Dr. Lynn McPherson:

This is Dr. Lynn McPherson. Welcome to Palliative Care Chat, the podcast series brought to you by the online master of science, PhD, and graduate certificate program in palliative care at the University of Maryland. I am delighted to welcome you to our podcast series, titled Founders, Leaders, and Futurists in Palliative Care. A series I have recorded with Connie Dahlin to support coursework in the PhD in palliative care offered by the University of Maryland, Baltimore.

Hello. This is Dr. Lynn McPherson. I am a professor at the University of Maryland, Baltimore, and program director of our online master of science, graduate certificate program and most recently, our PhD in palliative care. And I'm joined by my colleague, Connie Dahlin, who's one of the faculty members in the PhD and the master's. And we're super-duper excited with our two guests during this podcast. We have Dr. Frank Ferris and Dr. Charles von Gunten. Welcome, gentlemen. How are you today?

Dr. Charles von Gunten:

Very well. Thank you for inviting us.

Dr. Frank Ferris:

Yes, thank you for the invitation to join you.

Dr. Lynn McPherson:

Absolutely. So I promised I would share just a little, tiny bit about your background and then turn it over to you. I know that how I first, I think, met you both was when my resident, years and years ago, said, "I want to go some place really cool for a month." I was like, "Okay. What do you call really cool?" She said, "I would give my best kidney to go to San Diego Hospice." So I was like, "Okay." So you had a training program, and off she went for a month. She came back glowing. She went on, and on, and on. Basically, color me jelly, I said, "I have to go." So I was able to arrange that I could come for two weeks. And I said, "I want to go in July when Doctors Ferris and von Gunten are the attendings."

So Dr. Von Gunten, I think I had met you also through the [inaudible 00:01:46] when they were in charge of the certification board. So I know you certainly were sending a hospital a long time, and then you went to OhioHealth, and just very recently, you've retired from that position and you're living the dream now. So, I'll turn it over to you. I want to know how in the world did you get involved in palliative care? Whoever would like to go first.

Dr. Charles von Gunten:

Okay. So the role that serendipity plays in life, I think goes under acknowledge. So serendipity played an enormous role. I chose to do my residency in Chicago at Northwestern University, Northwestern Memorial Hospital. And though, I didn't know it, they had a hospice program, including a hospice unit in the hospital. And when I was admitting patients all over the hospital as an intern in internal medicine, we also admitted patients to the hospice unit. And I remember being struck that this care is better care than elsewhere in the 750 bed academic medical center.

I was admitting patients just like them elsewhere in the hospital, and they were getting better care. And that was the [Colonel 00:03:03], and I had been ... So I did a rotation as a second year resident there and made home visits. And I'd been reading about consult services like at Cleveland Clinic and what they had in England. And I did a fellowship in medical oncology because there was no career path. And it was oncology where palliative care had been most developed at that point. And I had money to

travel and see what they were doing in England and to visit Cleveland Clinic and Memorial. And I wanted to do a consult service.

And the chief of oncology said, "Charles, I'll give you a year. It makes sense. You still have to do medical oncology, but you can do brain tumors and melanoma because in the '90s, there wasn't a lot we could do for either." So I learned from him that sometimes it's better to beg forgiveness than ask permission. So I started a consult service in the 750 bed academic medical center and push the hospice unit to be an acute palliative care unit because the licensure permitted that. And the rest is history then. I mean, that's how I got going, but it was the patients, the patient care, the families, the collaboration with other team members. It was intoxicating.

Dr. Lynn McPherson:

Wow. [inaudible 00:04:42] it turns out like a rocket dude, didn't it? [inaudible 00:04:45] gain ground.

Dr. Charles von Gunten:

It did. I think the ... Looking back, one has selective memory, but the two things, Northwestern Memorial was a pretty standard U.S. hospital, community private hospital. And the way we set things up turned out to be highly generalizable. And I got some other money to do a training program where people could visit. Most of the names that you know visited us in the '90s. And they saw what we were doing. I was like, "Well, I could do that." You remember the song from Broadway, I could do that. And there was this broad then dissemination of similar models in hospitals around the country. Dave Weissman was doing very similar things in Wisconsin. And so that, by the way, to me, that's the brief summary, at least how I view how I got started and how my career got started. Frank, how about for you?

Dr. Frank Ferris:

I have a little bit of a different story, in that I'd finished medical school and just before I graduated, my father died, and did not die well. It was pretty unexpected and not handled in a good manner. I went into internal medicine because I thought, "Well, that's the best strategy to get to know good medicine." Finished that, and had loved oncology and I love toys. So I went into radiation oncology and studied that for three more years. And in the process of working in a cancer hospital, one of the largest in Canada, I heard people moaning in the corridors at night, and in terms of being on rounds and listening. And I thought, "This is crazy."

At the same time, Robert Twycross published his medical clinics of North America on pain management. And I devoured the book in a day. And I said, "I can do this. This is not hard." And I began actually doing pain management in this large tertiary cancer hospital, that was Princess Margaret Hospital in Toronto, very successfully. And of course, the nursing staff thought this was fabulous because I would get patients comfortable. And ultimately, I realized, as I started to even teach pain management, this was much more rewarding for me to get immediate gratification, as opposed to radiation oncology where the, it was really interesting, but the results occur weeks to months later.

So as I finished, I talked with a colleague, Ian Kerr was his name, actually a medical oncologist up at the, what was then the Toronto Bayview Regional Cancer Centre. It's now the Odette Cancer Center. And said, "Can I do a fellowship? And can we build a palliative care service?" That he said, "Well, no, I'll never be known as a palliative care doctor, but we can build a symptom management service." So I grew that, did some research on a variety of projects over three and a half years. And at the same time, nursing out in the community had really started to develop palliative care, and two very influential

women, Marilyn Lundy and Shirley Herron said, "You need to do home-based palliative care, Frank." In the process, I met Larry Librach, who was at Mt. Sinai Hospital at that time.

And in 1991, I started working with him. Saw patient one in a home-based palliative care service as he was running the inpatient service. And over the next, that was effectively nine years. Through '91, through '99, we grew the largest home-based palliative care service. I suspect it's still one of the largest in the world, seeing patients at home as well as consults in several hospitals. And I realized this was what my love was. At the same time, I was also motivated by the death of my partner. And again, it was better, but it wasn't ideal. And I realized there was a real opportunity to grow palliative care, really in the community, as well as inpatient services. And to really turn it into a medical sub-specialty.

Now, there were also lots of resistors. I could still see the orthopedic surgeon saying that, "You would never, ever, ever see one of my patients." At the same time, a colleague of his said to me, "You need to see every patient I admit." And I said, "Oh, my goodness, be careful what you wish for." I just got more consults than I could possibly handle. And it was an exciting adventure.

Dr. Lynn McPherson:

Absolutely. I think that's been a recurring theme that we've heard. Don't you agree, Connie? So many three launched with serendipity and just happened to me in the right place at the right time. Absolutely.

Connie:

Yeah.

Dr. Frank Ferris:

Well, and not just by nursing colleagues, yes?

Dr. Lynn McPherson:

Yes.

Dr. Frank Ferris:

Who had recognized the importance of doing this and said, "We need Dr. Companions to help us with the prescribing." But people who were really superb at caring for patients in the community.

Dr. Charles von Gunten:

Well, and you can't omit the role that the pharmacist played in our careers as well. One of my early projects was taking the model of, I mean, a glycoside dosing services, which were pharmacists in an advanced practice fashion take over the management of aminoglycosides and dosing because they do it better, and more scientifically with higher quality, and applying that to opioids, because the opioid dosing was such a challenge. And having that be pharmacist based. Well, it changed practice in the hospital. It also elevated the role of pharmacists in the eyes of the rest of the medical staff in terms of being collaborators in the care of patients.

And I had the same orthopedic story, where we had five pain services at Northwestern when I was there. And they were as territorial as they are today. And in the midst of that, it was the orthopedics ward that wanted palliative care to do their pain management, not anesthesia, not neurosurgery, not rehab, because we got better results. And it was skillful use of opioid dosing, combined with the multimodality interdisciplinary care that some of the really challenging orthopedic

operations they were doing, particularly the chairman was into scoliosis. And the pain management there is extraordinary, but the palliative care model got much better outcomes than anybody else, people got out better, had better outcomes. And it was because of the pharmacist's role in that.

Dr. Lynn McPherson:

Well, thank you for them.

Dr. Frank Ferris:

And we can't forget the value of the counselor as well, because it was early in my career as I was developing, that really incredible social worker, Michelle Shaban, said to me, "Frank, this is much more than pain management. We can really help people live differently and we can help people through the transition of people dying as evocative." Because I remember one day a young man had died of malignant melanoma in our service and he had a twin. And they were actually from the Middle East. And wailing started. It could be heard two floors up and two floors down, and are in a modern facility. You could imagine the intensity of it.

And her message was, "Just hang on tight. We've got work to do here. We've got to look after this family." And of course, the transition for them was completely different because we were there. And it taught me the importance of us working as a team on a large scale, nursing, pharmacy, social work, occupational therapy, physiotherapy. All instrumental in helping people live the best possible life and manage the transition of dying.

Dr. Lynn McPherson:

Absolutely. Connie, were you going to say something?

Connie:

Yeah. I was just going to say, it's so interesting that you both have this community basis, and yet you both were in the hospital. And I'm just curious, how do we get back to that community focus and really using everybody? Because I think some of that's gotten lost over the years because we are still pretty hospital-based and thinking about, in my mind, health equity and quality and where patients want to be is in their community. I'm curious what your all's thoughts on the work you've done with that?

Dr. Frank Ferris:

Well, I feel very strongly it's driven by the funding model. So it was important in that period in the '90s, for me, I was at a single payer system in Ontario, Canada, to negotiate with the funder and get the funding to be able to provide the community-based services. And we were successful. By 1999, we had a million dollar grant for the system to actually be able to really grow much more service in the community.

Dr. Charles von Gunten:

Well, I'm remembering, Frank, you also became the expert in using the Ontario physician payment plan and the coding plan. You became the expert at how to do the right coding to maximize income, so you could employ a physician workforce, working with the existing nursing home care funding models. So combining that being very savvy about how does the money flow? How do you maximize it to support the care to do the right thing? You cannot just say, "Oh, well, this is the right thing," and then ring your

hands that nobody has come along to pay you. You went out and went toe to toe with the ministry to get what you needed.

Dr. Frank Ferris:

Oh, it was the ministry. And it was the Ontario Medical Association. We actually created some new funding codes to be able to actually pay for a physician-based services. So there was these two angles, one for paying for the physicians. And again, we grew into it, by 1999, there were 24 physicians working in the community. And at the same time, we wanted to make sure that the home-based services were well-funded as well. So we got a grant to do a model demonstration project. And that has continued.

Dr. Charles von Gunten:

But I think-

Dr. Frank Ferris:

That's very important.

Dr. Charles von Gunten:

The point you make, Connie, so I think funding, the business models being very clear about what they are and why they're that way and using them. But then you have to go to the, how are health professionals made? Physicians, nurses, pharmacists, social workers, even chaplaincy. Our training is still deeply medieval, right? It is like they are guild systems. We have apprentices, and they apprentice themselves to masters. And over years, they take on the behaviors and the attitudes and the knowledge of their masters. Well, where does all that happen? In most places in the world, it's in hospitals.

It was in the 1100s when hospitals were first formed as a convenience to physicians. If you have money in the middle ages, the doc came to you in your home, but for the convenience of physicians and for people who didn't have wealth, we formed hospitals. And the same thing is true today. The intensity, that convenience of going room, to room, to room, makes education much more efficient. But if people only train in a hospital, then taking care of somebody in the community, in their office or in their home is a strange world. And although there has been some development, it is modest in the ability to train people in the office based setting. There isn't well developed home-based teaching.

And if you don't have role models, the message to a trainee is, "Well, there is no way forward." And back, when I made home visits in my second year of internal medicine residency and was just seeing hospice patients at home, it was extraordinarily rewarding, but it is scary, because the power differential changes dramatically. You are a guest in someone else's home. And when you think about the models of, and I know best, Connie, you can speak to nursing, but I see the influence of hospital-based nursing training in home care nursing, all right, I'm going to order this and I'll give orders and that's what will happen. Well, that doesn't happen at home. Patients say, "Hell, no, I'm not doing that. I'm doing this." Or, "I think this is what's wrong."

You learning how to manage really sick patients in their homes where they're in control and their explanatory models are the ones that matter, requires a whole different skillset than what you see in the hospitals. And if funding doesn't support it, you're not going to have the strong role models, let alone being able to teach in the home. Patients love it, but getting the role models out there is going to be key, but no amount of cognitive demonstration of improved quality is going to change it until we have the funding models to provide the [inaudible 00:19:23] models and people can apprentice in people's homes.

Dr. Frank Ferris:

Well, [inaudible 00:19:27]-

Connie:

I think the other thing that I would say is, when I started the service at Mass General with Andy, we brought ... So Andy and I both come from hospice practice, right? So that grounded us in a very different way. And I don't think that happens. I mean, I think we had a lot of people doing palliative care who had that. Now you have a lot of people who don't have that. And I think the challenge was, as we brought a new physicians, they would be like, "You can't take care of that patient. That patient can't go home." And you're like, "Oh, yes, they can." I mean, half of our patients would have stayed in the ICU and you're just like, "This needs to happen."

Now, the same thing I think for, I will say for some of my hospice colleagues, and you had this too, that we had people that were saying, "We can discharge these people from the ICU. They don't need to go to the step down." And they'd be like, the hospices would be like, "No, no, no, you have to take out their central line and do whatever." Like, "No, no, they're not going to live that long. You're going to learn how to take care of her central line. We're not going to do this for your convenience."

So it is very strange of this. What you speak to is this skill set. And I would just say for nursing, we've created this insane thing that particularly now at the master's and doctoral level, you have to decide whether you're going to do acute care or primary care before you've had any experiences. And, oh, by the way, even if you're doing primary care in that, you have to have a hospital experience, but we don't make the people in the hospital have that other experience. So you're right, it's still kind of crazy.

Dr. Charles von Gunten:

Well, and the point that you made earlier about what we were able to do at San Diego Hospice to make it into really, a preeminent academic hospice, that the ability, and this is a decision at the hospice level, of who are we going to take care of and how? And Laurel Herbst who was the medical director at the time, was medical oncologist by background and strongly of the point of view that medicine is medicine and you can do it anywhere. It is an illusion that you can only do something in the ICU because the hospital's policies say that while you can only have a dobutamine drip in the ICU on a monitor, that's peripheral. What is dobutamine doing and what does it take to manage a dobutamine therapy at home?

And it turns out, you can hang it from a curtain rod and it's, as long as there's electricity in the home, and you can have a pump, okay, no big deal. And wound care and line care at home is the same as it is in the ICU. So there's, what's the illusion versus fact? But then the willingness to support that, oh, yes, hospice care includes dobutamine and other pressors at home. You can have people on ventilators at home, you can have people dialyzed at home, but that's a commitment. It has nothing to do with the medical facts. And I would say it takes very strong physician leadership in hospices, hospice agencies. And then [Jan Chetty 00:22:44] who was the CEO, who her career had been in building large programs in hospitals, took the same view to building the hospice that you need to have strong physician leadership in addition to all the other disciplines being strong. And then you have to go to size.

In a fixed funding model, which is the model in most of the world, the way you make it financially viable is you need to go to size. We ended up with 1,200 patients per day at home, which doesn't make us the largest home hospice program, but large enough that for those few patients on dobutamine, or for those few patients that are getting other pressors at home, you can afford it because you have the largest group, but it comes back to them. What are the business principles? What are the

funding models? How do you make it work? But at least it's been demonstrated that it's possible, but what you infer is it takes leadership.

Dr. Frank Ferris:

Well, I want to comment about just that, what you talked about in terms of nursing training. So, as I was doing my fellowship from 1987 to '90, I was involved with the incur and we were publishing on subcutaneous delivery of pain medications using small portable pumps in the home. Same time as Eduardo Perrera was doing that. All of our medications were delivered subcutaneously. Now, what about nursing training today? The nurses in our hospitals in Ohio don't know how to manage subcutaneous administration. We've lost this art, which is silly because it's cheap, that families can change the needles, they can change the lines. All it needed was a nursing visit once, maybe twice a week, and somebody on the phone in case they had a problem, as opposed to IV technology.

I remember when I first came and saw Charles working, and I said, "Why do we have all these pumps and lines hanging?" I never had any of that. And he said, "Well, it's a funding model, because I can't keep a patient in hospital and justify it if it's not IV. If it's sub Q, they have to go home." Well, of course the whole U.S. funding model is built around hospitalization and corporations making money. They don't make money on home care. They sure make money on hospital-based care. So there's these two realities, right? The funding model.

And I want Charles to comment about, Jan Chatty was an insightful administrator. What about the administrators we've met recently? Did they know home care? Charles, how did you get them to say, "Oh, my God, these patients are sick at home." How did you do that? When you were getting people coming to me? But tell me, [inaudible 00:25:52] you're taking the administrators out in your car to see what's going on, because the administrators don't know it. All they know is the hospital-based. So again, if we want ... I mean, where do you want to be, Connie, when you have an advanced illness? At home or in hospital?

Dr. Lynn McPherson:

Yeah.

Dr. Frank Ferris:

Where do you want [inaudible 00:26:13]? At home or in hospital?

Connie:

I want to be in a residential hospice facility. That's where I want to be.

Dr. Frank Ferris:

Well, but all your illness experience?

Connie:

There you go.

Dr. Frank Ferris:

I mean, the whole illness experience, you want to be-

Connie:

Oh, no, no, no. Of course, not. At home.

Dr. Frank Ferris:

You want to be at home mostly. Right?

Connie:

Yeah.

Dr. Frank Ferris:

So again, we all want to be at home, and isn't it, medicine is there to empower life. It's all about life. Don't we need to teach these skills and make sure people can provide the care in the setting where we all want to be? Of course, you ask every administrator where they want to be and they'll say home. Every physician, nurse, social worker, pharmacist, they all want to be at home and yet nobody's breaking the cycle.

Connie:

Yeah.

Dr. Frank Ferris:

We've been doing it for years, very successfully. And the reality is the Medicare hospice benefit is the best funding model in the world for doing this. Again, as a society, we don't take advantage of it. We sign up with a median length of stay of 10, 14, 20 days. Let's take advantage of this incredible funding model, which turns out when you match it against hospital-based care, is very cost-effective.

Dr. Lynn McPherson:

And Charles, no, I think you also speak as something, it's this very interesting part that we have no problem taking out our clinical partners to see what's going on, but just this very weird part about, well, I can't take an administrator. I can't take a researcher who might be doing your study, or I can't take these non-clinical people. It's like, yes, they sign the same form, they're not going to do clinicals. They're just observing. But it's been really interesting about the perception of bringing administrators or non-clinicians out to see that.

Dr. Charles von Gunten:

Well, the point you make, that is something inside us, our assumptions and the assumptions are wrong.

Dr. Lynn McPherson:

Right.

Dr. Charles von Gunten:

You can take anybody to somebody's home. And the experience, you learn so much when you walk through somebody's door. A word doesn't have to be spoken, already you learn volumes. Frank's getting it. Recent anecdote, a new person was hired in our system at OhioHealth to be in charge of all the new technology over the next 10 to 20 years that the institution would need to be able to purchase in order

to keep up with healthcare. And as he was making the rounds, I was on his docket. And he came to visit me. And my role there was vice president medical affairs for all of home care. And I asked him what his experience had been in healthcare.

Well, he hadn't had any, except with his two parents who lived in India, that's it. How was he going to evaluate technology? And particularly, it's clear that technology has a huge role to play in the home setting. And so I said, "Well, why don't you come visit ... Come with me, let's make home visits. And we'll go visit a patient in each branch, in the home infusion pharmacy branch, in the home health branch, in the home hospice branch, in the medical equipment branch, and we will see examples so that you'll have some vignettes in your head against which you can compare this volume of information." Well, oh, my word, his eyes got big as saucers in each of these homes. And of course, my nursing colleagues, very strategically picked which places, which people we would go meet that they defied description, but he was changed.

And then what did he do when he went back to the huge IT department in which he worked? No, of course he talked. "Oh, my God, ..." I heard from presidents and senior VPs and the CEO about all these things that he had learned. And he was telling everybody about what was going on in home care. From a few home visits, that's ... So in leadership, and I think it was what Frank was getting at, when each of us is responsible for bringing along other leaders. This, "Come with me. Come see the work," it takes effort, but the rewards are extraordinary.

Dr. Frank Ferris:

Well, and I think that there's a mindset that we have. You said it a minute ago of who's our customer? As a palliative care service, we all think our primary customer is the patient and the family. And I'm going to say wrong. Our primary customer as a palliative care consult service is the referring team. The physician who says, "Please help me with my patient." And we need to, what I'm going to say, practice consultation etiquette to actually engage that physician. And of course, the nurses often know much more than the physician knows, or that social worker on the team, engage with them, talk with them. Give them pearls of education, support them.

And that's our first customer. Of course, the patient is our second customer and their family. But the third customer that nobody ever talks about is the people who pay our salaries and our bills. The administrators. The fact that Charles was engaging with administrators was crucial for our success at OhioHealth. We arrived there in early 2013 effectively, by 2021, we've got consult services. Now in eight of the hospitals, full teams. The hospice has tripled in size. Why? Because the administrators supported it. Clinicians all wanted it, but it was making best friends with the clinicians and best friends with the administrators, and making sure people knew how to use the existing funding models.

I think another major issue is that many providers don't know how to chart properly. They write way too much. We had one of our colleagues write 1,000 word history. That's nuts. We're the consult service, we're not the managing service. It's, again, write the minimum to get the documentation past the reviewers and know how to bill U.S. time-based or complexity based billing appropriately, but people don't know how to do all this. So there's all these really administrative tasks and realities. We're all charging out to do the pain management, the nausea management, to hold the hand, to make sure they get scopolamine if they've got crackles, when they're dying, we've got that down, but we need to get this other piece down, which is about really growing our service capacity.

Because the other thing I think that happens is that be careful what you wish for, that I highlighted, the clinician, the orthopedic surgeon loved what I did so much. He said, "Please see every patient I admit to the hospital." Oh, my gosh, overwhelmed. And of course, then burnout. Right? And of course, in the face of COVID, I don't know about other services, but at OhioHealth, because we were so

loved, we were named the core responder along with critical care, the emergency room and the hospitalists. And our teams were running.

Dr. Lynn McPherson:

Yeah.

Dr. Frank Ferris:

And again-

Dr. Lynn McPherson:

So you just made your own case here. You can't retire. You guys have to keep going.

Dr. Charles von Gunten:

Two things that I would say to add to what Frank said about our time at OhioHealth. The first is, despite the massive growth and that was all paid for out of current revenue, no grants, no special investment, and we didn't lose a dime. It all paid for itself under standard fee-for-service models. Required nothing else. Okay. Now that's, I don't know what else to say and what not to say.

Dr. Frank Ferris:

Well, I was going to say is that, yes, that's true, but at the same time, you Charles were very creative at understanding the vision, the mission and the motivation of the organization at the CEO and administrative, VP level. And you also started to think about where were the tension points financially. So it wasn't just about cost shifting, as you didn't build the service based on our revenue as billers, you built the service based on what it did for OhioHealth.

And most recently, you also enticed peripheral community hospitals based on understanding they could actually have more revenue by keeping the patients at home rather than shipping them off to the tertiary care hospital for the conversation, and then they died there, two hours away from where they live, the family couldn't visit. If they just spent a half a million dollars on a consult service, they could have five, six, seven, eight million dollars of new revenue in their community. So it's thinking creatively, you're the master of this.

Dr. Charles von Gunten:

One of the things that people like to marvel at my career, but I would say that the core skill I learned as a resident. The Bob Buckman's, How to Break Bad News book, when I was an oncology fellow and I read it, changed my life. But it turns out those same skills start by asking open-ended questions, listen carefully, respond to the emotion. They work outside of patient care, they work with administrators, they work with others. And that's how you find out what they need and so that you can be targeted. So, those are key leadership skills of finding out about other people, because motivations, everybody has a story. Everybody has motivations. And the role as a leader is to harness that to what your objectives are. So everyone comes out feeling like a winner. That's how you build programs.

Dr. Frank Ferris:

Well, and that's the basis of consultation etiquette, isn't it?

Dr. Charles von Gunten:

Absolutely.

Dr. Frank Ferris:

Because the best is, it's not the palliative medicine team that advocates for more resources. It's the hospitalists who turn around to the hospital and say, "If we don't have more palliative care services, we're not going to be able to see as many patients."

Dr. Charles von Gunten:

Or oncology says, "We've got to have palliative care in our offices. In order to do the best and in order to keep our oncologists, we have to have palliative care embedded," or it's specialty pulmonary. At OhioHealth, it was the surgeons. Again, they're associated with the biggest revenue in healthcare. And when they say, "By God, we must have more palliative care here. I cannot do my specialty surgical program here without expert palliative care." And we just sit back and say, "Why? Thank you." I just love it when they get to the microphone of the big meetings. And then our challenge is we just say, "Well, then the cost to have the service that will help Dr. X build his program is this." And you've just walked through the door that the others have created for you.

Dr. Frank Ferris:

Well, and the cardiologist who wanted the LVAD program. And, of course, to be commissioned to actually do that, you have to have palliative care service.

Dr. Charles von Gunten:

Or to drive down their mortality figures.

Dr. Frank Ferris:

Right.

Dr. Charles von Gunten:

You got to have palliative care embedded in cardiology.

Dr. Frank Ferris:

So how do you think about what the system wants or what the individual physician wants to help them be successful? I'm still reminded of what CAPSI established, which is what physicians don't like is long conversations that take forever. "Frank, will you please have this conversation for me?" Sure. Happy to. Delighted. They don't like conflict, families that are angry. Yes, let me help you sort it out. And they want to be able to bill effectively for their services or even more, but we can help them, can't we? Because we can help their throughput. But at the same time, we're helping the patients and the families.

And I think the other piece of consultation etiquette is, particularly then highlighted recently, this is a very stressful patient. Isn't doctor? You must be really upset. And my experience was about 40% of my consults were not really to help the patients. They were to help the team, the doctor who was struggling. Well, we can be there for them. And of course, then you become best friends and they want you to see more patients. Well, it's all about relationships and it starts with Buckman's, let's start with inquiry. Doesn't it?

Dr. Lynn McPherson:

Yeah. It sounds to me like even though you both had spectacular, amazing careers, it sounds to me like you define your success as a series of small daily wins and not the huge ... Oh, my God, you've done so many things. Let's talk about that. Let's talk about, name the three things you were each most proud of in your career? My God, we could go on forever. Your work with the academy, and accreditation boards, and publishing, and teaching the whole world about wound care and on and on and on. So, who would like to go first?

Dr. Frank Ferris:

You first.

Dr. Charles von Gunten:

In addition to, one is establishing a generalizable model for how you organize palliative care in standard community hospitals and health systems, the one I'm most known for, of course, is driving the specialization recognition in organized medicine. But Lynn, you're absolutely right. It's the same set of skills just applied. So as I was building the program at Northwestern, I had a challenge. I was the only doc, I had a 10 bed unit and I was the attending 24/7. I had a consult service for 750 bed hospital. I was the only doctor. They were asking me to see outpatients. I was still in a clinic and I was supposed to publish and get NIH grants. And then I was also starting to be asked to speak and be on committees. Oh, my God, you got to grow.

And so I pulled together all the physicians who I knew who were hospice medical directors, who had appointments at Northwestern, I invited them for breakfast. Martha Twaddle likes to tell the story. And I said, "We are the division of palliative medicine for Northwestern University, School of Medicine. Here we are. Will you all do some service time for me? And beyond the consult service, you can keep the revenue from your billing. And there will be a specialty someday." On one hand, that sounds mad, but it was so obvious. This was the direction. And then the serendipity, most of organized medicine is based in Chicago. I was downtown Chicago. The key people were a cab ride or a 10 minute walk away. My engagement with them, how do you do this, finding out?

It's the same skillset just applied to organized medicine. And it came to pass and they would say it took 10 years. And there were many people that collaborated, of course, but they would say, the ACGME and American Board of Medical Specialties would say, "We establish the specialty in record time," but it was because of using those same palliative care skills, of communication, finding out what the driver, what the real issues are, working within the rules. And I'm deeply proud of it because not just for the practical details of accreditation and funding and fellowship programs, it has an enormous symbolic value when you are a recognized specialty. And then nursing pursued theirs. I know pharmacy has pursued specialization. Your PhD program as an example of the professionalization that comes from being recognized. Those are the things I'm proud of. How about you?

Dr. Frank Ferris:

My career started off at a very small scale in a hospital, but then I got involved in our community and the community association. And I think one of the landmark activities that we did as a group, this was Canadian based, was create the Canadian national norms for palliative care, which were published in 2002, and became a really national model of an approach to providing care, that still stands. It's been modified and tweaked a bit, but it really created a consensus of multiple healthcare organizations, the Canadian Medical Association, Canadian nursing. We can go on, the pharmacists. And the government put money behind it as a result of one voice. It was replicated in Spain. They've done something very

similar. It's been used as a model in different places. Diane Meyer took the concept to create the national consensus project here in the USA. So that was my first.

Dr. Charles von Gunten:

Well, it's good to emphasize the message you got from the government when you first started.

Dr. Frank Ferris:

Right. Which was, if you all come with different opinions and different asks, we will not fund anything. If you come with one ask and everybody agrees, I have to fund it.

Dr. Lynn McPherson:

Wow. [inaudible 00:45:42].

Dr. Frank Ferris:

So we had more than 700 and then 1,000 people participate to create this one voice product all across the country. We were very active about it. It wasn't about the same way as it happened in the U.S., which is three associations came together. This was individuals, associations, multiple players, and we created one voice. And they funded home-based palliative care, as a result, they put money behind it. It's been a voice that was very important. And it's an important message, which is, don't be split. If you are, you kids can go play in the sandbox.

Dr. Lynn McPherson:

Sure.

Dr. Frank Ferris:

But if you've got one voice, we have to pay attention to. Especially if you are speaking for many people.

Dr. Lynn McPherson:

So when you think-

Connie:

And that's about our leaders for the future though, you guys both have some important messages. So what do you think of the issues right now? And where do we need to learn from that and go for the future? Because our students are watching this. They're hearing from you about what we've done. And so would that continue to work? Are there different ways they need to go in the future? Because I think it's been interesting that people don't know the history, one. And two, the focus is different, because that was about the specialty. And now we're trying to, or if we're trying to think about inculcating it into the whole healthcare, that's like a different skillset. Right?

Dr. Frank Ferris:

Right. But then my second step, and I think it's an important model, we were invited by Linda [Manual 00:47:14] to come to the American Medical Association to review her project on Epic. We stopped it. We invested a huge amount of energy in creating a curriculum. And she had set up a model where it would be reviewed by leaders from across the country. 280 people came, arms crossed, ready to hate it,

walked away, loving it. And it had huge ripple effects. Subsequently, it's been used as the core curriculum. One model for teaching palliative care. We modified it with Epic oncology in partnership with the NCI and ASCO in 2005. And I'm currently doing the next generation, which is the palliative care interdisciplinary curriculum. It needs to be online, open access, available to everybody.

And part of what I'm doing is now in the process of beginning, translating it into 10 other languages, because on a global scale, and you know one of my big impacts has been teaching internationally, there are curricula in English, there are curricula in Spanish. There are very few curricula in these other languages. And if we really want to access the global perspective of palliative care, we need one curriculum which really teaches the concepts. We don't need people doing their own curriculum. It's huge amount of effort. It's a huge amount of work. Take what we've created as a group centrally. And this has had the input of hundreds of people to create what we're doing now. And we'll continue to do that. Make it open so people can adapt it to their personal perspective, but you don't have to reinvent it.

So I think it's that working together, it's the creating consensus is a really important step. And then how as another step, do we engage organizations? Charles and I have both spent more than 20 years working with the American Society of Clinical Oncology. We published papers with them. We've had many initiatives. ASCO is now completely behind the concept. I'm the past chair of the education council. Imagine a palliative care doctor having oversight to be chair of all that ASCO does. That's fun, but I would have never dreamt of this 20 years ago. And ASCO is now teaching internationally and courses. They're proud of palliative care, the same as they're proud of their breast cancer work of others, integrate with the tribes. It's a very important message.

One of the key features that I got to do as well as work with Open Society Foundations, Kathy Foley and Mary Callaway. And again, how do we find financial partners to help us with creative edges? Robert Wood Johnson Foundation was early in this. Then Open Society Foundations. Every foundation will get out of this. But how do we find partners who can be philanthropy to support us, but then how do we integrate right into organize medicine, either in our country or other countries? It's back to this administrative piece. You've got to recognize who your customers are.

Dr. Lynn McPherson:

Absolutely.

Dr. Frank Ferris:

Oh, there's the clinical developments. How do we make sure we've all got leadership skills because physicians don't have that. I think another one of my proudest activities was working with Kathy Foley, Mary Callaway to create the leadership development initiative. There's now a parallel initiative subsequently called [inaudible 00:51:13] in Europe. We need leadership skills. It's not enough to just be a doctor, to be a nurse, to be a pharmacist, to be a counselor. We need to lead. This is the tsunami wave of the next generation of modern medicine. It's not only integrating the best of disease management. It's the best of the experience for the patient and family in the setting in which they want it.

Dr. Lynn McPherson:

Wow. That sounds like a note to end on. What do you think, Connie? [inaudible 00:51:44]-

Connie:

Charles, do you have any other thoughts for that? You [inaudible 00:51:48].

Dr. Charles von Gunten:

Keying off of your advocacy, what is the way forward? What are the work of those who are now training, who are going to lead this field forward when Frank and I are long dead? But to me, the four big innovations that have come out of the last 20 years, the first is that people live longer. It turns out, yes, there's death measure, people live longer building on that, developing it. It's a key unexpected outcome of all the work that's been done.

Dr. Frank Ferris:

And you're saying they live longer because of what we do in palliative medicine?

Dr. Charles von Gunten:

Yeah. It's not because the other drugs work better. The second is that when this is integrated in hospitals and health systems, keep their patients, you stop the leakage. One of the biggest things on the mind of every health system is making sure their patients stay with them and don't go somewhere else. Palliative care clearly plays a role there. It also plays a role in lower turnover of the other professionals, the docs, the nurses, because palliative care is there. That's a huge financial savings when you can keep retention of your staff because of specialist palliative care.

And then if you can take care of more sick patients well at lower cost, so you've got high quality, low cost, that is the value equation, and we deliver on it. That also means you avoid the opportunity costs of building more beds and building more capacity because you take care of people better. These were all unexpected discoveries in the last 20 years. To me, this is the bedrock for the future research initiatives, the dissemination science, the implementation science has got to come out of this. And lastly, I would say that medicine, healthcare is industrializing. The quality imperative that you decrease variation in order to improve quality, well, where does palliative care fit into that as a response to industrialization? What if what we do must be the same, and yet patients and families are looking for deeply personal connections, particularly related to when they have serious illnesses.

When I have my colonoscopy, I do not care that I'm treated like a bag of potatoes when tossed around, nobody knows my name, nobody knows my background. I want them to do it well and I can be out. An industrial model works for that. And advanced serious illness, the industrial model doesn't work so well. That's why people leak out of their systems. That's why there's ... So what role do we play? What skills do others need to have versus the role that specialist palliative care plays in the industrial model that clearly delivers it? These to me are the leading edges of the research questions that should be moving us forward into the next 20 years.

Dr. Frank Ferris:

Well, and to me, it's not only about the industrial model in the institution, but it's the ripple effect for the funder, and how do we help them cope with the fact that there's going to be a huge number of us needing care? These same principles apply. We need to, again, recognize who all these different customers are for us. Use the inquiry technique and help them find ways that they believe they invented. Just new to them though.

Dr. Charles von Gunten:

Yeah. That could change the world if you don't want credit.

Dr. Lynn McPherson:

But that's quite a reservoir now.

Dr. Charles von Gunten:

Doesn't matter. We want to make sure this is out there.

Dr. Lynn McPherson:

But you created this incredible demand and we can't keep up with the supply.

Dr. Charles von Gunten:

Well, when there is something that is in short supply, what you pay for it goes up. We noticed this in Ohio. The salaries that we pay everybody have more than doubled in 10 years in order to keep up with the supply and demand problem. There's nothing wrong with there being a demand. And then the cost of that and what you pay people in order to attract them to feel it goes up. The business model still supports the implementation, but it's being engaged in that. I utterly reject the notion that, "Oh, we'll never have enough specialists. We have to teach everybody to do it themselves." I think that is crazy. We have to be clear that there is this need and what specialists bring, and then let the market do its work. And if there are fewer dermatologists and more palliate tours in the world, fine.

Dr. Lynn McPherson:

There you go. I think the thing I'll take away most from knowing both of you for such a long time, it's such a human thing. When I was at the San Diego Hospice, Dr. Von Gunten, we were rounding one day and I remember you were wrapping up with a patient and you stood up and said, "What other questions do you have for me?" Instead of saying, "Do you have any questions?" And that was so impactful on me. That just warmed my heart. And Dr. Ferris, I remember we were talking about bowel regimens one day and you looked at the dietician and said, "I think you should whip up a batch of you all come up pace for tomorrow for us all the taste tests." So, it was so much fun. And I have so much respect for both of you. And Connie, any last comments or-

Connie:

No, I think this has been great. I think just also of hearing how the two of you were thinking and moving forward, because I do think that we've talked to some people and if you think about where we were in this country first about starting hospice, then the Medicare benefit, then getting palliative care programs started. And so there was this very much acceptance and getting the clinicals pieces down. I think of moving forward, I think where you've said is this expertise. And I think we have a whole different generation with different values, and it's going to be really interesting to see what they take.

And then to the point that Lynn was saying is that I think we will still work on the clinical part. We have a good foundation of that, but moving into this business part about what is reimbursement, but also working in this technology, because I think that's one place we haven't gone. And we'll have millennials and Gen Zers who we're going to think about how do they want to communicate? Because I think you would probably agree with me that this generation, the way that we've done palliative care in-person is also a generational part of face-to-face. We have a whole next generation that that is not how they communicate. And so it's going to be really interesting just to see what they take and how they move it forward. So you all have given them some good principles of where we've come and where we need to go to, and it'll just be fascinating and how it continues to move forward.

Dr. Lynn McPherson:
Yes. Gentlemen, thank you.

Dr. Frank Ferris:
We will be very interested to watch from the sidelines.

Dr. Lynn McPherson:
Absolutely.

Dr. Frank Ferris:
As we said at our mountain chat. Shall we?

Dr. Lynn McPherson:
Thank you for your amazing careers and thank you for your time with us today. We appreciate it.

Dr. Charles von Gunten:
For inviting us to participate.

Dr. Frank Ferris:
Such a delight to be with you. Thank you so much.

Dr. Lynn McPherson:
I'd like to thank our guests today and Connie Dahlin for the continuing journey in our podcast series titled, Founders, Leaders, and Futurists in Palliative Care. I'd also like to thank you for listening to the Palliative Care Chat Podcast. This is Dr. Lynn McPherson, and this presentation is copyright 2021 University of Maryland. For more information on our completely online master of science, PhD, and graduate certificate program in palliative care, or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.