Katie Caviness-Crolley 26:51

Welcome to Medicine Made General, where real doctors break down real health issues. Do you have questions about your health? Well, we've got clear, practical answers with no complicated language. I'm Katie Cavanus Crowley, Communications Specialist for the Division of General Internal Medicine at Johns Hopkins.
I'm joined by my co-host, Dr. Bimal Asher, the interim director of GIM. Hi, Bimal.

Bimal Ashar 0:17

Thank you, Katie. You know, I'm excited today we have Doctor Nathan Gray. Doctor Gray is an assistant professor of medicine and in the section of palliative medicine, but he's also a graphic artist, which is fascinating and.
And his work is incredibly fascinating. So we're going to touch on a little bit of both today. But before we get into the questions, Doctor Gray or Nathan, just tell us briefly about your journey to medicine and and to do what you do.

Nathan Gray 0:55

Well, excited to be with you guys today. I'm A. third generation in my family of doctors. I had uncles who were doctors. So medicine seemed like A. A. really natural fit. In fact, the only other career I seriously gave A. lot of, well, two careers. I I did give some thought to being A. cartoonist when I was A. kid. I also really.
Wanted to be Batman, and Batman didn't workout. The cartooning thing has turned out to be better than I expected, but medicine was sort of the default career. I did my medical school and residency out in Texas at University of Texas. Southwestern went to North Carolina to Duke University, where I did my.

Bimal Ashar 1:17

Yes.

Nathan Gray 1:32

Palliative care subspecialty training. I was there about 8 to 9 years on faculty, followed my wife up here to Johns Hopkins. I've been in Baltimore coming up on four years.

Bimal Ashar 1:44

Well, we're happy to have you and and we love the fact that your wife dragged you here. So, so you getting to the heart of the matter. So palliative care, you know, this

is, you know, a fairly new field in medicine and one that I think that there's a lot of misconception about.

Katie Caviness-Crolley 1:44

Nice.

Yeah.

Nathan Gray 1:57

OK.

Bimal Ashar 2:04

Not only among patients, but among physicians themselves. And so I wonder whether you could just explain what palliative medicine is to someone who's hearing about it for the first time.

Nathan Gray 2:17

Yeah, sure. So there's the the practical description that I give when I meet A. patient in clinic. There's the philosophical description that A. lot of smart people in our field have spent many years going back and forth on. The the the larger philosophical description is that palliative care is A. philosophy of care.

That prioritizes patient quality of life anywhere along the trajectory of serious illness, and that type of care is specifically interdisciplinary. It brings to bear the expertise of doctors, nurses, social workers, physical therapists, respiratory therapists, really anyone in the hospital or clinic setting.

With with expertise to bring to the care of A. seriously ill patient and the goals are helping families and patients cope along the roller coaster that can be A. serious illness like cancer or heart failure or stroke.

Katie Caviness-Crolley 3:11

Gotcha. So some people. I'm sorry, go ahead.

Nathan Gray 3:13

So.

Oh, no. So I was going to say, practically speaking, that that philosophical paragraph definition can be A. little hard to actionalize or to to bring into action for patients. So

when I meet A. patient in clinic, I'll typically explain that I I wear two hats as as their palliative care doc. One of those hats is helping with symptom management, so things.
Like pain, nausea, shortness of breath, fatigue, low appetite. The other hat is just helping people as they navigate, as they navigate their preferences for care, as they communicate with their doctors, as they communicate with their families about their wishes. So it's it's A. real wide umbrella of things we end up talking.
Talking about in clinic, everything from the bowels to people's daily lives and working or caring for kids. So I really love the free range aspect of what I do and it allows me to really focus on what matters to the patient.

Katie Caviness-Crolley 4:08
Thank you. That's a really, that's a great explanation. I mean, so while we're talking about what palliative care is, you know, there's oftentimes people think palliative care only happens at the very end of life. Can you talk about how it's different from Hospice?

Nathan Gray 4:24
Right. So in my mind, palliative care is one large umbrella under which Hospice fits. So Hospice is A. part of the palliative care philosophy of care. That said, it's A. special type of palliative care, which is typically reserved for people who have elected not to pursue additional disease-directed treatment.
So for example, the patient with cancer who has decided either because of side effects or because of their own wishes, that further chemotherapy really doesn't make sense for them and elects to focus all of their medical treatments on quality of life. Many times that's A. patient who then might enroll in Hospice for their palliative care for me as a.
An outpatient palliative care and hospital-based palliative care doctor. I see patients really anywhere along the spectrum of illness. So patients can be receiving active disease directed treatments. So they could be working their way toward A. heart transplant or working their way toward A. stem cell transplant for A. leukemia or bone marrow transplant. Excuse me.
And I I'm working still in that sort of holistic approach to their quality of life, but I'm working in tandem or in in in collaboration with those specialists, the cardiologists, the oncologists, whoever it is that is helping drive those longevity focused care care

aspects. So the people who are trying.
to promote cures or or recovery or maintenance.

Katie Caviness-Crolley 5:45
OK. And second question, if I may, you know, you kind of started to touch on this, but are you able to put like you know for our listeners just like simple terms of or at least examples of when patients might benefit from palliative care earlier rather than waiting?

Nathan Gray 6:01
Right. So I I can speak, I I work primarily in the oncology clinic in my clinic practice and so I will have referrals for patients who say are are in the thick of chemotherapy and really struggling with side effects, whether it's nausea, whether it's depression and adjustment and coping with their their new diagnosis and.
Even if those patients, you know, are on A. path toward cure and the hope is that with treatment, with surgery, with radiation that they come out on the other side, well, sometimes medicine can be really rough. Going through treatments can be very challenging and having that extra layer of support for A. lot of patients can make A. really big difference.
How they go through their treatment. We have now several decades of of data showing that palliative care can improve quality of life for patients dealing with serious illness.

Katie Caviness-Crolley 6:49
Yes.
Hmm, OK.

Bimal Ashar 6:55
Anthony, you mentioned that one of the first things you do when you meet a patient is to talk about kind of the philosophy of care. I'm wondering whether you know there's a what the more common questions or worries that patients have when you do introduce.
Palliative care to them. Is there other certain themes that come out?

Nathan Gray 7:20

Yeah, I I I love getting to meet A. patient for the first time in clinic because sometimes people are A. little scared. Like what's this visit going to be about? I have some patients who come in having done A. lot of digging online and are fully prepared and know plenty about palliative care. And I also say I would have A. heavy portion of patients who either.
Don't don't have any concept or preconceived notion about what palliative care would be or have have some myths in mind that perhaps I'm primarily there as A. Hospice provider or that that that would be what we're addressing. So one of the first questions I often ask when I meet A. patient, so I'll you know.
Spend time reading through their chart prior to clinic and understanding what their other doctors are are working on, what they're what they're being treated for. And so I'll say, you know, I I know A. little bit about you, Mr. Jones, Miss Smith, but tell me what have you heard about me and how can I be most helpful?
Sometimes the answer is I I don't know nothing. I don't, I don't know anything about you. I know nothing about palliative care. I saw this appointment pop up on my schedule. I came in today. I'm I'm always very impressed with such diligent patients we have that show up to A. visit that they weren't even really sure what it was for. But then I love that because we have A. blank slate.

Katie Caviness-Crolley 8:16
Mm.

Nathan Gray 8:35
To work with. And so I'll tell them about those two hats that I spend time wearing in clinic. And then we really just jump straight into doing the meat or the work of palliative care where I'm asking, you know, how are things going with this diagnosis? How are you feeling? What's bothering you? What worries you? What are you hoping for? And I'm really kind of.
Narrowing it down to what it is the patient's interested in talking about or what the hardest part of their current illness experience has been. For me, that's A. really gratifying aspect of palliative care is I get to walk into most visits without any sort of agenda on my end. I'm really there to go where the patient wants me to go and again with that wide.
Free-range scope of care. It really does give me A. lot of variety in my day. I have days where I'm really heavily involved in pain management. I also have days where

we're talking about mood or depression or appetite. I have days where also people are trying to work through family struggles where people are talking about how hard the illness has been.
On A. spouse or their kids or parents and helping them as they navigate this process.

Katie Caviness-Crolley 9:42
I want to touch more on support and what that looks like because, you know, this is a very emotional process for people. You know, there's a lot of difficult decisions that have to be made, you know, surrounding quality of life and other things. Can you talk more about what kinds of support palliative care?
Does offer beyond just medical treatment?
Yeah.

Nathan Gray 10:15
At any side effects. But then there's also times where I'm connecting people to others, like so trying to help them connect with a therapist to deal with some of the more complicated psychosocial or familial aspects of the illness. There are also times where I'm helping someone get connected either through their oncologist or through myself with a physical therapist or someone to help.
With their mobility concerns. So there are lots of times where we're, you know, adjusting medications, titrating things or tuning, fine tuning with meds. But there's also a lot of times where we are focused more on the holistic aspects of care. Sometimes people will come in and ask questions about cannabis or ask questions.

Katie Caviness-Crolley 10:35
Yes.

Nathan Gray 10:54
About non-prescribed things they're trying, I I often will have to educate myself alongside the patient if it's something that I wasn't taught about in medical school to like learn more about that alternative therapy or that herbal medication that the patient is taking.
We have a pharmacist in clinic who is also a great resource. We have a connection with our inpatient social workers who we can reach out to as well as in our oncology clinic, our oncology social workers who are great sometimes at helping with those

logistical.
Concerns and then a hefty portion of each visit is also focused on how families are adapting, how people are addressing their concerns about the road ahead. People do have a variety of ways of approaching illness. I have a lot of patients who say, you know, I'm, I'm just trying to get through today.
And meanwhile, that spouse or that parent or that child is really wrestling with planning for the future and says I need to talk to someone about how we navigate these changes in mobility. Or what do I do if I can't care for this patient at home or my loved one at home? And so I've even, you know, had days where I was doing divided clinic visits where we focused on.
The present for the patient in the room and we focused on the road ahead for that family member either in the hallway or in a conference room down down the way to give them a chance to to to ask questions.

Katie Caviness-Crolley 12:14
Gotcha.

BA

Bimal Ashar 12:16
So I mean very, very kind of intensive visits that's very inclusive of of the family as well. So I mean that's unique to in medicine, right. I want to, I want to switch gears. And I want to talk about your work as A. graphic artist as well. And I wonder whether you can tell us how you got to the point where you're using it to explain complex medical topics, conditions.
You know how you actually got to that point?

Nathan Gray 12:52
Yeah, I I I never conceived of myself as a palliative care doctor. When I started in medicine, I thought I could be a pediatrician. One of my mentors from middle school and high school was a pediatrician and I saw myself in that path. So I to to land in adult medicine and doing serious illness care feels very different.
In a way, but it also has a lot of overlaps in terms of helping people navigate new territory. So where a pediatrician is helping someone, a new parent or or even a veteran parent navigate changes for each child is different. Each illness is different. I end up navigating.

Katie Caviness-Crolley 13:12
OK.

Nathan Gray 13:27
Those illnesses as A. an adult provider. So it it's interesting how artwork has sort of made its way into my life in medicine. I never, never predicted that I would not only be A. palliative care doctor, but also be be doing artwork at the same time.
I started off, I I burned through my artwork. I put it on the back shelf during medical school. I thought when you went into medicine, you kind of had to make A. choice. Either you're going to embrace the scientific side of your brain or you're going to embrace the artistic side. And so I put A. lot of that stuff.
Away and let it gather dust. But then A. big part of my life I found was missing that that piece that allowed me to express myself through art, how I always had as A. kid and through high school. And when I started pulling those sketch back sketchbooks out in late in residency and early outside of training.
I I realized how much it mattered to me to keep doing that. I also had A. little more time once I got out of my residency to do those things. And I I started just doing, actually, my wife encouraged me, said you should do like medical comics, like find A. way to to integrate the two. And I thought, I don't know, I don't know. And I did.
If you.
Of gag comics and then got A. doc who's an emergency medicine doctor in London named Monica Lalanda. She's or sorry, she did her training in London. She's A. doc in Spain and had A. degree in cartooning, reached out to me and said, hey, you know there's there's other doctors like you making artwork.
About medicine. And there's this whole kind of community of patients, doctors, humanities, folks exploring the intersection of graphic art and sequential art or comics and health care. So that really got me kind of on this train. I started by doing A. long form comic about A. patient I had cared for in residency that had particularly touched me.
I did it sort of anonymously, but then it was published and I I really was shocked by the amount of wonderful feedback I got in the way that the topic of this particular topic was care for A. patient who was undocumented and how much struggle with with inequity and injustice in our health care system that patient had faced.
And to get to kind of participate in the national conversation about how we provide

health care in an equitable way through A. comic really floored me. And so I have then since I started making A. lot more comics. I I've had the amazing privilege of getting to work some with newspaper outlets, with other non.
Non newspaper outlets with medical journals to do artwork about about what I do in palliative care, about the issues families and patients face when they're going through serious illness or even death and dying and working through those in A. way that's very accessible.
It's it's truly A. privilege, A. privilege I never thought I had when I was that kid, deciding whether to pick A. scientific career and put the art books on hold.

Katie Caviness-Crolley 16:21
Yes.
So thinking back to your own experiences using your comics or illustrations to, you know, connect with patients and explain, you know, something as complex and sensitive as palliative care. Can you give some examples of what makes comics, you know, especially powerful for patients in these moments?

Nathan Gray 16:47
I think there are there's there's A. stickiness to comics that's helpful. Meaning when you look at text on A. page, particularly if it's not about A. topic you don't really want to tackle, it can be easy to avoid that. So comics do have A. stickiness and A. A. memorability that I think makes them A. great.

Katie Caviness-Crolley 17:02
Mhm.

Nathan Gray 17:07
Entryway into topics that sometimes can be A. little scary or uncomfortable, like life threatening illness. So there's that that inherent stickiness to A. picture. I think we all kind of we start with picture books early in life before we ever grab A. book with chapters.
And so there are some primitive, I think, parts of our our cognitive experience that are touched by by graphics and by imagery. I'm A. big proponent for people making their own comics. I even had A. patient bring me A. comic last week when she had done some Googling about me before my clinic visit.

And brought in A. cool little graphic that that patient had made about their illness experience. So I I find it's A. great way to express, but also A. great way to receive information. There's also A. cool thing, you know.

Katie Caviness-Crolley 17:44
Mhm.

Nathan Gray 17:59
We've got videos, we've got the Internet, we've got 3D imagery and virtual reality. Why? Why comics? It seems like kind of A. dated, you know, 1920s newspaper format for receiving information. But there's an interesting dynamic that happens with comics where the reader gets A. lot of leeway.
To move through things at their own pace. It's why like if you go to A. conference and somebody puts A. cartoon up on the board and they read it out to you, it loses something. Or if they put A. comic up and people kind of chuckle at different times, if it's A. gag comic or A. funny comic, everybody's processing that on different times on their own terms. So when I.
Put out A. comic, people have the freedom to move through it, to spend on time on A. picture, to dwell on it, to to receive it in their own way, in A. way that just being kind of sat in front of A. video that plays on autoplay and moves at whatever pace that author or producer wanted you to move at.
That that freedom is not there. So, so there are A. lot of very cool advantages to comics. I'd say everybody has A. different way to be spoken to. And so I know that there are some patients who I can reach with with comics, not necessarily in the clinical setting, but more in the public setting. I'm and other patients were going to say that's not for me and that doesn't hurt my feelings at all.

Katie Caviness-Crolley 19:14
Mm.

BA

Bimal Ashar 19:15
Along those lines, I mean, are there limits to, I mean how do you determine who you know, what you think a patient would respond to or are there limits to what you think the comics or or actually pictures in general can can have an impact on a patient's medical issues?

Nathan Gray 19:33

Yeah, yeah. So there's there's A. big this, this graphic medicine movement that's kind of studying the intersection of comics and healthcare and has done A. lot of work in terms of promoting what they call graphic pathographies or these illness narratives in comic format.

And we have some like early literature to suggest it can help. Like reading A. patient's story in comic format can help providers understand the patient experience of illness. We also know that patients can gather useful information from reading other patients' stories of illness. So if say you're a.

Patient with breast cancer. There's several great breast cancer comics out there where people can see themselves in that story. I'd say with palliative care, there are some limits. So I don't bring A. lot of comics specifically into the clinic room. A lot of my patients are, you know, having A. very heavy day the day they meet me. They may have had other appointments that day. They may have received bad news. They may have had.

Scan or blood work. I really try to be sensitive to what kind of information they're ready to receive in that clinic visit. And I also don't want the spotlight to be on me as like, oh look, I have this hobby here, come look through all my work. I don't want patients to feel like they have to humor their doctor by looking at what I've produced in my.

Side life. So I don't tend to bring a lot into the exam room with me. That said, sometimes patients ask about it and we talk. Sometimes patients want a dialogue about art. I've found that it works great publicly because people can engage with it as much as they feel like when it comes to palliative care, you know, I have patients. Who are on a trajectory of recovery or maintenance. I do also see patients who are on a trajectory of decline where their illness is going to take them one day toward death and dying. And everyone moves at a story like that at their own pace. As I was talking about earlier, there are patients who say, you know, my goal for today is to survive through the day and get to tomorrow.

They're not ready to flip ahead in a book about a patient with like, say, breast cancer that died or a patient with lung cancer that died. They they need the strength to get through that day. And so I the the idea of confronting them with a story about a patient whose whose chapters take them to a different place.

May not really be helpful to them in that moment. So I'm very sensitive to where

people are in their story, and each story is different. So I don't prescribe a comic to a patient typically, or, you know, even even strongly recommend that they read something because it may just not be something they're ready to process in that moment.

Katie Caviness-Crolley 22:03

Hmm.

So, you know, I know we're almost out of time, but I do want to ask, you know, if you say you have a patient or a family who's not sure if palliative care is right for them, what would you say to them?

Nathan Gray 22:14

Yeah, I wouldn't. So certainly when palliative care is mentioned by doctors, I always do step back a little bit and ask the question of what is being recommended in terms of palliative care. I know that palliative care at one place may look a little different from palliative care at another place. So I.

Let's say a patient, their doctor has recommended palliative care. I think it's a great question. Just ask that doctor for clarification and say like, what are you hoping for out of that palliative care visit? Many times that cardiologist, that oncologist can put the patient's mind at ease and say I really want them to help with your shortness of breath or your mood or your appetite.

I really want them to work on those things. So I I caveat by saying like, I want to make sure we know we're talking about the same palliative care that I'm talking about. But when it comes to the palliative care that I'm talking about, where we're talking about holistic support anywhere along the trajectory of illness.

I strongly encourage patients to give it a try. So meaning meet with the palliative care provider that's being offered to you in that in that setting. If it's a palliative care doc in the hospital, the team would like you to meet just just meet them. If if things go well and it's a useful relationship, by all means continue.

If, you know, I tell my patients when I meet them for the first time, this visit is for you, not me. So if it's helpful, let's pick a dose of me that's useful to you. If it's not helpful, give it a break for a while. Come on back later if there's something else I can address and that doesn't hurt my feelings in the least. The patient's care is what matters most.

Katie Caviness-Crolley 23:40
This is.

Nathan Gray 23:50
to me. So if I'm providing a valuable service, many times patients are like, how soon can we see you again? And then occasionally I'll have a patient who says, you know, this was a great visit. I'm doing really well. I actually think I'll just, you know, reach out if something else comes up. So we're learning that the dosing of palliative care can really be kind of adjusted to
What the patient needs?

Katie Caviness-Crolley 24:12
H.

Bimal Ashar 24:14
I mean, this has been fascinating, both from the aspect of palliative care in general and you know, your use of art is in medicine. I'm wondering whether if you have any suggestions for people who want to learn more about either palliative care or about your artwork, where they can go.

Katie Caviness-Crolley 24:16
No.

Nathan Gray 24:32
Yeah. So I would say there there is a lot of great, there are a lot of great resources out there about palliative care. The American Academy of Hospice and Palliative Medicine has some patient-facing materials. Also the Center to Advance Palliative Care and or CAPCCAPC if you were to Google CAPC palliative care.
Information that would pop up a website called Get Palliative, and that website not only gives some plain language information about about what palliative care is, but also has a database of palliative care providers around the country that can be helpful if you are, say, in another part of the country and looking to see whether there's a palliative.

Katie Caviness-Crolley 25:06
Mm.

Nathan Gray 25:12
Provider in your area. I wish I could say that every single town and and county in our country had good access to upstream palliative care of the type we've been talking about. That said, there are broad differences in access around our country, so it's a great resource to be able to look and see if there's somebody nearby.
That might be able to help.

Katie Caviness-Crolley 25:34
Thank you. That's fantastic. And what we could do is, you know, post those resources onto the website. So it's super easy for patients to find. But yeah, just reiterating what Bimal said, thank you so much for joining us for this. I feel like I learned a lot.

Nathan Gray 25:46
Yeah.

Bimal Ashar 25:48
Yeah, this has been great. I mean, I learned a ton, so very, very fascinating work that you're doing. And and I do have to put in a plug in for your wife again, who not only brought you to Johns Hopkins, but also made you follow your passion.

Katie Caviness-Crolley 25:51
Yeah.
Yeah, and I completed that.

Bimal Ashar 26:06
Um for graphic artwork.

Nathan Gray 26:08
She is truly my better half in so many ways. So yeah.

Katie Caviness-Crolley 26:09

She should also support you in your journey to become Batman. I feel like we. I feel like we glossed over that way too quick.

Nathan Gray 26:15

Oh, there you go. I I think, yeah, she's probably going to want me to stick to my day job. I don't think she wants to see me in tights. Or it probably doesn't want anybody else seeing me in tights either. I'll say that.

Thanks for tuning in to Medicine Made General. We hope you found today's conversation helpful. At Hopkins GIM, we're not just advancing medical knowledge, we're working to make healthcare more equitable and accessible for all. Until next time, stay informed, stay healthy.