# Transcript / Breaking Barriers: Ketamine's Role in Hospice Medicine with Dr. Rohini Kanniganti

**Melody King:** 0:01
Welcome to TCNtalks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host Chris Comeaux.

**Chris Comeaux:** 0:23
Hello and welcome to TCNtalks. I'm excited. Today we have an incredible guest Dr Rohini Kanniganti is joining us. She's a hospice physician, Rohini. Welcome, and so good to have you.

**Dr. Rohini Kanniganti:** 0:34
Thank you so much. Yeah, it's such an honor to be with you again, Chris.

**Chris Comeaux:** 0:41
I love that you said again, because you were like one of my second or third guests when we envisioned TCNtalks well over four years ago. I didn't know what the hell I was doing then, and so you were so wonderful and gracious. So it's great to have you back, and I'll put the word that we're going to be talking about ketamine. Before we jump in, though, I'd love for the audience to know what would just be good to know about you. You're such a fascinating individual human being in person. What do you think would just be good for them to know?

**Dr. Rohini Kanniganti:** 1:12
Oh, my goodness, it's been such a huge path, but I want to thank you, Chris. I just want to take a moment to really thank the grace and service that you offer. This is a very relational field hospice and we are necessarily interconnected. We don't need to reinvent wheels about how to take care of our patients. And thank you. Thank you for the clarity and nonstop dedication that comes through you, and I want to thank and honor our listeners. You know, whoever you are, whether you are staff or leaders, thank you for all of the service that you provide and that all of the evolutionary process that you're in, constantly knowing that what we offer is an approximation and we want to get closer and closer to something that supports relief from total pain while not doing harm. And thank you also for this space in which our patients are the teachers, because, necessarily, we're going to

be our patients sooner or later. And, yeah, and I'm thankful, I'm thankful to those we serve.

**Chris Comeaux:** 2:47
Well, just, you're so good, You're such a treasure. Just in that little answer right there there's so many little action, packed little pearls that maybe a couple we may come back to. But I, absolutely I picked up on your tip of the hat to Cicely Saunders about the concept of total pain.

**Dr. Rohini Kanniganti:** 3:04
Absolutely yeah.

**Chris Comeaux:** 3:05
That that that'll be a perfect segue to really what we're going to be talking about today. And you were kind of castigating me in a good way about not calling you Dr Kanniganti and I was sharing with you that Dr Janet Bull. It only took us I don't know 18 years of working together within the last couple of years, and I was raised as a Southern gentleman, so trying to be respectful to others, but I will try to refer to you as Rohini throughout the rest. Just because you are just such an amazing IDG team member, an amazing physician, thank you. I know that because you work with one of our TCM members and I still see some of the amazing comments that hospice staff they just love working with you. Because just in your one little answer you already got me in some cool Zen space. Imagine being in that space with you, working with patients and families is a pretty cool honor.

**Dr. Rohini Kanniganti:** 3:56
Thank you, thank you, thank you for your gift of seeing the light in people, chris, and, to name it right, that's a part of the healing journey for all of us.

**Dr. Rohini Kanniganti:** 4:06
And yeah, such such so great, so great to be here and it. You know, I think one of the things that I loved about love, about being in hospice, and one of the many things that drew me in, is that where we sit at a round table right, we're with nurses and with social workers and with chaplains and sometimes volunteers, and we all lose our first names. I mean, we all lose our last names and we sort of take off the masks and the scarves because we know what's the most important thing out there is our care for our patients.

**Chris Comeaux:** 4:48
That's really good and you wouldn't even know this, but I went through this interesting kind of we'll call it a Bible study and you go through this study and because in biblical

times right, someone got a new name and you will smile at this and I still have not fully embraced it, but my name at the end of that study was light actually.

**Dr. Rohini Kanniganti:** 5:06
Well, not surprised, actually. This is the sort of intuitive, ineffable space that our spiritual, our deep contemplation, our spiritual work gets us to, this intuitive space that you know, you can't make this up stuff.

**Chris Comeaux:** 5:28
That's so good. And again, all of this is building to like, how do you make a segue and then talking about ketamine. But actually I think it is a great segue Because so let me think about how to ask you this question. So first off, you alluded to total pain. I had first started hearing probably about seven years ago.

**Chris Comeaux:** 5:46
I have a really good friend who was the CEO of a hospice. That hospice got sold, so then he was being more as a consultant advisor for other hospices and one of his best friends in the world. His wife then went through a horrible end of life experience. They could not get her pain under control. He happened to be involved in an interesting business venture where they were bringing treatments of ketamine to folks with like PTSD, and so they actually tried it in that hospice experience and had pretty miraculous results. So that was the first time it hit my radar screen and so that's, I'd love for you to talk about that. So in fact, you and I knew each other and then I can't even remember what made me reach out to you about this. And then all of a sudden you're sending me all this material and I'm thinking, oh my gosh, she's like an expert in this area. So talk to me about ketamine. Um, there's a lot of interesting things out there.

**Dr. Rohini Kanniganti:** 6:41
There are.

**Dr. Rohini Kanniganti:** 6:42
There are a lot of interesting things and I think that the field is now really full.

**Dr. Rohini Kanniganti:** 6:49
If you're, you know I'm a bridge between two worlds the world of hospice I'm a board certified family physician, as you know, and one leg of me is in hospice and palliative care and the other leg, for the last few years really as long as I've been with TCN has been in the field of integrative mental health, integrative psychiatry, teaching people, physicians

and psychotherapists how to use ketamine for this off-label use for depression and, you know, intractable depression and anxiety and trauma and particularly suicidality.

**Dr. Rohini Kanniganti:** 7:26
Also some treatments for addictions, OCD. So I feel like a bridge between these two worlds and at this point you know I've seen a thousand, over a thousand people personally receiving ketamine and have prescribed it in a very, very, you know, structured, incredibly careful set and setting and gosh. Every single time I'm either going wow, this is really sold me, there's really something here, and there are multiple times where that treatment either doesn't work for whatever reason or is not a great treatment for somebody. You know it could potentially even be harmful. Now I under my care. Harm has not come to anybody Because, because you know, then I get to bring this to hospice and model incredible carefulness, and I love thinking about carefulness as care dash fullness.

**Jeff Haffner / Ad / Dragonfly Health:** 8:41
Thank you to our TCN Talk sponsor, Dragonfly Health. Dragonfly Health is also the title sponsor for Leadership Immersion Courses. Dragonfly Health is a leading care-at-home data technology and service platform with a 20-year history. Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single, efficient solution for caregivers, patients and their families. The company serves millions of patients annually across all 50 states. Thank you, Dragonfly Health, for all the great work that you do.

**Chris Comeaux:** 9:28
So could you maybe talk about some experiences of bringing an end to end-of-life care in particular?

**Dr. Rohini Kanniganti:** 9:33
Yeah, yeah, I absolutely could. You know, when I before you and I met and before you knew me, I was with a large hospice in Denver, the Denver hospice, you know, huge, like the one I'm currently with Mountain Valley, no-transcript. And so you know I bring in together that, the science and the sacred, in everything that I do, which is why I love hospice. But while I was with the Denver hospice, we started to use ketamine because we we were really um, working in conjunction with the University of Colorado, so we were an academic center and doing sort of state-of-the-art work with anything that we could have access to to support patients. And at that time, I was using ketamine in our IPU to get people off of the incredibly high doses that they had come to of dilaudid or morphine, fentanyl, and a small amount of ketamine infused was rapidly, in a way, re-energizing their receptor system so that they did not. You know, we pretty much brought people to zero

while using ketamine, low doses, infused over a few days, watched carefully and observed carefully for side effects. And you know, I remember not only was that really cool, because we know that ketamine has been around for decades as an anesthetic and is on label, so to speak, for the use of pain management. But what I observed is that there was one young patient in particular who was very addicted to opioids and here she was for her condition on very high doses of opioids. So we were in a double bind there and what we noticed is not only did the ketamine help her lower her opioid level to zero, but a young woman for the first time saying I feel better than I ever have, I'm going to go home with my grandmother. And we actually graduated her off of hospice, if you can imagine that, because all of that pain that she was having was actually looking like end-of-life symptom. It was purely helplessness and a lost will that she regained with the ketamine. We didn't even know it. And then she went home off hospice with her grandmother receiving medical care for her chronic conditions. I don't know what happened after that.

**Dr. Rohini Kanniganti:** 12:56

And then another example is a patient who was probably in her 60s had metastatic cancer may have been metastatic pancreatic cancer and, as you know, Chris, it's just high pain level and with the help of our pharmacy, you know I prescribed her ketamine to be at home and I know this is something we'll discuss a little bit more. You know where is this going to be administered and I gave her ketamine at home, like I would opioids right, like we do benzos or whatever, and it was a low dose. When you do oral ketamine or sublingual ketamine it's much less absorbed, so you give a slightly higher dose and even there I was giving a much lower dose than we would use for mental health reasons. And so she had 20 milligrams, starting with 15 milligrams three times a day, went to 20. It was really very little and I said, okay, you know your pain.

**Dr. Rohini Kanniganti:** 14:06

I wanted to do this short term. Are we in a place where we can take you off of this medicine? We can continue on your others. She said no, actually, my depression's lifted and I almost cried because I didn't know. Actually, that ketamine was already being researched, had been researched for quite a while. And for those of you who are fans of Andrew Huberman, the Huberman Lab, he does a really good podcast, just one podcast, it's an hour and a half on how ketamine works in this mental health way. That might be really helpful. I mean, I think in the context of this hour, Chris, you and I aren't going to be able to get to it.

**Chris Comeaux:** 14:54

You know the details Great point, so we'll put a link to that. That's an awesome idea. We'll put a link to that Huberman podcast. We will.

**Dr. Rohini Kanniganti:** 15:01
And then it was after that that I joined the Integrative Psychiatry Institute when I went through all of their training fellowships, you know, in integrative psychiatry, and then the ketamine provider training and then also you know other other fellowships they have and became faculty for them and also the lead physician for their training program with physicians and therapists on using ketamine. So they would come in for they still do I mean I have one in a couple of days, a practicum to come and actually receive teaching in person and receive the ketamine so that they can experience for themselves what it's like. And that's actually a fairly important thing to do, so that they can then go out and prescribe it in a meaningful way. Because when we're talking about ketamine and the reason that you did this and it's, by the way, thank you, you know you're you're again sort of talking about a state of the art treatment that many hospices haven't thought about, haven't really considered, and it's courageous because it isn't like prescribing a benzo or an opioid.

**Dr. Rohini Kanniganti:** 16:23
It is best done with a psychospiritual awareness that this affects multiple layers of our being and that if we hold it really carefully we could do a lot of good. There is a tremendous, if we're talking about total pain. There's a tremendous amount of demoralization, isolation, an increased level of suicide and anxiety in our hospice patients that's not seen in the general population, and you know I start. And also existential anxiety, this terror about dying and often, you know, we don't have practice in dying.

**Chris Comeaux:** 17:15
I love this holistic wisdom that you're applying and you nailed me. It's exactly why I want to have this conversation, because we really built a pretty good following of bringing relevant, important information to hospice and palliative care leaders. I think it's important that we think about this because it is becoming like the fact that it's on Huberman Podcast it is becoming, at least, more discussed. So just a practical question so is it both orally shot IV? Is it all of the above?

**Dr. Rohini Kanniganti:** 17:51
All of the above. I just saw a study that came out in 2023, why? In coworkers? I think this was a New Zealand group who'd been working with sub-Q ketamine with their hospice and palliative, knowing that sub-Q is the way that most of us would go in the IPU, and they got some great results from it. So you can do subcutaneous, you can do IV, you can do intramuscular, you can do intranasal, and you can do sublingual.

**Dr. Rohini Kanniganti:** 18:25

Now it all depends on where that patient is in their capacity, because a sublingual thing isn't just a matter of swallowing a pill like you would an opioid or a benzo or in heartburn medicine. You have to swish it around your mouth. Now there are formulations that are rapidly dissolving on the tongue, but they're not quite as effective. But that's okay. You know we always have to be thinking about what our hospice patients can tolerate. You know, nausea is really high as a symptom in so many illnesses and the last thing we want to do is increase that by having something yucky in the mouth. But it allows people to do it at home, as many, many do right now.

**Chris Comeaux:** 19:15
So I feel like you've been alluding to that, and I feel like I've heard you say both that and one. In some cases, you want to have very close administration, which then would be like a hospice IPU, but you've also had some circumstances where you administered in the home. I think this friend who's involved in some of these clinics they've had a situation where it's only doctors or CRNAs who could actually administer it. So, can you talk about that a little bit?

**Dr. Rohini Kanniganti:** 19:40
Yeah, first of all, let's back up a little bit. Ketamine is a schedule three controlled substance, so anyone who's most people who are listening will know what that means. That means it's schedule two is opioids and I think schedule four is benzos. So somewhere in there these schedules happen because of abuse potential. So, ketamine is considered less abuse potential than opioids are. So, for that reason we always want to have a physician, or a nurse practitioner very closely involved and, of course, the medical directors and the CMOs, the chief medical officers of the organization, closely engaged with, especially in the beginning with prescribing ketamine, if we are doing ketamine.

**Dr. Rohini Kanniganti:** 20:35
There's any number of clinics that have popped up like mushroomed all over the United States, led by ER docs or anesthesiologists with very good intention of providing, you know, service for intractable mental disorders where people are just getting infusions and then they go home. And that is not great care. That's not the way that we would do it in hospice. If somebody was at the IPU, they would be surrounded by care at all levels, which is just exactly what's needed, and we could easily do an intramuscular shot of ketamine, shot of ketamine. But then, you know, have somebody sit and observe, sit with the patient and observe what happens for them and make sure that they're you know, that they're not frightened by things that might arise for them. If you look at the FASFACTS, you know it's a Wisconsin-based hospice. Fast facts, you know there is 2019 is the most recent edit of the one about ketamine for pain. And they talk about oh, there's all these side effects that are you know that we don't want. Well, there's all these side effects that we don't

want. Well, it's actually those very side effects that create this kind of neuroplastic peaceful change in the brain.

**Dr. Rohini Kanniganti:** 22:10
I think about ketamine as a human fabric softener, but when it's kind of a dreamlike state, it could be psychedelic. Not always it's not. It's considered an atypical psychedelic. People might see things, or they might feel things in their body, they might feel lighter, they might feel as if they're being turned around. All of those things are okay. And the way that ketamine works, it's actually, for the most part, not at all frightening because it's such a soother. It's so soft and so gentle.

**Dr. Rohini Kanniganti:** 22:48
I remember one of my students had this extremely intense experience with the ketamine and she leaned into me. She said Rohini, this is so intense and so gentle, and this is the reason why, you know, sometimes people don't see anything. They just see all gray and they go. What is that? Why did I see all gray? And the therapist you know, one of my co-teachers for these weekends said to them well, you saw all gray, but how are you feeling, how's your depression? They said oh, it's gone. I just feel really peaceful inside. And so, the question then becomes how long does that last? How do we keep going?

**Chris Comeaux:** 23:33
How do we not Matthew Perry, anyone, wow, I didn't even think about that actually until you just said it. So, I think people have a perception that, actually, until you just said it. So I think people have a perception that the regulations are preventing the use of ketamine inside of hospice, but I'm not quite hearing. I mean, it's no different than the typical regulations we deal with already.

**Dr. Rohini Kanniganti:** 23:51
right, yes, so it's a controlled substance.

**Dr. Rohini Kanniganti:** 23:55
Any of us can prescribe it. The prescribed use? Except for an inhaler called Spravato. Spravato has an FDA approval for depression. That's the only formulation, not sublingual, not IM or IV, but I'm not sure what that's all about. But you know, and it works really well. I'm not sure the intranasal is really good for our hospice patients. In the same way that we don't really think that inhalers are great when the PPS is less than 50, because we don't know what's going in and it's, but we have.

**Dr. Rohini Kanniganti:** 24:35

We use plenty of medications with off-label uses. You know, let me you know. I wrote a few of those examples for myself. It's like Namenda. You know Namenda is on-label use for Alzheimer's. However, it's also being used for OCD. We may not be using it for OCD. However, it's also being used for OCD. We may not be using it for OCD, and for both children and adults. I mean, who would think?

**Dr. Rohini Kanniganti:** 25:13
Clonidine, which we use for decreasing blood pressure, is also used for ADHD. Quetiapine, which is Seroquel, which we use all the time, we use it for insomnia, but that's not what the labeled use is supposed to be. You know, it's for schizophrenia and bipolar disorder, but we use it sometimes for insomnia or frequently for insomnia. You know, gabapentin, it's approved use is for seizures, we use it for pain, so you know I can continue. I mean morphine, it's approved uses in adults, but we also use it for children. So hospices already use many medications.

**Dr. Rohini Kanniganti:** 25:53
On off-label uses, you know, I have actually a kind of cute funny story about another hospice doc, one of my inspirations for getting into hospice. One of her patients had and this is not medications, but had intractable C diff, just recurrent, kept coming back and coming back. This was clearly not a patient she was going to send to gastroenterology to have a fecal transplant. So she took a big syringe, she took, you know, the poop from this patient's brother, mixed it around in water and, you know, did a fecal and gave him essentially a little enema with and cured the C diff, wow, and cured the C diff, wow. So this is, you know, we do this in hospice, we have to do what is necessary to bring relief. And there's also a question of access. You know, if we don't pick up ketamine and figure out what protocols to use, we're really relying on the wealth of a few of our patients to go out and seek care in these more expensive clinics.

**Chris Comeaux:** 27:11
Interesting. Well, and I'm actually having maybe an aha, I just need to verbalize it and you could correct me. I've always thought the brilliance of the hospice model of care comes down to the IDG, that true interdisciplinary and like the holy grail right is transdisciplinary, where it's like magic, kind of like you and I talking right now. It's just like how do?

**Chris Comeaux:** 27:32
those people do what they do but it's like magic. Is that what maybe gives a really good, efficacious use of ketamine? Because it's in the context of that IDG when some of these clinics I heard you say earlier, by just going to get some type of ketamine treatment

you're not walking alongside me. There isn't that IDG approach. We don't really have a care plan on what we're focusing on Right, that's it. That's exactly it.

**Dr. Rohini Kanniganti:** 28:00
You know, a truly excellent masterful care with ketamine involves a very robust screening process, robust communication and a robust consent. In the hospice and palliative context, especially hospice, it's not just us with the patient, right, it's our team meeting the team of their family and, in a way, making sure that they're all on board with the ketamine. And we should talk a little bit more because, you know, first is primum non nocere, first, do no harm, and we need to be have a very harm reductive mindset. Who could this do harm to? And I've created, in the ways in which I teach in the space, five areas in which we need to think about harm reduction, which is, you know, look at their physical and medical condition. You know, do their conditions, do their medical conditions allow for the use of ketamine? If so, how much?

**Dr. Rohini Kanniganti:** 29:02
And what's really meaningful here is that in the outside, the hospice population, we're going to have pretty strict contraindication criteria In hospice. It's a can we really work with this in order to bring, but it's still a harm reduction topic. We need to know the laws right, we need to act absolutely strictly within laws and credentialing right, and you've, we should talk about training and things like that. And we'll go there next, right, and we should talk about training and things like that, and we'll go there next Right.

**Dr. Rohini Kanniganti:** 29:40
And then the third thing is and these are all related to ethics the third thing, of course, is the emotional state of that person. Are they really in a state where they can process? Do they have the energy to process what's arising for them in the treatments, to process what's arising for them in the treatments? And we have to look at their cultural background. You know, what can their cultural background and their collective background support? Because we don't want to disturb that. And incredibly important to know what their spiritual background is, because if they believe one thing but they experience grace in a very different way during a ketamine treatment, would this come? Would they feel like they no longer had the resources you know I have to name some of this right. It often doesn't happen, but it could where suddenly they thought they would encounter divinity in one way and you know their ideas at the end of their lives are being challenged. We don't want that. So a really robust communication and consent is really needed for this space, and then we can talk about what it means to do good.

**Dr. Rohini Kanniganti:** 31:01

And you know I mentioned Matthew Perry and people are frightened of many cases in which I think there was a case in Colorado where somebody was overdosed by EMS and on their way very, very aggressive. They were very combative, they got too much ketamine, and they died, and it became just a huge, huge case. I think ketamine for the most part, is safe. It's given to children in ERs now all the time. You know. If a child has to have a mild surgery or sutures, they give them a little bit of ketamine to soothe them and calm them down. It's really pretty safe. But still we need to never be arrogant in the space, never be assumptive and have, you know, excellent IDG conversations. Not only IDG but the whole organization needs to be on board, especially the leadership.

**Chris Comeaux:** 32:05
Yeah, this is where I'm sitting, reflecting and just how spoiled I was growing up in hospice, having Dr Janet Bull, dr John Morris, and we had a very robust physician model, which is not the norm in a lot of hospices. A lot of hospices have a contract physician that flies by and does an IDG once a week, and so that leads me to my next question is what percentage of hospice physicians out there, Rohini, do you think are properly trained on the use and effects of ketamine, and are there training programs specifically for hospice docs? Are we so leading edge right now that that's more kind of coming?

**Dr. Rohini Kanniganti:** 32:45
You know there's more and more are being trained and there's a ton of people who are deeply interested in this work. You know, I would also recommend for interested physicians and hospice leaders there are two online listserv organizations that I would recommend start joining. One is called Big Tent Ketamine, and this is a place where people are really exchanging information about ketamine. So, you know, it's a big body of research that's expanding through people's experiences. The other one was started by Dr Michael Fratkin in California, who's a hospice and palliative care doc, and Michael started something called the Psychedelic for Palliative group and there's a big discussion there about you know, about ketamine. He, more and more physicians are getting trained. You know the Integrative Psychiatry Institute. You know I just started a program and we did. We graduated, I think, close to 20 physicians and and mostly physicians and a couple of therapists last August after a very you know pretty robust two to three month program, but they had already gone through.

**Dr. Rohini Kanniganti:** 34:11
All of them had already gone through. No, not all of them, that's not true. Many of them hadn't. About half of them had gone through our very extensive and robust training program, and then the rest of them who hadn't, they received a lot of information through us and were advised to pursue further training. So this isn't. There's any number of training programs across the country and some of them are weekends and three to

four days, and I just don't think that that is going to cut it. I think that the training needs to be robust.

**Chris Comeaux:** 34:51
Maybe we can include links to the big tent that you mentioned ketamine and then the one from Dr Fracken. Maybe we could include links to both of those in the show notes.

**Dr. Rohini Kanniganti:** 34:59
Yeah, and these are for discussion groups. There are organizations like the one that I work for, the Integrative Psychiatry Institute, that offers five-month programs to work with ketamine. Of course that's a lot to go through when you're going to only prescribe ketamine very little. But there are. You know, there are other programs. It's possible. I think it may be most cost-effective for hospices interested in doing this to bring in people who are highly trained to train everyone at the same time over a couple of days and then give people asynchronous material to read and then to discuss and bring it all together in that way. I mean, I think we have to consider the cost, but the most robust thing to do, of course, is to go through, and the direct answer to your question is more and more, but I still think it's probably less than 5%.

**Chris Comeaux:** 36:05
I don't know if this is a horrible idea, Chris, but I'm just thinking about the trajectory of the use of methadone in hospice, and we even had Mary Mihalyo on the show at one point in time and we kind of joked that she became known as Methadone Mary because she became such a champion in the space, and so do you think it's going to take something similar?

**Chris Comeaux:** 36:35
Rohini ketamine just doesn't have the same ring as methadone, Mary, but do you think it's going to take a champion, or is it going to be like hospice was much more kind of grassroots, a lot of national experts.

**Dr. Rohini Kanniganti:** 36:47
I don't think so. You know, the data for methadone and palliative care has been around for a couple of decades and people have been urging its use for a long time. Methadone is a great drug, but it's an opioid. It's not going to have sympathomimetic effects. It's not going to have the psychospiritual effect that really needs support.

**Chris Comeaux:** 37:13
That's what makes this so unique.

**Dr. Rohini Kanniganti:** 37:14
It's what makes it so unique, and so I you know I could be robust Rohini or Kanniganti, Ketamine Kanniganti. There you go.

**Chris Comeaux:** 37:25
There you go. That does actually, that's got kind of a ring to it. Well, that probably leads to my next question that does actually, that's got kind of a ring to it. Well, that probably leads to my next question. If you look into kind of your crystal ball of the future, what do you predict, maybe the near future, regarding this? Maybe acceptance and uptake and utilization by great hospices?

**Dr. Rohini Kanniganti:** 37:42
I think that in order for hospices to step forward, we really need to figure out some of the barriers right. We really need to figure out some of the barriers right. One is people are already stretched really thin. Especially with Medicare funding cuts and all of that, everyone is stretched thin. Who's going to have the time to sit with a patient for an hour? It's a very real question, right, and it could be that you know that we engage family members to, as a part of our consent process, to sit there right and with nurses around that can be called in. The other thing is, of course, the training is going to. We can't do this without training. It's going to take some investment of time and energy. So, I think between those, I mean not to mention sort of the stigma right around the use of medicines like ketamine, but if we just look at the money, the staffing and the time and then the need for the training, that's a huge barrier. I think we should talk about that.

**Chris Comeaux:** 38:57
Well, I'm going to go out on a limb. We've been doing a lot of research lately because you know I've been blessed to be doing this for 30 years now. Obviously, I was 10 when I started. No, I was just joking, I thought you were five.

**Dr. Rohini Kanniganti:** 39:10
I started.

**Chris Comeaux:** 39:11
No, it's a joke, I thought you were five. So our customer has been the greatest generation. That is changing now, and the baby boomers have. They have not gone quietly in any segment of the economy as they've gone through, and I think we would be fool hardened to think that's not going to be the case for end-of-life care. I would be willing to go on a limb and say don't you think baby boomers are going to bring this to a head Like I want this part of my experience potentially I hope so.

**Dr. Rohini Kanniganti:** 39:40
You know, I think that that's going to be the case probably in more well-resourced areas of the country, the more wealthy baby boomers in particular. You know places like Boulder, you know True Hospice is probably seeing this. I mean this other small hospice that I work for, trailwinds they're hearing this from their patients and clients. Right now what they're doing is just sort of referring them out because they haven't had the infrastructure, and I was actually brought in to be their Ketamine Kanniganti and they've gotten stalled around. What's the staffing?

**Chris Comeaux:** 40:22
What's the staffing to be able to do? And they don't have an inpatient unit.

**Dr. Rohini Kanniganti:** 40:25
They don't have an IPU yeah, they don't have an IPU yeah.

**Chris Comeaux:** 40:29
Would it qualify what crisis care would not? Would not be a one-to-one correlation right to be able to bring to utilize crisis care in the administration of ketamine?

**Dr. Rohini Kanniganti:** 40:40
I guess it depends upon the circumstance, wouldn't it? Well, I think people have. I think we could talk about agitation. We could talk about unresolved you know, unresolved anxiety is already an indication and people come into IPUs for that. Probably not, you know, underlying depression. But I think we could do anxiety and agitation, which are part and parcel of unheld underlying trauma that so many of our patients have. Suicidality would be another thing.

**Chris Comeaux:** 41:17
Wow. Well, I know we're going to have to land the plane in just a little bit here, but what would you like clinicians to know? Picture it like you've got the ear of a lot of wonderful hospice and palliative care staff and leaders. Take the staff first, those IDG team members. What would you want them to know about the utilization or just the availability of this potential drug?

**Dr. Rohini Kanniganti:** 41:42
It's a relatively inexpensive offering and it's a relatively safe offering. So I would say I would want to soothe the nervous systems of all of our colleagues, all of our brothers and sisters, by saying done right, it's safe and it can really enhance the quality of life and bring deep comfort where we haven't been able to, because antidepressants only work on 30% of the population. If that and I think that you know we need to be well-versed in the do

no harm and the do good of what we've been talking about we need to know that the arc of a ketamine experience is only about 45 minutes and that they and it really depends on the capacity to metabolize and all of that but it's a fairly short treatment and it's doable and that preparation and integration are really key to bringing about this relief of total pain and that everyone needs to be on board.

**Chris Comeaux:** 43:01
Which is then the last question is what would you want leaders to know?

**Dr. Rohini Kanniganti:** 43:07
I would want leaders to know that this is really worthy of discussion, and I would want leaders to bless themselves with courage to try something that hasn't been tried. I would say to invest in proper training because I think it would go a long way. You know, a training once is a gift that's going to keep giving. I think that I would have leaders empower best practice development within their organization to start using ketamine for pain.

**Dr. Rohini Kanniganti:** 43:51
Start there, you know, don't just let's not jump to the psychological well-being just yet, but at least start trying it for pain relief, for physical pain relief, and see what happens. I think to develop some training for patients and their families to offer this and really develop extremely good, robust consents for the use of this and to utilize all of the resources. I mean there's a huge conversation about ketamine all over the country. Of the resources, I mean there's a huge conversation about ketamine all over the country. Hospice is kind of a latecomer into this conversation, and I think it would be great to jump on. You know whether it's Huberman to reach out to me ketamine Kanniganti.

**Chris Comeaux:** 44:48
I think we've actually coined a term today.

**Dr. Rohini Kanniganti:** 44:49
Yeah, if someone just, you know, just wants to even have the first level of discussion and this is a huge conversation to be had consider joining the groups that I talked about. Consider looking actually for oneself. All the research that already exists with this is very, very good, robust research. And the last thing is that there is an article that came out, I think in 2022. It's called the top 10 tips. Palliative care of clinicians should know about psychedelic assisted therapy in the context of serious illness. Oh, wow, this came out. I think this was a paper written out of the University of Colorado with a number of people that I know. An excellent article that you know we should all start by reading.

**Chris Comeaux:** 45:41
Yeah, I wonder if we could get a link, include a link to that as well.

**Dr. Rohini Kanniganti:** 45:44
Yeah, I've got a link that I'll give you Perfect Well, Rohini, final thoughts.

**Chris Comeaux:** 46:08
Perfect Well, Rohini. If there's anything I know about you as far as, like your superpower, your gift, that is what you're all about, and you raise other people around you to be about that, which is so cool, because that's supposed to be what the mission of hospice and palliative care is supposed to be. And so, and again, I see the emails back and forth where you're just pouring into the people around you to truly care for people, the true mission of hospice. Some of those things that we've lost sight of maybe not we listening here, but when you look at the hospice collectively throughout the country.

**Chris Comeaux:** 46:43
I'm not picking on all for-profit hospices, but some of the icky side of the for-profit out there and also some of the slouching side of the nonprofit that have lost sight of what is it we're here to do for patients and families. So, Rohini, thank you, because you take me back to that. I just love your spirit; I love your heart and love why you do the work that you do. And again, when I started thinking last year, I need to have someone on the show, I can't remember what made me reach out to you and then we kept emailing like, okay, I know who the person is to talk to. It's just based upon the back and forth. I had no idea that you were immersing yourself and becoming a true subject matter specialist in this area. So, thank you. We're going to include your contact information as well in the show notes, as well as all the other things we talked to. So, thank you, thank you so much.

**Chris Comeaux:** 47:33
Well to our listeners. We thank you. We really appreciate you. Make sure you hit the subscribe button, pay this one forward, especially to a lot of your hospice team members. This is one that we literally had you in mind when we did this, wanted you to know about this, that this is something that you're going to bump into, and there's nothing more frightening if you don't have good information. So, we went and found one of the best people to talk about this subject. So, thank you. We always want to leave you with something to keep you thinking and keep you listening. We call it just our quote for TCNtalks, and I ran this one by Rohini and she said absolutely, it's from Patch Adams. And I ran this one by Rohini and she said absolutely, it's from Patch Adams. You treat a disease, you win, you lose. You treat a person. I guarantee you you'll win, no matter what the outcome. Thanks for listening to TCNtalks.