

Dr. Lynn McPher...: 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'm very excited to have two guests today. Simran Malhotra, who's a physician, a palliative care physician, and Carlie Pierorazio, who is an advanced practice nurse working in palliative care. Welcome, ladies. I'm delighted you're with us today.

Carlie Pieroraz...: Thanks, Lynn.

Simran Malhotra: Thanks for having us for sure.

Dr. Lynn McPher...: Oh, for sure. So why don't we start off with, either of you jump in, please share your story. Who you are. What you do. What's the 411?

Simran Malhotra: All right. I can go first. So my name is Simran Malhotra. I live in Maryland with my husband, my two kids. I'm originally from outside Toronto, Canada. I moved down here in 2012, for my internal medicine residency, which, after I finished, I went to Hopkins for a year to do my hospice and palliative care fellowship, and I finished that in 2016. And since then, I've been working as an inpatient palliative care clinician.

However, I've also my own personal health journey over the past four to five years, that's opened my eyes to some other interests. So I'll share a little bit about that as well. So personally, I have a very strong family history of breast cancer. My mom, in particular, had breast cancer at 33 and, again, at 49. And we later found out that her and I actually share a genetic mutation known as BRCA1, which increases our lifetime risk of breast and ovarian cancer. So I found out I had the mutation when I was 25, and, at that time, I frantically started researching. I knew there was preventative surgeries, but, other than that, what else can I do to decrease my risk of cancer? And so... And everything I'm about to say, don't get me wrong. I'm not saying that... I'm going to talk about a lifestyle habits, but I'm not saying that just those alone are going to eliminate my risk of cancer. I am getting the preventative surgery, but they're something that gives you back a lot of control in your life.

And one of the first stories I read that actually had a huge impact on me as a person, but also as a palliative care doctor, came from a book by Dr. Michael Greger called How Not to Die. So it's the first book on evidence-based nutrition that I read on my journey. And he shares, in the first chapter about his grandmother's story. So at 65, she was diagnosed with end-stage coronary artery disease, and she basically was sent home with hospice care, something that we're all very familiar with. And after she got home, she actually enrolled in an intensive lifestyle medicine program on the West Coast, she actually ended up completely reversing her heart disease and ended up going on to live another 30 fruitful years and died in her 90s. So, as a palliative care doctor, to me, that was really hard to wrap my head around, because it's something I'd

never seen clinically. It's something I'd never heard about. Nothing I was taught about in medical school.

And so, over the last four to five years, I think I've learned a lot about the impact of positive lifestyle habits and behavior change. And it's been incredibly powerful, not just for myself, but for a lot of my family and friends, and that's where Carlie and I connect a lot, but also for a lot of my patients who suffer from these chronic illnesses. So on the side, I just finished... I love to cook. Lynn knows that. I love to cook, so I just finished my Culinary Coaching certification. So I'm hoping to use that to empower patients and families, probably more so families, to help cook healthier meals at home for patients, which can be good for their quality of life. And then, I'll be taking the Lifestyle Medicine Board Exam coming up in November, along with Carlie. And so, she'll share her story, but, ultimately, we're hoping to merge our passion for cooking, lifestyle medicine and palliative medicine to provide a comprehensive approach to patients with serious illness to improve quality of life.

Dr. Lynn McPher...: Well, I think you'll be very happy to hear, I believe that our School of Medicine actually has a kitchen in the School of Medicine to teach lifestyle medicine.

Simran Malhotra: Oh, very cool. So they're doing culinary medicine [inaudible 00:04:33]?

Dr. Lynn McPher...: That's what I heard, I believe.

Simran Malhotra: That is really neat. There's really not that many med schools with culinary kitchens, so that's pretty awesome.

Carlie Pieroraz...: University of Maryland has an integrative medicine program, I believe. So I wonder if they're using that as a part of that program.

Dr. Lynn McPher...: Perhaps.

Simran Malhotra: Yeah, it's possible.

Dr. Lynn McPher...: So Carlie, what's your story?

Carlie Pieroraz...: So I'm Carlie Pierorazio. I am a nurse practitioner. I got my nursing degree in 2008. I finished nursing school, went out and worked at the bedside for five, six years, since I completed my nurse practitioner degree from the University of Maryland. My initial certification is in geriatrics and adults. And then, after a couple of years, when I met one of our mentors, and he asked me to join the team, I went back and got my subspecialty certification in palliative care, as an advanced practice palliative nurse.

So for the past six... Let's see, six years, I've done palliative care and in an inpatient consult setting. Simran and I crossed paths in 2016, when I was asked to cover her for maternity leave. And then, I just never left the hospital that she

worked at. They said, "Do you want to stay?" I said, "Sure. Why not?" And that's how our professional relationship and friendship really began.

My interest in lifestyle medicine and nutrition came, in part, because I also have a strong family history of breast cancer, but I do not have any known gene linkages. So it almost creates a different type of anxiety, because it's almost like you feel so strongly that you're destined to have this disease, but you don't know when it's going to happen. You don't know if it's going to happen. You just know that you have a really strong risk. And then, through my experience in palliative care, seeing very, very sick patients... In the earlier part of my career, it was mostly cardiac patients, diabetes, but when I came to my current hospital, where we have a huge cancer center, and I was starting to see people my age with very advanced cancers, I developed a lot of anxiety around that, particularly after I became a mom. I have two young boys. I'm married. And, at that point, after I had my first son, my own mortality became very real. Before, it's not something I ever really thought about, but after I had children, it was always in my mind, "Oh my goodness. I can't leave my young family behind." So I started to become more interested in the things I could control to improve my own health and my risk of disease. So that's how I initially became interested.

And then, in working so closely with Simran and seeing the food that she was bringing to work, because she was vegetarian... I think when we met, she was vegetarian. So I never saw her eat meat. And then, during her second pregnancy, she became vegan, and it was very intriguing. I would see the things she was eating. I would hear the different tidbits of knowledge she was sharing. And it's something that definitely piqued my interest. So after my second son was born... A couple months after, I made the decision to go plant based, mainly for health reasons. And as I don't more and more into plant-based eating and knowledge and how our foods are sourced, it became clear to me that for ethical and animal welfare reasons, it just seemed to make sense for me and our family. So that's how I got to where I am now.

As Simran said, I'm getting my Lifestyle Medicine certification in November. We're taking the test at the same time. My other professional goals for 2021 would be culinary medicine, as well. But I also really have wanted to become a yoga teacher for a long time, so that's something I'm hoping to incorporate with our patients and families as a form of stress release, physical exercise and mindfulness. So good things to come.

Dr. Lynn McPher...: Lofty goals.

Carlie Pieroraz...: Yeah.

Dr. Lynn McPher...: So you've been throwing around this term "lifestyle medicine." Can one of you to define this for me? What is this? What are you referring to?

Simran Malhotra: Yes, that's a good question. So lifestyle medicine... There's actually a college for this known as the American College of Lifestyle Medicine, and it's basically an evidence-based approach to preventing, treating and, potentially, even reversing chronic disease by replacing unhealthy habits with healthy ones. So it seems pretty common sense knowledge, things that we should all be doing. Unfortunately, I think the way that conventional medicine works for most of our chronic diseases, things like heart disease and cholesterol and blood pressure, the first step is always... the [inaudible 00:09:33] prevention is always for lifestyle change; however, in medical school and residency, we're really not taught about how to actually empower patients and actually how to teach them to do these things. So lifestyle medicine is a whole college just focused on that. And so now, it's a very rapidly growing movement. There's a lot of people gaining interest in it, because, as we know, especially as palliative care clinicians, people take medications and they get surgeries and they get all sorts of things, yet they continue to get sicker with the time. So the question is, "What are we doing wrong?" And lifestyle medicine seems to be one of the answers to that.

And there's six big pillars to lifestyle medicine. So the number one, and probably the most important, is eating a healthful diet. In lifestyle medicine, they usually recommend predominantly a whole food plant-based diet. And we can talk a little bit more about that in a little while. Number two is moving. Not necessarily following a strict exercise regimen, but just increasing forms of physical movement. Number three is developing strategies to manage stress, which is something that we're... You know, stress is something that we're all very familiar with. Improving sleep. And then, forming and maintaining healthy relationships, which we know, in the palliative care population, is extremely important. Patients that have family and loved ones around them do much better. And then the last one is avoiding risky substances.

So I think similar to palliative care, lifestyle medicine interventions can be used alongside conventional life-prolonging treatments and can be used for prevention, as well as treatment of chronic disease. As we all know, the WHO definition of "palliative care," what is it? It's "an approach that improves the quality of life patients and their families facing a problem associated with life-threatening ailments." Right? But when most of us think about life-threatening illness, we're thinking stage 4 cancer, we're thinking end stage heart failure, but I think what we really need, especially in this country, is we need to shift our mindset on what serious illness means, because of the current epidemic of chronic illness in this country. And what I mean by that is, high blood pressure, high cholesterol, diabetes. These are all of the silent killers that, over a number of years, are what lead to the serious illnesses that we have eventually see in our patients.

And so, I think, as I was saying earlier, much of conventional medicine or traditional medicine focuses on managing symptoms, focuses on managing disease, rather than going after the root cause of the disease, which, for most for the top 10, or at least the top three, causes of death in America, which are

heart disease, stroke and cancer, 80% of those are caused by bad lifestyle habits. So having said that, I think, as palliative care clinician, if we see patients at the time of diagnosis, which I know hardly ever happens, because we're consulted so late, we can educate them about these lifestyle factors and give them a chance at treating, potentially reversing. But if none of that happens, at the very least, these lifestyle factors can at least improve their quality of life, which is what we are all about.

So part of... and we can talk about this later one, but part the struggle for us is, as inpatient clinicians, we often don't see our patients until the last hours, days or weeks of life, especially recently with COVID. So it's really hard to practice lifestyle medicine in the in-patient palliative care setting.

Dr. Lynn McPher...: So, I'm curious, you talked about the first pillar being eating better, better nutrition. It just seems to me that if someone has a serious or an advanced illness, that seems like a hard sell to me. I mean, if I was circling the drain, I don't think I'd want to hear about walking the straight and narrow. I would want to go to steady diet of Twinkies, I think, as solace. So how do you sell that, and does it really make any impact?

Simran Malhotra: Yeah. I think you have a good point there. And that's where, like I just said, I think because people still think palliative care and hospice are the same thing, when we are consulted in the in-patient setting, it's usually for end-of-life care. And so, I think lifestyle interventions in that setting, just like chemotherapy, just like the next cardiac procedure, just like everything else, we have to weigh the risk and the benefit, put it in the context of the patient's prognosis and their overall goals of care. This is certainly not something that is going to help every single patient. But I think what our little hearts are really hopeful for is that as we pave this path, we can educate people about earlier palliative care consultations at the time of diagnosis of that stage two or three cancer, where they're still getting aggressive treatment, where we can... They're still functional enough to do these lifestyle interventions that, along with conventional medicine, in synergy, is going to give them better long-term results. I don't think everything that we're talking about is for the patient at the very end of life. I think we're really talking about people who are diagnosed with a serious illness, who are still functional, who are still eating, who are still drinking.

And that's where I think our struggle comes, also, in our career, because we're so passionate about this, but the patients that, by the time we get consulted, we really can't share this education with them, because it's a little too late.

Carlie Pieroraz...: Well, we also see a fair amount of patients who are young cancer patients, basically, begging. They're saying, "What can I do differently to improve my survival? What can I do now?" And even at the very end stages... And I'm thinking about a patient that Simran and I saw together. I don't even remember when it was. It was within the last year and a half, and she had a very advanced form of colon cancer with four young kids, a husband at home. She was "circling

the drain," as you say. She was really, really sick, saying, "Anything. Tell me anything I could do to just be here a little bit longer." And so, diet was actually something we talked to her about. Whether she went home and made those changes or read the books we suggested, I'm not sure. She did pass shortly after we saw her. But even at death's door, patients are still saying, "What can I do now to have even the smallest fighting chance?"

Dr. Lynn McPher...: Mm-hmm (affirmative). Well, I think there is cause for hope. I know that MedStar has really worked hard to establish a presence in the outpatient palliative care environment, as well as Telehealth. So I do hope... I've always thought that that was a missing link in palliative care. We have, as you said, inpatient palliative care, particularly close to the end. We have hospice care, but the missing link has been providing supportive care for people upstream. So, hopefully, we will continue to evolve there.

So let's talk about that second pillar. What is the role of physical exercise in the palliative care populations?

Carlie Pieroraz...: Yeah, so physical exercise is super important. You hear all the time on the news, in the magazines, "Exercise. Exercise. Get X amount of minutes or hours a week." And it's very important, but as you well know, a lot of our patients are just not able to physically do it, either because of poor mobility, debilitating symptoms, fatigue, whatever the reason. But I still think that there are some ways... We just need to get creative to get people moving. Many of our patients are, as I said, far too sick to follow a strict exercise regimen, but if we could work on the first pillar, which is nutrition, and we'll talk a little bit more about that, can we get them feeling a little better... less fatigue, weight loss, which would maybe improve their mobility? Can we get them a little bit better to be able to move more? And making these baby steps over time adds up to a big results.

You don't have to do a regimented exercise routine to get benefits. In fact, I, myself, am not on a strict regimented routine, because I have two young kids, and I just don't have time. So I do a 10-minute video here, a 20-minute video there. I park farther away, and I speed walk into the hospital. I take the step. So you don't have to have access to a gym. Some of the barriers a lot of our patients face, whether it's financial, physical, getting out of the house, whatever, I think we can get creative, even if it's sitting in the chair doing arm weights. We tell people to do their incentive spirometer, "Every time a commercial comes on, take 10 breaths." Well, how about every time a commercial comes on, we do leg lifts. Pick our legs up off the sofa or reach our arms up and down, like this... anything to get the body moving... even chair yoga. There's so many different forms of exercise that our seriously-ill patients can engage in to really improve their function, their pain and, hopefully, their quality of life.

We know that patients, for instance, with severe osteoporosis, bad knee pain, bad back pain... They move, because they're in so much pain, but it's interesting, because if they moved more, their pain might actually improve. So it's finding

that sweet spot between the barriers and making it happen. Eventually, we can get them moving more to improve their quality of life.

Similar to physical benefits of exercise, we've all heard there's mental benefits to exercise, so stress relief. There was actually a study... It's an old study, but 1999 out of Duke, where they looked at a 156 older adults with major depression, and they separated them. So one group participated in group exercise. The other group received sertraline. By 16 weeks, both interventions were proven effective. So the question was, "Was it the group exercise, being amongst peers, or was it the exercise itself that made the difference?" Then they tested individual exercise. 30% perceived improvement at 80 minutes a week. 47% perceived improvement at a 180 minutes a week. And no difference between three days of exercise versus five days of exercise. So it actually doesn't take much to get even a little bit of benefit. So if we're not going for the physical benefit of exercise, it can have a huge benefit for depression, stress, anxiety. And, as we know, our seriously-ill patients have a lot of this. Most of them have comorbid depression. So can we do something to improve that in any way?

Dr. Lynn McPher...: Mm-hmm (affirmative). Wow. That's a very impressive goal. I think that's very laudable.

So let's turn our attention to something to think we could all use help with, which is stress management. How are you going to handle that, ladies?

Simran Malhotra: I mean, I think stress is unavoidable for everyone. Right? All three of us here have it, Everyone listening probably has it. Our particular, fragile patient population that is dealing with serious illness, especially has it, specially as they're trying to navigate treatment, they're trying to navigate their prognosis and the healthcare system. But I think, interestingly, how we think about stress and how we manage stress has the ability to either make us sicker or make us feel better. And the reason I say that is because it's not the actual stress that's killing us. It's the way that we react to it. So that comes back to Carlie's point about doing something to relieve the stress. Exercise is one form.

But what we know about chronic stress is that it leads to chronic inflammation, which is a cornerstone of chronic disease. And so I think this stress can, particularly for our patients, can lead to worsening symptoms of pain, insomnia, anxiety. And so, it comes down to very simple physiology. Right? Are you activating your parasympathetic system? Are you activating your fight or flight response, chronically? And I think that's really important to think about, because there's so many adverse effects from chronic activation of your sympathetic nervous system, and just to name a few, particularly for our patients, things like decreasing bone density, muscle mass, cognitive impairment, insomnia, slower wound healing, lowering immunity. We don't think about these things, but that's what chronic stress causes. And so, in our particular palliative care population, that's going to lead to worse outcomes in

someone that's already very fragile. And so, I think it's something that we don't talk enough about with our patients and empowering them with very simple self-care techniques is a very powerful way to combat this stress, which will make them feel better, improve their outcomes and improve their quality of life. And there's a lot of evidence behind it that's the thing.

So simple... There's so many different forms of relaxation techniques. The most common that everyone talks about, hears about these days is meditation and mindfulness. They did a... There was a randomized controlled trial that documented the benefits of meditation in young breast cancer survivors. And all these women reported improvements in depressive symptoms, stress and fatigue. And so, there's a lot of simple techniques... moving, meditating, journaling... Even things... There's been evidence behind things like journaling things that you're grateful for, making time to laugh, watching comedy. All of these things can have a very powerful impact, but they're not things that we talk enough about. And they're things that don't cost money, so anybody can do them. And before COVID, it's something... When I was at the same hospital as Carlie, it was something that I frequently did with my younger cancer patients is, at the end of our encounter, we would do a three to five minute meditation, especially for patients that were anxious or having pain. And they almost always reported that they felt better right after.

Dr. Lynn McPher...: Yeah, I think that I was going to ask you that is, I've often heard that even meditating for five minutes can be beneficial, and that when you really get in the groove of getting used to doing this, when you encounter a stressful situation, you can get back in that zone very quickly. Is that true?

Simran Malhotra: Very much true. The thing is that you can start with five minutes, and if you're consistent with that, over time is where you get the benefit. So it's not necessarily that you do one hour once every two months. Even five minutes a day or even three minutes a day, but if you're consistent with it, it will give you a much more powerful benefit. And the way you got to think about it is, your brain is a muscle just like your biceps, so stress-combating techniques, like meditation, mindfulness, exercise, these are all things that make our bring more resilient. And so, when you're in a stressful situation, you're able to react to it better, because your brain is stronger, if you will. Your muscle's stronger.

Dr. Lynn McPher...: Mm-hmm (affirmative). Yeah. I think I'm not going out very far on the limb to suggest that either of you would recommend jumping on this with the Ativan prescription. I think you'd certainly prefer the methods that you've been describing.

Simran Malhotra: Most of our patients [crosstalk 00:25:52]-

Carlie Pieroraz...: I mean, I think-

Simran Malhotra: Go ahead. Sorry.

- Carlie Pieroraz...: I was going to say, so many of our patients have polypharmacy, so they're on antidepressants and opioids. And so, if we can do something to, not even eliminate the Ativan, but maybe be able to use less of it. I think that can only benefit the patient.
- Dr. Lynn McPher...: Mm-hmm (affirmative). I agree. Particularly look at the drug interaction between opioids and gabapentinoids and the benzodiazepines and the risk of sudden death. That'll take care of their stress right there, won't it? So not a good look.
- Carlie Pieroraz...: No interactions between meditation and Ativan.
- Dr. Lynn McPher...: Yeah.
- Simran Malhotra: Yeah. Right. But then, we keep adding these pills, and we always chase the side effects with more pills. So at some point, just like Carlie said, the polypharmacy in itself decreases the patient's quality of life, which is the opposite of what we're trying to do in the first place.
- Dr. Lynn McPher...: Well, speaking as a pharmacist, who's very should vary into deprescribing, I feel like I'm in good company here.
- Simran Malhotra: Okay. There you go.
- Dr. Lynn McPher...: So this all sounds awesome, but what are some barriers that you see in integrating lifestyle medicine in palliative care, aside from what you already mentioned, which is picking up the patient days before they die? What other barriers exist?
- Carlie Pieroraz...: I'm looking at my notes here. Yeah. So barriers, again, as Simran said, late consults. Most of the patients that Simran and I see... We're doing all inpatient. Where I work, especially... and Simran, too... Palliative care is so misunderstood. We're synonymous to hospice for most people, including many medical providers. So we're getting consulted so, so late, and that's a huge barrier. As you said, if somebody is on their deathbed, are they really going to want to change their lifestyle or have the tools to change their lifestyle when they have so, so much going on.
- Th standard American diet, in it of itself, is a huge barrier. It's calorically dense; nutritionally deplete; high in fats, cholesterol, refined sugars, and it's everywhere. That's such a huge barrier. It's in our face. It's in the grocery store. It's on TV. And everybody around us eats that way, too. It's no fault of the patient's. It's just, it's so hard to change when you're surrounded by the thing you're trying to change. Just like somebody trying to become sober from opioid abuse or alcohol. You can't possibly change if you're surrounded by that substance. So I think that's a big barrier for a lot of our patients.

We hear from many that finances are a barrier. You'll hear Simran and I argue against that. It's actually very inexpensive to eat well. You just have to know how to do it. And I think most people just don't have the education... not education, but they aren't given the tools or the knowledge to know the difference. You know, a bag of beans cost 99 cents, whereas, a 12-pack of chicken breasts may cost upwards of \$15, \$16. But if you only know how to eat that way, you don't even think of the 99-cent bag of beans, right? So I think, just knowledge is a barrier, just as it is with anything else.

Simran Malhotra: [inaudible 00:29:19] this for the general population. I think that, again, that goes back to the medical providers as well. I remember when I was a resident in a primary care clinic, and my patient would come in with high blood pressure and be like, "Okay, doc. So you want me to change my diet. What should I do?" And they would always be like, "Eat low fat... and don't eat sodium... and, um..." It was always like... There was no clear direction, and so, six months later, they come back and, of course, their blood pressure is the exact same, so now it's time to get out the prescription pad. So I think it has to go... And this is why we love lifestyle, because it's just like palliative care. It goes all the way back to med school. This is something that needs to be taught much earlier on.

Carlie Pieroraz...: Yeah. We're the barriers for a lot of patience, because majority of clinicians, like Simran said, aren't given the knowledge themselves to educate people. I did primary care before I did palliative care, and I would routinely check cholesterol levels and A1C on patients, and a lot of the times it came back elevated. And what did I tell them to do? Cut back on your sugar. Cut back on your fat intake. But I, myself, didn't necessarily even know what that meant. And I was going home and eating cheese pizza on Tuesday nights, because why else? I'm young. I'm healthy. I can do that. But that wasn't the right thing.

And, again, going back to the late consults. That's just a huge barrier. Fortunately, with the newer ASCO guidelines saying that we should be consulted at diagnosis of advanced stage cancer, hopefully, we'd be able to capture patients at that point. Will we be able to reverse their cancer? Maybe not. There are cases where people have reversed their cancer. If you look into the Radical Remission Project... That's a whole different book and conversation. But I think if we can get people as early as possible, that would solve a lot of problems.

And it also takes a discipline or multi-disciplines. Just like palliative care, it's not an NP alone. It's not a physician alone. You need dietitians and even counselors in some cases and physical therapists. It really takes a team, just like palliative care.

Dr. Lynn McPher...: So you both made the point that it's unfortunate that most health care practitioners today don't understand this body of knowledge themselves. So we can't send them all back to pharmacy, nursing, medical school. So what can we/you do to educate the cohort of practitioners who are out there, because this is really confusing for patients?

Simran Malhotra: Yeah. And that's where it becomes challenging. Right? It's like... Just like goals of care, if we go in there and we're saying something to the family, but they haven't heard it from the medical team or the oncologist, then the family's like, "Wait. What are you... This is the first time I'm hearing this." It's the same thing when you go in there and see a cancer patient eating candy and drinking Coke, and we try talking to them about why those things are not helpful for their disease stage. And they're like, "Well, my oncologist told me I can keep my diet the way it is. It doesn't really matter." And so, if we're not all giving the same message, you're right, it's going to confuse patients.

And so, again, this is a slow path, but I think looking at the bigger picture of America and the epidemic of really chronic disease in this country starting at a younger age as the years are going by, I think all physicians and clinicians, in general, are going to have to start learning about how to treat these root causes of disease, which, again, are all lifestyle factors. So one of the big things, and in DC this is soon going to be a thing where at least physicians, in particular, every year, are going to have to have CMEs for nutrition. And so, there's the Physicians Committee for Responsible Medicine. They actually have a website, and I think it's called nutritioncme.com, where you can literally go online and just watch nutrition videos and get free CME for them.

Dr. Lynn McPher...: [inaudible 00:33:30]

Simran Malhotra: So there's a lot of resources. As I mentioned, the American College of Lifestyle Medicine is a great resource it for clinicians to go and get information. There's tons of conferences every year on nutrition, on lifestyle medicine. And so it's definitely accessible information.

Carlie Pieroraz...: And they actually, I think, recently came out with programs to be integrated within residency programs. So a residency director, I'm assuming... Simran might know more about this than I... would reach out to ACLM, and it's all on their website, and they can... I don't even think you have to purchase, it's free to be integrated within a residency program. So the information is out there. We just need people to know that it is out there in the first place and how to access it.

Dr. Lynn McPher...: Well, I think you ladies should put on your to-do list to write a book on lifestyle medicine for practicing clinicians. So can you put that on a list for me?

Simran Malhotra: Well, I mean, I think we should, because the crazy part is this: You look at most health care practitioners in most hospitals, and most of us are unhealthy. And when we learn... at least particular for me, for my husband And Carlie's experienced the same thing, and this has rippled into my family, as well. And as we've learned all of these things about lifestyle medicine and the benefits of behavior change over the last five years, we've become happier people. We've become healthier people. And the biggest example that you can set for your

patient is yourself. If they see you, and you tell them to do something, they're more likely to be do it if they see your attitude and how you love and all of that.

And physicians, in particular, I can speak for, we have extremely high rates of suicide, extremely high rates of burnout, substance abuse. And so, the stress of being a physician in this country is really hard, and how we come at that is by binge eating our favorite foods, binge watching TV, not exercising, risky substances. So I think the lifestyle medicine actually could be life changing for the clinician themselves, even before It transcends to the patient.

Carlie Pieroraz...: I agree. I remember very clearly as a brand new nurse working in Charles Village at Union Memorial, and I would have a bad day, be there 12 hours. And I would literally drive down to Charles Village right after work, go to Cold Stone, get the largest ice cream they had and sit in my car and cry over my day and eat the ice cream. So I mean, I've come a long way. And I don't think I'm alone. There's a lot of nurses, there's a lot of medical professionals that probably do the same.

Dr. Lynn McPher...: Mm-hmm (affirmative).

Simran Malhotra: Especially for palliative care.

Carlie Pieroraz...: Yeah.

Simran Malhotra: The work we do is extremely emotionally challenging. And so, I think this is where this really is important.

Dr. Lynn McPher...: Yeah. And you know, I think what's also important is, I don't care if you're an MD Ph.D., if you're not familiar with this... And Simran, I know you're good at doing this, because you and I have spoken before, is what are some simple steps that you can take to try and start to turn the ship and not just go from you Domino's and McDonald's and a Twinkie to red beans and rice for the rest of your life overnight? That's just not going to work.

Simran Malhotra: Nope.

Dr. Lynn McPher...: I do think baby steps.

Simran Malhotra: Yep.

Dr. Lynn McPher...: Another question that I have is, as you're talking to patients, many times, family members are sitting there, listening to this. Do you ever have caregivers, informal caregivers, family members, say, "I'm kind of interested in that, too?" Do they also benefit from these conversations, in your opinion?

Carlie Pieroraz...: Yeah. I would think so. A lot of times, those caregivers are the caregivers for people with irreversible, incurable disease and, just [crosstalk 00:37:25]

Dr. Lynn McPher...: [crosstalk 00:37:25]

Carlie Pieroraz...: And just as the patients want to stay around forever, their loved ones want them around forever. So they get to this point of desperation where they're also saying, "I will do anything possible to keep mom, dad, brother, sister around as long as possible. Tell me what I can do to change that." So they're very engaged and invested in knowing how they can help to keep mom around a little bit longer. So I think that is definitely a motivating factor to getting people on board, and it rubs off on them. It's hard for me to give any examples, because working inpatient, we don't see them through the course to know, "Are they actually going home and doing what we told them to do?" I don't know. But they definitely get a little bit of excitement in their eyes when they hear, "Yes. There's actually something I can do to help myself and my loved one."

Simran Malhotra: And they're the tribe. They're the tribe, right? So they're probably the ones at home that are cooking. They're probably the ones at home that are helping with physical therapy. They're probably the ones that are consoling them when they're having a panic attack. So they're actually almost more important to talk to than the patient themselves, because if you arm them with the artillery, they're going to go home and do those things. Because the patient, they're already so overwhelmed with everything they receive in the inpatient setting, which is also why this is very difficult to do in the inpatient setting.

I think lifestyle medicine and positive behavior change, in general, regardless of whether you're talking about patient and family or colleagues or within husband and wife, when one person starts to make positive changes, it tends to be a ripple effect on the other person. Because when someone's feeling good, they have a lot of energy, they're doing all this stuff, you want to know what they're doing. So that's, I think, regardless of who's listening, it's something that, no doubt, as humans, it's going to benefit all of us, if we want to live a long, healthy, happy life. And there are communities around the world that thrive like this. Have you ever heard of the blue zones, Lynn?

Dr. Lynn McPher...: Yes. Yes.

Simran Malhotra: Yeah. So these are people, living-day examples of these behavior changes that we're talking about. They eat predominantly a whole food plant-based diet. They have very limited substance use, so it's like a glass of wine. They move. So they don't go to the gym and get on a treadmill for an hour. They move. They walk. They just move their body. They do a lot of stress management, basic relaxation techniques. And the biggest thing is, they're so big on community and spirituality. Their community's everything. And they have a purpose in life. And so if we look at these communities in particular, they have the highest prevalence of centenarians. So the question is, "Why? What are they doing different than the rest of the world?"

Dr. Lynn McPher...: Mm-hmm (affirmative). I heard that yams rule in the blue zones.

Simran Malhotra: Oh yes. Sweet potatoes are life. They're everything.

Dr. Lynn McPher...: So ladies, if you had a crystal ball and you could say, "Yep. This is what I see for the future..." Is maybe an outpatient clinic and lifestyle medicine in your future? If it was a world according to you, what's on your wish list?

Simran Malhotra: I think just to go back to... For us, there's so many commonalities between palliative care and lifestyle medicine and which is why we're so passionate about those fields. They focus on the whole person. It's a team approach. We work in combination with conventional treatment. You meet patients and families where they're at, with the ultimate goal of improving quality of life. But like we said earlier, it's really hard to do that in the inpatient setting, when we're getting consulted when patients are really near the end of life. And so, I think what we are hopeful for is that we eventually branch out into the outpatient setting. Now with telemedicine... thank you, COVID... I think the potential is enormous, because we'll be able to reach even more, as long as it sticks around, we'll be able to reach even more patients than before.

And when I was at Hopkins, and we did outpatient palliative care, our no-show rate was 50 to 60%, because these patients are often just too sick to come into the clinic. And so, if we had telemedicine, it would do wonders. The other piece of it, of course, is I do think before we can do all of that, I think we have to continue to educate on, "What is lifestyle medicine? What is the difference between palliative care and hospice," so that we can actually see these patients much earlier. Because even if we do telemedicine, if the patient's in the last days to weeks of life, we're not going to be able to do this.

But like Carlie said, patients and families they're hungry. At this point, when they're diagnosed with a serious illness, they're hungry to know what they can do at home after losing all of this control when they're diagnosed. And so, I think the basics of the food they put in their body, the way they move, maintaining their relationships, are all things that they can control. For the most part, of course, apart from buying food, they're free. But they need education and coaching, and that's where we hope to provide that. And Carlie said that, too. Most of them, especially our younger patients, are willing to fight. They're willing to do anything, as they say, to stay alive. And so, these are simple techniques that I think they would benefit from.

Dr. Lynn McPher...: Carlie, anything you want to add to that list?

Carlie Pieroraz...: Yeah. No. I would echo everything Simran said. In a perfect world, I would be working in a clinic that meshes both lifestyle and palliative. I'm not hoping to lean more towards one than the other. I really think that they're both important in combination, in synergy. In my dream world, I've told our leadership all the time, when I do outpatient, I don't want it to be this rinky-dink clinic. I want the real deal. I want physical therapists and yoga classes and nutrition classes. And so, I'm a big dreamer. I have big goals.

I think part of our barriers may be reaching past healthcare leadership to help them understand the value of doing these things, to provide the resources to fund such a clinic. But I think it'll happen one day, and I look forward to when it does.

Dr. Lynn McPher...: Mm-hmm (affirmative).

Simran Malhotra: There is one more thing, though. One of our colleagues in the South, in MedStar South, is doing community culinary cooking classes. And this, I think, would be more for patients with not end stage disease, more so for families, as well, where they come into the hospitals in DC, and she basically does culinary cooking classes with them. So, not only does she empower them with the nutritional information, like "Why is this good for your disease," but also the culinary or cooking skills to help them cook at home, which there's so much evidence to support cooking at home is much healthier than eating out.

Dr. Lynn McPher...: And that's been my husband and I. That's our biggest observation of COVID and staying home, is how much money we have saved-

Simran Malhotra: Yeah. That, too.

Dr. Lynn McPher...: ... by eating at home. My goodness. It's been astounding. Well, I'm going to put in a bid that when you guys take your board exam in November, I think you should start a podcast series on lifestyle medicine for healthcare practitioners. [crosstalk 00:45:09]

Simran Malhotra: We would love to do that. Besides our jobs and both our two kids each under four, we're going to find the time.

Dr. Lynn McPher...: Well, I would say, "Sleep is for suckers," but that's pillar number five, and you'd probably spank me for that, so I won't go there.

Simran Malhotra: We still aim for seven hours. We do. We still aim for seven hours.

Dr. Lynn McPher...: Okay.

Simran Malhotra: We're past the newborn stage, so we're good.

Dr. Lynn McPher...: Ladies, this has been very illuminating. Are there any final thoughts, any take-home points you want to share with our listeners?

Carlie Pieroraz...: No, I think we covered it pretty well.

Dr. Lynn McPher...: Awesome. Well, thank you so much. Again, this is Dr. Lynn McPherson. And I'd like to thank our guests for today and talking about lifestyle medicine. Very, very interesting. This is Dr. Lynn McPherson and this presentation is copyright 2020, University of Maryland. For more information on are completely online Master

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