox**

For a **WEB EXTRA** with links to further information about the DHMC Palliative Care Program, including several videos, see dartmed.dartmouth.edu/sp11/we05.



Communication is key to the team's work, so they all know how patients are doing—from problems with pain to disputes with family. Here, Dr. Diane Palac (far left), confers with Dr. Sharona Sachs, as Dr. Jennifer Savoca (far right), an intern, gets a briefing from Lisa Stephens, an advanced practice nurse.



Dr. Ira Byock (left), long a leader in palliative care, has been the director of the program at DHMC since 2003.

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After the morning meeting, members of the team head out for a busy day seeing patients. In 2010, they saw nearly 1,500 outpatients and over 450 inpatients.



Palliative-care clinicians often work closely with other physicians who are treating patients with serious illnesses, to help them figure out how to integrate palliative care into their patients' ongoing treatments. Physicians at DHMC tend to be very open to palliative care, Sachs says, perhaps in part because the team is willing to work with patients at many stages of illness, not just those who have exhausted all possible medical treatments. Above, Sachs (far left) and Stephens (second from the right) confer with Dr. Rick Hildebrand (second from the left), a resident; Mina Ghaly (third from the left), a DMS medical student; and Dr. Anne Chehade, (right), a hospitalist.



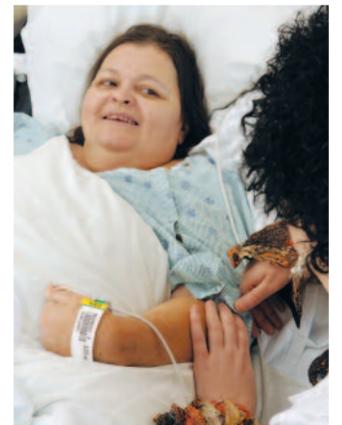
The oncology unit is a regular stop for the team, since many palliative-care patients have cancer. There, the palliative-caregivers can get an update on the condition of the cancer patients they're following and on any changes to their treatment regimens. This morning, Sachs and Stephens discuss several current patients with Dr. Konstantin Dragnev, a medical oncologist. Above, Mary Ellen McCormack (left) looks on during the exchange. McCormack is visiting DHMC as a participant in a two-week peer observer program run by the palliative-care program. "It's been a really great experience," says McCormack, a nurse who is the homecare/hospice director at Pemi-Baker Home Health and Hospice in Plymouth, N.H.



Time seems to slow down when a member of the palliative-care team enters a patient's room. Conversations unfold at a deliberate pace. After all, there are complex issues to discuss. Here, Sachs and Stephens talk with patient Susan Hayna, who has severe diabetes. Hayna recently fractured both of her ankles, requiring a stay in the hospital. As a result of difficulties healing in one leg, she may need an amputation. Sachs asks Hayna how she is doing. Her left foot is causing quite a bit of pain, Hayna replies. "I'd rather have it amputated than be in this much pain," she says.



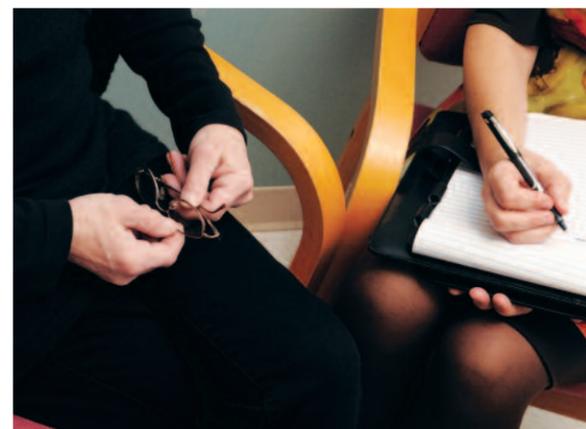
"In thinking about amputation, what do you need to know first?" Sachs asks Hayna. Together, they come up with questions that Hayna wants to be sure she remembers to ask her surgeon before making the decision about amputation, while Stephens writes the questions on a whiteboard. Hayna is worried about the possibility of infection from surgery, about dealing with pain after surgery, and about how well she will be able to get around. "How will I get around—best, worst, most likely?" reads one question. As with many of the conversations the palliative-care team has with patients, there are no easy answers, but it's important to ask the questions. "She's an incredible person," Stephens says of Hayna. "You can have a hard conversation with her because she knows what she is dealing with."



Despite the health problems that she faces, Hayna remains upbeat. "I feel very lucky to be here," she tells Sachs and Stephens.



After meeting with Hayna, Stephens has an outpatient appointment with John Dennett, who has both advanced lung cancer and bladder cancer. He is at the Medical Center today for chemotherapy, and while he's there he meets with Stephens to talk about some of the side effects he's experiencing from his treatment. His wife, Virginia, says his cough has been bad lately, especially at night. Stephens tells them it's possible that the radiation therapy Dennett received caused an inflammation that has worsened his cough. In addition to discussing these medical issues, Dennett and Stephens chat about a blues and rock band he plays in, the Rocking Chairs. Most of the group's gigs are close to Dennett's home in Bath, N.H., he says, but they've performed as far away as England.



Physical ailments are not the only side effects of a serious illness. Social work coordinator Donna Soltura spends much of her time helping patients and their families cope with other problems that arise during medical crises, from disputes among family members about the best course of treatment, to dealing with the possible death of a loved one, to paying all of the medical bills or even the regular household bills. Here, Soltura talks with Nanci Szalucka, who is being treated at DHMC for cancer, about some of the side effects of her treatment. The two also discuss some other complications in Szalucka's life, such as the expense and paperwork that come with a serious chronic illness. Soltura helps Szalucka work through the difficulties she is facing and mentions some programs she's investigated that may be able to help. "It's hard, that's for sure," Soltura says of having such a discussion. "But I'm so glad *someone* has had that conversation with the patient." Soltura came to DHMC about four years ago, inspired to join the palliative-care team in part because she had long admired Byock's work in the field. She tries to help patients turn what seem like overwhelming situations into a series of manageable steps. Dealing with a serious illness, she says, "doesn't have to be every moment of their lives."



One part of getting to know patients well is the physical exam, which Stephens conducts here on Dennett.



Stephens talks to the Dennetts and their daughter, Danielle Dauphine, about the next steps in John's treatment. She says she'd like to change the pain medication and cough suppressant he is taking to try to get a better response. The Dennetts travel to DHMC quite often for John's treatments—a 50-mile drive from Bath—but they don't seem to mind. "I love it down here," John says. "All the doctors and nurses are wonderful," Virginia adds.



Soltura likes to laugh, and she likes to help her patients laugh as well. "You have to know when and where to use humor," she acknowledges. But "it helps patients realize that they don't have to cry all the time."



Briane Pinkson, the healing arts coordinator for the palliative-care team, offers a neck and shoulder massage to Christine Fortin, who has cancer and is awaiting a bone marrow transplant. Outside Fortin's room, the hallways bustle with doctors and nurses. But inside the room, it's calm and peaceful. Pinkson began offering massages to DHMC patients about 20 years ago after she took time off from her job as a nurse to take a massage therapy course. When she returned, she found that many patients appreciated the chance to get a massage. The oncologists she worked with were supportive as well—especially after she gave each of them a massage to help them appreciate the technique's benefits. "Comfort is such a big concern" in palliative care, Pinkson says. She believes that nontraditional therapies are becoming more common at major medical centers and that most doctors at DHMC welcome such efforts. Rigorous studies are beginning to show measurable outcomes from these and other elements of palliative care. Marie Bakitas, a member of the DHMC team who holds a doctorate in nursing, led a 2008 study which showed that being enrolled in palliative care improved patients' quality of life. Other recent trials have found that palliative care can extend the life of patients with terminal cancer.



Pinkson also offers Reiki to patients. She describes this ancient Japanese practice to Fortin before she begins. "The idea is like jump-starting a body," she says. "It gets your energy flowing." Pinkson puts her hands on Fortin's abdomen and holds them there for several minutes. She then moves her hands down Fortin's legs. Patients respond differently to Reiki, Pinkson says, but most appreciate it. "I noticed warmth, especially along my legs and feet," Fortin says. "It felt good."



Pinkson offers a foot massage to Marilyn Koczur, who has acute leukemia and, like Fortin, is in the hospital to have a bone marrow transplant. Koczur says the massages help with her pain. "That feels so good," she says, as Pinkson kneads her sole and gently stretches each of her toes in turn.

While Pinkson works, she and Koczur talk about how Koczur is doing. Some patients like to talk as they get a massage, Pinkson says. But others prefer to close their eyes and retreat inward. Pinkson explains that there is scientific evidence for the benefits of massage: a 1999 study conducted at DHMC found that patients undergoing a bone marrow transplant who received regular neck and shoulder massages reported feeling less anxiety and nausea than patients who did not receive massages.



Even if palliative care cannot cure patients, Pinkson explains, it can help to heal them. The kind of touch she uses when massaging patients is—like the conversations that Sachs, Stephens, and the other members of the palliative-care team hold with patients—gentle enough to be reassuring and yet firm enough to get results. It's an approach that takes the entire patient into account. As Stephens says, "Patients get embraced by palliative care." ■