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.

Connie Dahlin:

Welcome everyone. We are so pleased that you're joining us for another of the University of Maryland's PhD program's podcasts, where we're really looking at the whole field of hospice and palliative care. My name's Connie Dahlin, and as you know, I'm one of your faculty for the PhD program, and I'm joined by Dr. Lynn McPherson, who is the Director of the Palliative Care program at the University of Maryland. We are very thrilled today to be joined by Dr. Inge Corless, and I have had the pleasure of knowing Dr. Corless for many years.

She is a Professor of Nursing at the MGH Institute of Health Professions, but she's had a long history, and when we've talked about people coming into the field from different ways, Dr. Corless has done so much work in HIV and AIDS, and looking at grief and bereavement. She's been one of the founding members of the International Work Group on death and grief and bereavement. She has been working, really, as an international expert in hospice and palliative care, internationally, as well as really looking at nursing research in terms of thinking about how to care for people who are HIV infected.

She's had numerous awards in terms of being inducted into the International Nurse Researcher Hall of Fame and Sigma Beta Tau International, she's a member of the American Academy of Nursing. And she's also been a President of the Association of Nurses in AIDS Care. So there's just sort of a wealth of knowledge that we are so thrilled to bring that perspective of, again, our birth to where we are now. So welcome.

Dr. Inge Corless:

Thank you so much. I'm so pleased, I'm delighted about what you're doing at the University of Maryland. Kudos.

Dr. Lynn McPherson:

Thank you.

Connie Dahlin:

Thank you. So, Dr. Corless, I gave them a very short version of really all your accomplishments and I know that you have really influenced so many people, and particularly a lot of nurses, in care. But, talk to us a little bit about your getting involved in hospice and palliative care, and your sort of passion around it.

Dr. Inge Corless:

Perhaps unlike many people, I had experienced death and dying in my own family. My mother was very ill when I was in my early teens, and I was the one who was assigned to providing her with her medication and it was injections. And I was taught how to do injections, and I would do them, I think I did them every other day. We had a system where I did it every other day. We had somebody from the outside come in to do it on a daily basis. I think that's what made me curious about it. I don't know what prompted me, when I was at the University of Michigan, to begin to study hospice programs in the United States. I did write to all the different programs and look at what was happening, and how it was developing, and what the components were.

I think there may have been some, I'm trying to think whose lectures I might've gone to that made me curious about what it was that was going on, but I decided I wanted to get a broader perspective of what was going on. And I also went to a meeting, I'm trying to think who it was. Oh, I'm blocking on her name, I'll think of her name afterwards I'm sure, who was doing a lot of work on death and dying, and talking about a lot of work in death and dying, but not doing hospice programs per se. Excuse me?

Connie Dahlin:

No, go ahead.

Dr. Inge Corless:

I heard some background noise, I didn't know if you wanted to interject something. But, back in, would you believe 1978 was when I conducted that study. And in 1979, I was invited to a meeting of the International Work Group on Death, Dying and Bereavement, in Canada, as a matter of fact. And after you go to a meeting and people decide whether you would become a valuable member, and I think it was the same year that Steve Connor was also there for the first time, we discovered that, and I was inducted into IWG.

That same year, I had met a physician who was interested in developing a hospice program in Albany, New York, at St. Peter's Hospital, it became St. Peter's Hospice. And what I liked about it was that it was not only inpatient care, it was also home care. And so we were seeing people in their own home settings, which is important for those people who are able to manage that, and have the family and support necessary to manage that. And we also had the home care, and we had bereavement care, so we did some work after, with the family, after the patient had died.

I also agreed, at that time, to participate in a study which was being done by Brown University. And it was a study, they were looking at these new hospice programs, and it was Vince Moore who did that study. And they knew I was a PhD from Brown, somehow they worked that out, and how could I say no? And so, we were one of the programs that, we were a control for the programs they were looking at.

And then while I was at Michigan, where I did the study, I also went to meetings of the nascent state nurses, state hospice association. I've so accustomed to saying nurses, but it was a state hospice association. And saw what they were doing and was very impressed with what they were doing. So when I moved to New York to be the Hospice Program Director, I got involved in the New York State Hospice Association, which was really just starting. So I was able to provide, they were very interested in what I had learned at Michigan and what they were doing, and so became involved right away with the New York State Hospice Association.

And I was active in attending meetings in Washington DC, when we were getting to the point of doing the hospice legislation. But that was a little bit later, but it was interesting, and I reviewed, the research background is really very, very helpful because you learn how to read things in a different way than you might have read them before you had that background. This may be a plug for your program, but it's really for doctoral study.

I could see where the problems would be because they were very, very clear, it became very clear that what they wanted to do was to make sure that if you got payment for a hospice program, you can't get payment for anything else. You could get payment if you fractured your knee, if there was a fall and you fractured your knee, but was not associated with hospice care, it was independent of that, you might get reimbursement, but otherwise there would be no reimbursement. You had to choose one or the other, and you had to forego your regular payments of insurance if you chose hospice. So I saw that immediately as a problem, not for the government, for the individual.

Connie Dahlin:

And I think that's important for people to understand, because I think we talk about how novel it was, considering that it happened in the Reagan era, and that when you thought about a per diem, per rate, that was a novel thing. I think what people have looked about, this is a great service, but I think you're really the first person to articulate this financial part where the government was sort of saying, okay, if you're going to say you want this, then that's all you get. You don't get to have that, so it's no mixing, you have one or the other.

I think sometimes we have continued to have the discussion since we're the only country that has done that, and what that has meant about hospice development here, and thinking about death and dying, is it a good thing or a bad thing? Because I think sometimes other countries just think we're crazy because we have such a delineation, but yet we have to, because of our insurance, whereas in other countries, there's this real sliding of palliative care and hospice and that. So I don't know if you have other comments or thoughts about that?

Dr. Inge Corless:

What my thoughts are, when you were speaking was, to think about, okay, what are we doing in terms of how I'm jumping to palliative care, and the way we're now defining palliative care. The term palliative care started with Bal Mount, in Montreal, and he used that term because hospice somehow didn't translate well into French. This is Montreal, Quebec, and everyone spoke French, and [inaudible 00:11:19] for me, but anyway, most people spoke English in the hospice as well.

Connie Dahlin:

So when you, I mean, but when you think about that and you think about then the development of palliative care, what are your thoughts about... Did you think that then that was naturally going to happen because people were having to make this difficult choice, and people don't like to. In American culture, people like to always have all the choices. They don't want to have one delineated for them.

Dr. Inge Corless:

Well, I just reviewed a paper for a journal, and I had to ask, they use the term palliative care, and I had to ask in the review, how are you using this term? Are you using it as an alternate term for hospice? Or are you using it in terms of palliative care is something we provide all the way along when there's a serious life threatening illness? My glasses keep sliding, you use a mask and all that, everything gets sort of slider. Yeah, it isn't clear how we're doing it, I'm not sure how palliative care is being paid for. Is it a palliative care with a small p or is it palliative care with a capital P? The capital P being you open it to hospice, and the small p being, there's sort of symptom management that we've always wanted to provide, but really looking more globally at the individual, all of the psychosocial issues, and some of the family issues.

Connie Dahlin:

Well, and I think, knowing the work that you've done in HIV, I mean, I think you bring up a great point, of the little p that people say, "Well, this is palliative chemotherapy." Or I was thinking the other day of, with AIDS care, it was so hard for hospices because the medications were more expensive and you had hospices deciding which medications were palliative or not, which, having taken care of some of these patients, which I know you have, at that point, the way that HIV was, like these were really sick people and they had a lot of symptoms. And there's people who had no experience with HIV deciding which of those medications were small p and which were big P. I think about it now, and I'm thinking, that was just insane.

I mean, if we had somebody like Dr. Fauci telling us that, that would be a whole different thing, but I think that was probably, in my mind, one of the first times of not only the HIV crisis, but a crisis for hospices, because if they were going to say anybody with a terminal illness, here they get this group of people who are really sick and, oh, by the way, they're younger, and oh, by the way, they have a lot of medications, but then you're going to say, oh, well, no, no, no, we're not going to do it for that group, so it set up a very interesting dynamic.

Dr. Inge Corless:

I want to be sure to mention, again, Bel Mount, because he's been an incredible figure. He's a physician, and an incredible figure in early hospice that I want people to know about. I had the opportunity, as did others, you have to apply, but I had the opportunity to spend a month in Quebec at the Royal Vic, and it was a wonderful, wonderful experience. I was looking at what they were doing in terms of care and their administrative process. They were very interested in what I was going to be doing in terms of home care at St. Peter's. So it was really a wonderful experience. I think, I hope, all around, but Bal Mount, by having that internship program, that was very, very helpful. I mean, Cicely Saunders, who needs to be mentioned as well, I'm sure that others have mentioned her, just a very impressive woman, her situation at the St. Christopher's Hospice was just amazing, amazing, to say the least.

I mean, she knew every, well, everyone knew her, and she knew a lot of the people who were involved in hospice because she was also a member of the International Work Group on Death, Dying and Bereavement. So being part of different organizations was important. The other person I want to be sure to mention is Florence Wald. I don't know whether anyone else has mentioned her before, but she was Dean at the Yale School of Nursing, and really was one of the founders, as well, of hospice in the US, she founded the Connecticut hospice, in what was close to New Haven. Anyway, and one of the first inpatient hospices, when it was built, it was really very impressive to see what she was trying to do, because she was trying to make sure that everyone had an opportunity to be outside.

At St. Peter's Hospice, we were up on sixth, seventh floor. It was very hard to be outside. You could sort of see through the windows, and we did some things with windows, but also protection with the windows, meaning you don't want someone to suddenly go out the window, or fall out the window, or something like that, that's what I meant by protection. But her hospice was on the ground, and so people could go outside into a little patio right outside their door of their hospice room, which I thought was really very, very creative in terms of the architecture that was done there.

Connie Dahlin:

And she also had a, so that was one of my assignments, so actually, Dr. Corless and I had a colleague, Dr. Sylvia Drake-Paige, who taught a death grief course that I had to take in school, and so I had a year long hospice. And we were required to go to see Connecticut Hospice in Bradford, and I just remember that the beauty of it was that not only were they able to go outside, but there was a children's center underneath because they wanted people to hear the circle of life, and to hear these children playing in terms of being like that. And so I think you're right, these people who are thinking not only of the physical care, but this whole, the circle of life and sort of thinking, "Yep, you may be really sick, and there's still joy in the world."

Dr. Inge Corless:

And Florence's husband, Henry, was also very, very involved with that, and also so supportive of Florence. So it was really the two of them working on it, but certainly led by Florence, who also later looked at issues in terms of being incarcerated, and did a lot of work on that, which was impressive.

Dr. Lynn McPherson:

And, Dr. Corless, that's sort of interesting because I know that Dr. Wald did a lot of work on that, I know that Dr. Kubler-Ross was sort of thinking about children and some of that, and it sort of felt like that got done. And then that population kind of got marginalized again, there was the Angola project, and it sort of feels like it's kind of starting to have some attention again, but that's an interesting kind of sociological piece about what happened in the intervening years. Did people decide this wasn't important or in the scheme of things? I don't know.

Dr. Inge Corless:

Well, Kubler-Ross ended up moving around a bit, in terms of her where she was located, she was in the South, and then she was in the West. I saw her in, she was living in a trailer in the West when I visited her. We had met earlier, saw each other occasionally on meetings. She was the person who led that meeting back in 79 that I attended, that I was very impressed with what she was doing. And that's where I met Michael Murphy, the physician who was also interested and invited me to join him, in Troy, New York, at St. Peter's.

Connie Dahlin:

Well, it sounds like, I mean, when you think about who you mentoring and guidance from, you were having this guidance from the stars. These were the people who were really in the middle, the movers and the shakers. And I mean, I have to believe that it was really exciting to be in meetings just where people were thinking, and trying to put this together, and what does conceptually need, but then what do you do when you are actually going to try to translate it into practice and what is excellent care?

Dr. Inge Corless:

Another person I should mention, I'm not name dropping.

Connie Dahlin:

No, no, this is really helpful for our students to know, we're going to be having them read about these, so I want to say to our students who are watching this, this is what you're reading about. This is really history in the making of somebody who's been part of it, which is just really a thrill.

Dr. Inge Corless:

Mary Vishan, who gave a lecture when I was on faculty at the University of Michigan. Mind you, I left Michigan to start, it was a choice of stay at Michigan or start the hospice program. So I decided to start to work on developing the hospice program, because instead of just writing about it, I wanted to do it. But I heard Mary Vishan and we clicked right away, and she was the one who told me about more about

Bal Mount and the program there, and supported my going there for a month to see first hand what it was they were doing. And she is still active in her own practice now in counseling, she's been very, very impressive and her name should have come up. If it hasn't, she's been very impressive over the years, and I think just a major influence, certainly in the early days. And then, as I said, she is continuing her practice, a psychosocial practice.

Connie Dahlin:

She really, for the students watching, she really also has been focused on caring, particularly for nurses, caring for themselves, that this is emotional work, and that you can't be effective unless you take care of yourself. So, really early about wellbeing and resiliency, and I think the other part about, in my mind particularly, because I think sometimes people are drawn to hospice are people who have had experiences and that can help their practice. I also think there's people who've come to it trying to work out their own things. So she was really good about sort of saying, you need to kind of be aware of yourself because it's not for the patient to heal you, you need to heal yourself, but you need to be aware about the environment that you're going to be working in. So when you think of [crosstalk 00:23:39], go ahead.

Dr. Inge Corless:

She was one of the early ones to talk about that.

Connie Dahlin:

Right. Yeah. So when you sort of think about, so we've kind of passed through, and then we had the AIDS crisis, and you started doing all that work, were there things that you felt like you'd learned early on that you could bring to that work to make it richer? Or were you sort of feeling like this is a population that is so important for us, that's going to kind of be an indicator for how we're going to be able to move forward with non-cancer diagnoses?

Dr. Inge Corless:

Actually, when I started doing the work and it was research that I was doing when I was doing a post-doc at University of California, San Francisco. And I had done work with Dolores Krieger, I don't know if that name is familiar to you, but it is, you're shaking your head.

Connie Dahlin:

I am, but I might've because of where my studies have been. Dr. McPherson may not know who that is, and our students may not know, so please give an explanation.

Dr. Inge Corless:

Well, she was one of the people who really originated, I think, therapeutic touch. Therapeutic touch is something you do, you don't actually touch the individual. We feel that we extend in some ways beyond our body in terms of the energy that's beyond our body. And I was looking at a lot of information on relaxation and then did the courses, both with her, I went through all the different courses, two or three courses we had to take to complete our training in therapeutic touch. And she and I communicated for a period of time afterwards. But I wanted to use it, at the time I was at UCSF, we didn't yet have any treatment for AIDS, so that gives you an idea of how long ago that was. We had no treatment at all, and

I thought, well, if it's the immune system, what can we do to quiet the immune system? How can we just sort of try to bring it down a little bit?

And I thought about relaxation therapy and therapeutic touch, and so developed an intervention that I used with these individuals. And I actually did the research and reported it at the third meeting of the International AIDS Conference, where I saw, Anthony Fauci.

Connie Dahlin:

Oh my gosh.

Dr. Inge Corless:

At the time he was carrying a little baby boy in his arms, and I have subsequently seen him, and he said that little baby boy is grown up now, after all the years that have passed since then, in terms of the work we've done. It was wonderful. I also developed audio tapes, and subsequently video tapes, on relaxation and thinking about it for other situations, such as, bone marrow transplants at the time were really isolated into a room and everyone spent so much time alone. And I thought, well, how can we use that to empower people to where they have a role and they're not just sitting back, they have a role in their own well-being.

And so I had proposed that for a study on bone marrow transplants, but back to HIV, as I said, I developed a tape that they could play in the morning, in the evening, or more if they prefer, a relaxation tape to help them, that they could use at home, and in between the times they came to see me in the office. And one of the things that I had them do was draw a picture of themselves. And everyone would say, as I would say as well, I don't know how to draw, but drawing the picture, I then asked the individual to tell me about their picture. And telling me about their picture is telling me about what's going on in their lives, which is what I wanted to get a sense of, because it's easier to talk about that person in the picture then perhaps talk about themselves.

So it's something, I mention it now because I think it's a very good modality, and I've never discarded those pictures. I may do something with them yet, because I think they were really very, very special, obviously without the names, but I think it's just a very special way of examining what's going on because you have a whole series of pictures of how the person is feeling. [crosstalk 00:29:01] words, but it's not the same.

Connie Dahlin:

Right, no, I mean, I think that's kind of beautiful and in some ways it's for anybody, for family members, it would also be an interesting part of them having that piece of that. So when you think about where we, I mean, and you've continued to teach at the Institute for the last 20 years or so, and have had a multitude of students. For those people who don't know, the MGH Institute started off with, part of MGH as diploma nursing, and then it moved, but it was one of the first progressive programs in the United States that did entry level as a Master's to Nursing, and then expanded to have a lot more disciplines. And so you've taught physical therapists, you've taught nurses, you've taught PAs, you've taught speech and language pathologists, occupational therapists. So, I have to believe that that makes you feel hopeful for the future in that you've been able to impart this knowledge about hospice and palliative care, but what are some of the messages that you feel like your students need to know now?

Dr. Inge Corless:

When I was thinking about it this morning, it occurred to me, I don't think we ever anticipated the pandemic. Even Ebola was over there, wasn't here. The pandemic now, is very much here, and there's so much work that needs to be done. I don't think we've really, yet, done anything about all the people who have lost loved ones because of the pandemic. All the deaths that have occurred because of this pandemic, we see the numbers, but they're just numbers. These are people, every one of those ciphers is a person who has a family, who was cared for by one or more people, cared about one or more people. What about big grieving process? What are they taking with them? What sort of support have we provided?

One of the things that I'm still running, something called the Hope Nursing Conference. I do that once a month, I'm the moderator. And I brought in a woman who is key in Ireland to developing, what they have an Ireland is, whenever anyone dies, they do an estimate of how much grief and support they may require. They take a look at the situation and do an estimate of how much bereavement support they may require. If this is a death that was anticipated, if this is a person who is well into their seniority, I'm not defining what seniority is anymore, but well into their seniority, has lived the life they've wanted to live, there may be less need for support than there is for someone where it's a death through violence, a death unanticipated, a death for a younger person with COVID.

All of these things might make a difference in terms of the needs for grieving. And what they're doing in Ireland is assessing that. In Canada, they're also looking at that, how can they do that for Canada? Ireland is a little bit more self-contained in terms of the population, but how do you do that in a major country like Canada? And then looking at that, Susan Cadell and Mary Ellen McDonald are looking at that in Canada. I don't think it's anything we have discussed yet, and I wonder whether any of your participants for these podcasts have mentioned that to you.

Connie Dahlin:

No, they haven't, but I think that that's also really important for us to. We know that our students are going to be thinking about different areas. I think what you're speaking to is, I think sometimes we think about pain and symptom management, but I think you're really speaking to this loss, grief and bereavement, not only in how to identify people, so thinking about the assessment piece that you're talking about. But I think the other part is, and I know that we've had conversations before, this recognition by some of our population, but not by all. The United States doesn't like to look at grief and bereavement as a psychological issue, and yet we know when we're looking at people's health care that a lot of people's health issues are based in a lot of grief and bereavement, but they cannot address. And so they cannot address it that way, then it actually manifests itself in a physical realm.

And we have yet to address that in this country, of really looking at, prior to the pandemic, what loss, grief and bereavement does, and the financial implications, sometimes as you know, that gets attention when we put dollars to it. I don't like that, but, the reality of it. And then, so what is this going to do? And I think people are so anxious to go back to normal, but I think all of us in this, right now, on this call would say, we're not going back to a normal. That normal is gone. So whatever we're coming to, we don't know what it is. And I think people are anxious about that, how do we even measure that? Because I thinking that your comment about when it looks like there's a, I can't remember the saying, but when it's a statistic like that and the number goes up, it depersonalizes it. And yet every one of those was, what you're saying, an individual experience. And I think that's really important for us to remember.

Dr. Inge Corless:

And some of the TV programs, CNN for a while, would make that more palpable by showing someone, talking about someone who had died, about that person who had died, so that it wasn't just a number. These are individuals with family members and friends who care, and who have experienced the loss of that person in their lives in a very palpable way. Although that person will always be in their lives, just as people that we've known who have died. Florence Wald always be in my life. She was just a remarkable woman, who actually came up here and she and Cecily Saunders, when I was living over in my other, came to my apartment, and we had just a small gathering there when Cecily was in Boston. So it was just a remarkable time.

And then what we've lost during this pandemic, being together in those sorts of ways. Well, a lot of people think about traveling, I think about traveling, but it's all a very different environment that we have now. And you're right to think about what it's going to be like in the future, and what is it going to mean to provide palliative care and be aware of, as we have in the past, with our rituals, various rituals, that there is a grieving period, things that we haven't been able to do. But I'm trying to think of, I was speaking of something else, I should have written it down, when you were speaking, but it provoked some other thoughts of what's going on and how we are going to be able to provide the sort of care.

Oh yes, I do. One of the things I want to be sure that the students understand is, it's not all giving on your part when you're involved in this. I received a lot of gifts. I don't mean that tangible gifts, I mean the gifts of people sharing with me. One gentleman, he had spent time in the Antarctic and he had his wife bring in pictures for me to see of him and his time in the Antarctic. That was a gift. I mean, they weren't for me to keep, he wanted to show me the pictures. But the fact that he did that was a gift.

There were other gifts, a woman who I was a consult for and came in to see her, and she said, "You look tired, you need to get more sleep." I thought that was just... What a gift. She was letting me know, she was a wonderful woman whom I enjoyed thoroughly, seeing her and trying to be helpful to her. But it's a reciprocal process, our patients and their families give us gifts as well. I have many more examples.

Oh, I have to tell you, one of my people I saw at, I was at Mass General, and I would go around, and I would do my rounds earlier in the morning, and he teased me about the fact that I was always there before breakfast with him. And it was just having some fun with me, he was a younger person who was seriously, seriously ill, and then he died during that hospitalization. But the fact that we could have some fun together, that he could tease me, and I could indicate that I enjoyed the teasing and the humor. That's so important, just being there, that's a part of being human, and we need to remember our humanity as we do this.

Connie Dahlin:

Sorry, I think of just all the different experiences and things that you've had with all the different people. I wonder what you think about, when you look over, you were there before the benefit, that's sort of the evolution process, the benefit, AIDS care, kind of think about this international work, where we are now. What are some of the things that you think that a PhD student who's going to be a leader by doing the PhD, but also as an interest, what are some of the things that they need to remember, or take with them as they step into the next role, that you feel like we didn't either get right, or you need to hold on to this?

Dr. Inge Corless:

Do the research.

Connie Dahlin:

Yeah.

Dr. Inge Corless:

Do the research, get the data. Unless you're someone who is well-known and has a reputation already, like Dr. Fauci, he can just speak. But the rest of us need to show what's the data, what have we found that supports what it is? And it may be data that somebody else has done, but be sure that it's fairly recent, depending upon what you're arguing. I'm surrounded by all sorts of articles that I've written on just a variety of subjects, but they all come back to death and dying and loss, and life and living. My most recent work, where now we're waiting to hear from the publisher on a paper on caring, I'm very interested in caring and what that means, and that is so central, to listen and provide care.

Connie Dahlin:

That's also timely because the American Nurses Association just updated their scope and standards, and their definition, and they have been very deliberate about putting caring in it, and then this whole advocacy piece. So I think that's fascinating.

Dr. Inge Corless:

Absolutely. We're the voice, you're so right. Advocacy is so important so that our patients and our families get what they need. The other thing I think is important is treating people as persons. I got that, I wrote something up, I think it will be published in the state newsletter. But I think treating people as persons, we just recently had a salute to nurses, and in that salute to nurses, I was really curious to see who was writing and what were they saying? So I've now collected the data on what was there, I'm just using what's in the newspaper on the salute nurses.

And I'm just using the ones right now that patients have written, and what is it that they find valuable? Is it what we do in terms of actions? Like making them comfortable in their bed? Or, one person wrote about the fact that the nurse always got the context that this person needed to be able to go forward in terms of their care. But is it the activity? Or is it something about the individual themselves? There's always interesting questions to ask, and we talk about nursing, and I would always think about it, it is what we do, but I think it's also how we do it, that makes a difference.

Connie Dahlin:

Which I think is for all of the disciplines. I mean, we all can have a task part, but if we just do tasks, we could be a robot, and so it is the personality behind the action.

Dr. Inge Corless:

And how we do it, it's how we interact with a person. How we help them prepare for discharge, how we answer their questions when they're concerned about what they need to do, rather than just doing it. What I'm concerned about in nursing is that we're just running around, we have all these tasks that we have to do, and I understand that they have to be done, but it's still how we do them, and how we interact with our patients.

I had a relative who was in the hospital, and who was given a nice warm breakfast after having been in overnight, and five different professionals came in, did what they had to do, which interrupted her from eating her breakfast, and by the time they were finished, the breakfast was cold. And I thought, what's wrong with this picture? We are looking at our time, and not the patient's time and what they need for themselves. And having a good breakfast, we all would urge that, nutritionist among us, most of all, and yet, we organize our time in ways that meets our needs, but not necessarily the patient's needs. So I would like people to be more concerned about that.

Connie Dahlin:

I think that's been a theme that I think a lot of, because I think that when you look back at the sixties and seventies, where we moved care to the hospital, it was for our convenience. And I still maintain that when it's easy for us, it means it's hard for the patient, that we don't have more evening hours, that we don't do more weekends, because that's when the crises happen, right? And the families in having to take over, and so it's been interesting because I think people say that's wrong. But if you think about a changing society, people, this nine to five, or seven to three, is this artificial thing that we did based on the workings of a hospital. So you have pharmacists, PT, everybody, you have a shift from seven to three, whatever, that's kind of taking from factory work, where that was the time shift, and thinking about that.

So I think you're right about how do we teach that? And I think that's my thought about, when you have this intergenerational part, those of us who are older in practice, we had to learn communication skills before we learned the tasks. But now, we have this younger population that has grown up with technology, which is great, and they're very good at it. I think the flip side is sometimes their comfort with the face-to-face communication, which is what you need in health care. You can do some telehealth, and I think that that's a really added benefit, but it's still meaning you're communicating with somebody and not just texting. That's a scarier process for them.

I remember when I used to have students that I would mentor, or precept from the Institute, I did the bio behavior principles class, and I would have groups of students. At first when they got assigned to me as palliative care, they would always say, "I'm in the wrong practicum." And I'm like, "No, no, you're in the right place, don't worry. We're going to focus on communication." But my whole point was to have them go interview patients together because they would say, "Oh my gosh, I'm going to die." I'm like, "No, I actually know what dying looks like. You're not going to die interviewing a patient. But you do need to go in there and learn this art, if you will, of understanding their story."

And I think for some people, for our younger generation, that connection is the one that is harder for them. They can do all the technology and do all the other stuff, but that personal part is just a different skill that they're not taught, even going through high school and all of that. Everything is done group work, doodle that you don't have to have a meeting about.

Dr. Inge Corless:

You should be asking, what are my needs, but most importantly, when we're with patients, what are my patient's needs?

Connie Dahlin:

Right.

Dr. Inge Corless:

I'm not saying that we shouldn't pay attention to needs to get things done, needs for rest and relaxation, or any of that, for the caregiver. It's clearly very, very important. But when we're with a patient, what are their needs? And how do we structure things so their needs are met?

Dr. Lynn McPherson:

When you think about, so going forward in the future-

Dr. Inge Corless:

I hate to do this to you, may I just?

Dr. Lynn McPherson:

Sure.

Connie Dahlin:

So I know we've had a lovely time with you, Dr. Corless. As our last question to you, I just wonder, since these are PhD students, you've said research and data, are there any other areas that you think, right now, are needed for them to focus on for research?

Dr. Inge Corless:

I think I've mentioned the aftermath of the pandemic.

Connie Dahlin:

Right.

Dr. Inge Corless:

And that aftermath is not just in the United States. What's the aftermath in other countries? What's the difference between our having a vaccine that some people want and some people don't, and in some countries without a vaccine, what difference has that made? For a while we thought there was less death in some countries in Africa. Why is that the case? What is it about that environment that may have led to less death? Is there undiagnosed illness that we're not even accounting for?

As you can see, my questions have no boundaries in terms of, I don't say this is what a pharmacist does, or this is what a physician does, or what a nurse does, in terms of asking questions. Questions are questions, and we should follow them and make sure we have, on our team, people with the expertise that we don't have. I've just developed a new team for this study we're doing on HIV and COVID, and I'm so delighted that my co-investigator said yes, and she has skills I don't have, which is terrific. It'll make for a far better study.

So the questions you're asking, to look into the future, I think, be flexible. Caring for patients hasn't changed, except I do remember in one place, not in the United States, where someone was able to smoke some marijuana with someone who was dying, who then, not died right that moment, but in the days that came. I mean, being open to doing things in different ways, being open to learning from other countries. Why is it that there have been fewer cases in certain countries than others? What does that tell us?

There's so much that's happening. What are we going to learn in terms of space? We've got people going out into space, sounds absolutely terrific. Not for me, mind you, I like it here on Earth, but what sort of supply are they going to be for those people who have gone? What does it mean in terms of prevention? Do they all need to be vaccinated so they don't bring some disease, some communicable disease, to another planet? When we get, we're getting there, we're on Mars, so that's a planet. There are so many interesting things that are happening in the world.

I think for the PhD students, just being curious about things, how is it that certain things happen? How is it, it's a question I ask about politics very often, you may or may not want to go there. I don't, except for myself. But just being curious about things as to how it is they're happening and what the implications are for health care for people.

Dr. Lynn McPherson:

Can I ask the very last question, Dr. Corless?

Dr. Inge Corless:

Yes.

Dr. Lynn McPherson:

Does your big old brain ever rest?

Dr. Inge Corless:

No.

Dr. Lynn McPherson:

I suspected not.

Dr. Inge Corless:

No. I'm curious about so many different things, and I tried to gather around me some of the things so I'd have the vibrations from some of the things that I've done that are really related to end of life care, and death and dying, and caring for patients. But I really am curious about a whole array of things, and it's wonderful to be curious, you know?

Dr. Lynn McPherson:

Really.

Dr. Inge Corless:

You don't have to go onto TV to be curious about something. You can just go out and take a walk and look around your own environment.

Dr. Lynn McPherson:

Very good.

Dr. Inge Corless:

You have the opportunity to talk with interesting people, like this morning.

Dr. Lynn McPherson:

There you go. Connie, you want to wrap us up here?

Connie Dahlin:

Well, I am so grateful that you took this time. I know you have many things you're still doing, obviously, and many projects. And I hope for our students, you have really sensed that this evolution, we've grown in many ways, we still have a lot of ways to grow in others, but I think for the students to know that this is still a work in process. And I think that really what Dr. Corless said about being curious, and when you're thinking about the future, there are no boundaries. You have this limitless area that you can step into. So thank you very much, and we're so grateful for your time.

Dr. Lynn McPherson:

Thank you.

Dr. Inge Corless:

Thank you very much for inviting me, and thank you very much for doing this PhD. I think it's a really important thing to be doing, and I congratulate you on it, and I've been very honored to be part of this.

Dr. Lynn McPherson:

Thank you.

Connie Dahlin:

Thank you.

Dr. Lynn McPherson:

I'd like to thank our guest today, and Connie Dahlin, for the continuing journey in our podcast series titled Founders, Leaders, and Futurists in Palliative Care. I'd 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.