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 and the PhD in palliative care offered by the University of Maryland Baltimore.

Connie Dahlin:

Welcome everyone to another one of our PhD palliative care podcasts. I'm Connie Dahlin, one of your faculty at the University of Maryland, and I'm joined also by Dr. Lynn MacPherson, who is the director of the pain and palliative care masters program at the University of Maryland. We are so thrilled today to have one of our colleagues, Dr. Loring Conant. Loring has been involved in healthcare and teaching medical care and hospice and palliative care for many years. I think the wonderfulness about Loring's experience is his on the ground experience, getting involved with and movement helping it percolate, helping along the way, thinking with education. He was part of the faculty at Harvard medical school.

He also was on the Tufts pain master's program faculty, hospice medical director for a hospice in Massachusetts, taught at the Harvard Center for palliative care, helped lead some initiatives that were in Europe in terms of thinking about palliative care. So that wide range of what we're expecting you as students to be thinking about, where are the opportunities that you may have on a day-to-day basis, and where are you helping and collaborating with other people to really think palliative care in a broad sense and then also help forward the movement. Dr. Conant, I guess I would like you to give more of a rounded introduction of yourself, so that people know a little bit about you. And if you want, you can also tell us another fun fact that people may not know about you right away.

Loring Conant:

Connie treasured, nurse colleague and Lynn treasured, former students from decades ago at PCEP. This opportunity to reflect with you, led me back to a very basic moment when I graduated from med school from Tuft in '65, Our Dean looked at us sternly and said, "Your best teaching aside from patients are your nurse colleagues." He used the word nurse colleague that was back in 1965. I mean, that is stunning at that particular time. And boy, was he ever correct? When I was an intern, I managed, well, I tried to manage, a lovely woman in her mid 40s who was seriously encumbered by Goodpasture syndrome, where she was literally bleeding out of her lungs and I remember standing at her bedside and say, "I'm sorry, there's just nothing more that I can do for you." That haunted me for many years until I had the good fortune of learning about somebody called Dame Cicely Saunders and Balfour Mount.

Constellation seem to come together in the late 1970s when I was in a practice in Cambridge, Massachusetts. I would fortunately I seem to have a wonderful patient population where they're aging and they were developing life-threatening illnesses. They invited me to look more deeply about how I could offer more appropriate care. Andrew Stage left Balfour Mount for the role of Victoria Hospice in Montreal and "the hospice movement." Early on, I think in the late I think it was '79, I was one of our early cadre of physicians who were drawn over to be taught at the feet of Dame Cicely Saunders, and Robert Twycross who did the original research on and Lynn this is appealed to use the pharmacologists of how effective oral morphine was and doing blood levels early on about how effective morphine was. You don't need heroin because I think heroin just scared the living daylights out of people.

So, he made it possible for us to begin to use morphine in a more scientifically based effect. So here I was, one week immersed at Teddies at Oxford being taught by the masters of... The English were ahead of us then. So, I store that away and came back and it's so interesting, that was an era when I was very active for physicians for social responsibility and here I was dealing with a global end of the end of life issues with a nuclear freeze and the threat of nuclear war, and then dealing with the hospice movement. I had this wonderful moment when I guess there's an early '80s, okay. I'm going to focus on a more manageable aspect of end of life care, instead of dealing with a global nuclear issue. I then focused on hospice.

Jo Magno had me be part of a national committee. I think it was on professional development, I can't remember, I don't have my files with me. But I remember finally being invited by a newly developed hospice of Cambridge to be their medical director. Fortunately, I was in a work setting where my boss was very supportive of my taking two sessions off a week to devote to the hospice of Cambridge. I'm very pleased that here I was a fulfillment of what the Dean said to me in 1965, I was being educated by my nurse colleagues. When we had a team meeting, it was oval table, the doctor did not sit at the head of the table, the nurse did. The opportunity to have a multidiscipline approach to try and to honor our patients and family needs was just very enlightening and encouraging.

I have to say, I made a distinct decision at that particular point that I wanted to have a balance of yes, having my hospice work but also I, I enjoyed my journal medical practice and I think having the opportunity to work with a multidisciplined team helped better inform how I cared for my general medical patients. Now I'm rabbiting on, I you want to ask some more focused questions. We were brought up-to-date in the mid '80s. Oh, I have to say one other point with the Hospice of Cambridge, we were able to develop our first residential hospice in the Commonwealth of Massachusetts and it was so interesting.

I would go around with a nurse colleague and have neighborhood visits and the image of what would happen if a hospice was set up in their neighborhood, oh my God, all the druggies from Harvard Square are going to be raging the neighborhood and there'll be dead people being driven off in hearses. We don't want dead people in our neighborhood. So fast forward, these people ended up being just wonderful neighborhoods. They became volunteers and it was just a matter of sitting down and breaking down their distorted images or misunderstanding, talk about false news or ideas about what would happen just by listening to them and talking with them, we brought them into the ranks would be wonderful source of volunteers.

Dr. Lynn McPherson:

Now I have to worry about a cannabis dispensary in their neighborhood, right?

Loring Conant:

Not only one, but holy smokes our local wonderful grocery store is being turned into one. What a metamorphosis.

Dr. Lynn McPherson:

They have eggs and your cannabis.

Connie Dahlin:

I think Loring what you talked about, I mean, is I know that you had been involved in that I know there was a hospice demonstration project that was going on here as they were trying to figure out the hospice benefit. This part about just trying to get hospice understood. And then you're talking about the palliative care movement, because hospice didn't necessarily translate that well. And then this innovation and so for our students, I actually remember all of this part going on the part about opening up a hospice house, which that is all by state guidelines as to what that is categorized. In Massachusetts, it was in this ambiguous part of not necessarily being a skilled facility, not being a hospital, not... So working through that was amazing.

Also, thinking, when you're going to move into neighborhoods, they are embracing or not and it was an amazing place. I think when you think about underserved patients who may not be taken care of at home, who really don't want to be in a long-term care facility and it's not appropriate for them particularly if they're younger age or they might have other issues having that group sensibility is so important because I think if we look at St. Christopher's they were their rooms were double rooms, they weren't single rooms because Cecily really felt that you shouldn't go through this alone and whether you are dying or not having that companionship was so important. I think in America, we tried to say, well, you have your own room and that's important for family care. Although if you think about patients who may not have families anymore or that support, there is something to be said for that. So I think it also opened up that whole room experience for that.

I think the other thing Dr. Conant, to think about is when you became a hospice medical director and then that role that you took on of being an educator for different professions of having people spend time with you, helping them learn concepts because you're talking about where you were saying, okay, we don't need to use heroin anymore for pain control and then we were thinking about methadone because that was around before we had the designer drugs of long acting that many of us learn. And now we're having to go back to it. This whole sense of that role that you took on whether it was intentional or not because there weren't that many hospices around and what you were doing even in the neighborhood was creative. You want to talk a little bit about how that role evolved and what you felt your mission was for that?

Loring Conant:

Well, I should first say that I was an apostle of the nurses who knew more about pain management that we were just not taught that at all. I think the opportunity to interact with medical students first on an elective basis, from the medical students they encourage, I'm talking about Harvard medical school, encouraged the school to developed a course where there was formal attention to the principles of care that we were trying to introduce. This is an investment in the future. It was very hard to bring a long early on all the docs out there was just such a worry about addiction and over over-medicating patients that yes, we would give rounds and try to do a one-on-one.

But I think I was drawn to working with medical students because it's delayed gratification but we're looking at another generation where they would be in more of a position of authority. One of the students who started this with Josh Hauser, who is now out in University of Chicago, I think, is that not right? Yeah. So I rest my case that he's able to expand this. Now I'm rabbiting on please, please refresh my memory. I'm getting on in my eighth decade so, I tend to get excited and rabbit on about things that may not be off [inaudible 00:16:02].

Connie Dahlin:

No, I think the sense of that you knew that you had to help teach some of the next generation so that maybe this could be incorporated as part of their regular care that as we were at that point trying to move the hospice concepts that we would have hospices, but we also knew that we needed more people to be have just a general understanding. So, I think you help to have people come and learn from you, but I think the other part is that you got involved with the course at the medical school in terms of the one that Dr. Hauser started. And then I think in terms of the-

Loring Conant:

And Dr. Anne Hallward as well.

Connie Dahlin:

Ann Hallward, that was a fascinating course because I think it was student driven of working with patients with serious illness, having these conversations, learning that they actually wanted to engage in these conversations.

Loring Conant:

Excuse me, for interrupting, but it's a very important model of that course. And that is part of the "faculty" with patients and patients, families themselves. They were framed in that fashion. So again, the Dean back in 1965, your vocation is being teachers of physicians.

Connie Dahlin:

No, I think that that was really important. And then I think that you ended up then being involved again, I mean, I can remember us co-teaching at the Tufts master's program in pain several lectures on that to have the pain people really understand these hospice concepts. And then you got involved with teaching through the palliative care education of course at Harvard, but then you also were doing some work because you had colleagues in Germany. I'm just wanting people to see this generative aspect that you started just with patient care and moved out to education locally, regionally, nationally, and internationally.

Loring Conant:

One of the great moments of that collaboration in Munich, there was this wonderful young hospice medical director, her name is Dr. Claudia Bausewein. And you could just see that she was a potential leader. Well, fast forward in a few years, she became a professor of palliative medicine in the University of Munich System. That was particularly significant and a very male dominated hierarchical academic setting.

Connie Dahlin:

Not that that exists anymore.

Loring Conant:

No more. [inaudible 00:19:02].

Connie Dahlin:

When you think about we're career and where you had the most effect, what were some of the really seminal moments for you in your hospice and palliative care career?

Loring Conant:

Well I mean, obviously, on a very personal level, the privilege of being present to patients and patients, families when they are undergoing a difficult journey and realizing that there is always something that one can do for that patient and the patient's family even when there's just a lot of complicated things going on. So, on a very personal level that stays with me particularly home visits. I think the opportunity to witness a multidisciplined approach to problem solving, what stays with me also is the student's interest in this. I've had the privilege of following one of their earliest Howard medical students who was her first year at Harvard medical school, she was part of our living with life-threatening illness course and she was assigned a pediatric case because her mother had just died about six months before and she wanted to focus more on the pediatric realm.

So, she took Nick who had advanced neck cancer to, he's seven years old, to the MFA and they talked about mummies and that just was so exciting for the patient and an example of how creative that individual is in understanding what might be helpful to a patient. Fast forward, she's now on the faculty at the Dana-Farber and doing research at on adult leukemia. So, interacting with students over the years is very fulfilling. I have not had the privilege of being a teacher for gosh now almost 10 years because I realized since I stopped seeing patients, I lost my authenticity in interacting with even a PCEP I thought that there's just so much you want to listen to somebody who is reminiscing in the past as I'm doing now

Connie Dahlin:

Well, I think you bring up this whole point about, there's a couple of themes that you've talked about. One is this part of clinical approach. So, we know that some of our students will be clinicians and that feels a comfort zone for them. I think that you also offer this whole part about if we're going to be in that realm, we're also educating and we have to be being thoughtful and just in time education and using all the opportunities that we can. I think you're also speaking to this really important role that as leaders and if they're getting PhD, our students to you, you become leaders and you need to mentor others. And so that's part of that role in palliative care.

I think also Loring, what you have intimated but maybe haven't said directly is along the way, you were clear of what was going on in the environment and stepped in, in different ways to be involved, whether it was clinically, whether it was working I would say, at a local political level to get the hospice house approved and all of that, to then thinking about this longevity. So for our students who don't know what PCEP is, Palliative Care Education and development. It's been around for around 20 years and it's in the beginning, it was really taking people who were leaders and going to develop programs. Now it's grown a little bit more for people who are wanting to do particular focused initiatives.

So I think, you're part about being involved in leadership as leaders we help other leaders develop. So, I can see these discrete things that you have done over your career that you just thought was part of your career and took them on. I think that's the part of what we're trying to have our students understand that there may be different phases and that there's a lot besides clinical care that we get involved in that we don't even realize sometimes and sometimes we might feel like we don't quite have the expertise but then we have to learn about it and then we get involved in that way.

Loring Conant:

Yeah. I think given the current context of what is happening in advances in therapeutics, I do remember that we used to say, I wish we would be able to have a referral early on in the terminal course of a patient rather than just one to two weeks before they're about to meet their maker. So, the late stage referrals I think is going to be even more problematic currently because let's face it, there's some remarkable advancements in therapeutics. There has to be boy, talk about the challenge for this new cadre, a creative way of looking at how you blend in more therapeutics that may sustain the individual without encroaching on their quality of life plus the economics are just overwhelming.

So boy, talk about bringing together everybody from the oncology to the pharmaceutical company families, as well as clinicians who are caring for these patients. My fantasy is that every oncology fellowship should have a required at least one to two months rotation through a palliative the care team.

Connie Dahlin:

I would think that, that actually is for everybody. I mean, I think about at the time, I didn't know how special it was, but when my first iteration as an oncology clinical nurse specialist, it was required that I do a hospice rotation. I think it was because of the people at the time were very forward thinking and new, particularly at that time because of our treatments that a lot of our patients were going to die. And so of course we should have a hospice rotation, but when I talked to least advanced practice nursing students, they don't have that because it's so focused on the therapeutics. So I think that that's an interesting proposition. Loring, I wonder if you ever worried that we weren't going to get off the ground enough, did you ever have any worries about the hospice movement?

Loring Conant:

No. I really didn't. I knew it would take a long time but boy, look at how rapidly it became a Medicare benefit. I mean, everybody across the... I mean, even today, looking across the aisle where there's so much enmity on either side, I mean, this is a common denominator for everybody. So, if that was clearly a common area of agreement. My frustration was and I vividly remember our poor nurse coordinator being on the phone trying to get we were... Our small hospice program was dealing with 19 different insurance companies. And we're not that big. And she was spending so much time on that bloody phone talking to people who were really not equipped to understand exactly what we're doing and you wouldn't have any continuity of care. I was afraid I'd burst an aneurism over that.

So, we ended up looking at the cost benefit of spending so much time in the phone. Look, we'll try to raise money if they don't approve of what we want to do, maybe we can raise money and pay for that. But you're taking away patient time. I so resented having patient time being taken away by dealing with insurance companies. So, don't let me started on single payer system which greatly benefit hospice and palliative care profoundly. The equity, that's another issue that I'm really worried about for a future of palliative care and hospice care. There are so many uninsured people or under-insured and we're not touching a number of our Black Lives Matter now, this must be bubbling up and in your discipline now.

Connie Dahlin:

Yeah. I mean, I think the issue you've brought up that, the insurance part, how do we get that? What's the consistency insurance. So that's a whole policy level. I think health equity, that's a whole... I don't think we focused on that solely before. I think that's going to need to be a sole focus within palliative care to think about that.

Loring Conant:

It's presence have to be felt.

Connie Dahlin:

Is there anything that you can say that has surprised you along the way, in terms of the development of palliative care that you did not expect, or that you were going [inaudible 00:31:09], I didn't see that cong.

Loring Conant:

Maybe it's my cynicism but I was surprised that it did take a while but pallet and medicine became a sub-specialty. I thought it would take a little longer because it was always considered soft medicine but I was surprised at the scientific basis to it finally got through to, I guess it's called the American Board of Medical Specialties, I don't know what it was.

Connie Dahlin:

Yeah.

Loring Conant:

That is-

Connie Dahlin:

Did you think that, that was helpful overall? I mean, because I know that before that, in terms of the American Academy of Hospice and Palliative Medicine, they had fellowships and they were letting people take the exam. And then once it got became a specialty then people, it was acquired that people had a fellowship. Was there anything about that?

Loring Conant:

The reason I thought it was helpful, it was a further authentic authentication of this very important part of healthcare.

Connie Dahlin:

So, you've mentioned, you're worried about health equity, you're still about insurance., you're worried a little bit about numbers. Are there other things that you're worried about for the future?

Loring Conant:

Oh, Lord yes. I'm worried about the patient. Even though, I hate the word retired, I guess I'm reconfigured, but I'm no longer [inaudible 00:33:00], it's so hard to give up my license and but I'm constantly getting phone calls and emails from not former patients but friends who are just totally flummoxed about how you navigate our healthcare system. I actually don't think it's appropriate to call that a healthcare system, I think it's really a healthcare phenomenon. There's an institutional momentum that a patient gets caught into and it depends on what region of the country it is. Good Lord and the horror tales that I get from Florida where somebody comes into a hospital who is end of life. And they end up doing all sorts of procedures and... don't get me going.

So, there is that institutional momentum and the poor patient, remember that Time Magazine cover back in the '80s Who is in Charge here? I guess with General Haig was on the Time Magazine and who was in charge of the poor patient's care? It's medicine by cabinet. I just worry about and it's so mechanical now, at least what I hear from people, the human connection with patients is just being severely threatened. So, we need the principles of palliative medicine very much so. I hope you have sociologists who are part of your multidiscipline team because boy, we need them.

Connie Dahlin:

I think you bring up, there's a lot of this part and I think with palliative care, we have been a high-touch, high in-person delivery, I think with COVID we have rapidly to translate to tele-health. I think palliative care people have been afraid of it and I think one of the things is we have to learn how to incorporate it. It can't be the be all, but I think when we think about access, we have to be able to incorporate it to promote access, but then thinking about making sure that people who may not have the resources financially or regionally have access to broadband or to smart devices and all that. So that's a whole thing.

I also think what you're speaking to is when we start developing these systems, we do need to think about the patient voice. We think about the family caregiver voice. I would suggest that we also have to think about the community in which they come from and push back from everything, being at the hospital to getting people back into their community and stopping them from having to enter this setting unless it's really necessary. So I think that's important. When you think about people going into hospice and palliative care, what are some of the other things that you would be advising them to think about or to consider as they embark upon a career in hospice and palliative care?

Loring Conant:

Connie, at what point are we having the conversation with these individuals?

Connie Dahlin:

They're going to start listening to them. They will have access to them as soon as they enter the program. So in the first semester, so this is the beginning part and they're starting to formulate their career and their pathway.

Loring Conant:

Now, who is they?

Connie Dahlin:

The PhD students.

Loring Conant:

Oh, PhD students.

Dr. Lynn McPherson:

Well, let me tell you the learning outcomes of the PhD program. Starting a PhD is a research degree, this is indisputable, but I'm really greedy. I also want them to have a keen understanding of the birth and the development evolution of what and what the future holds for hospice and palliative care. I want them to be amazing leaders. I want them to be advocates for palliative care in the profession and in the community. I also want them to be amazing teachers, so I'm really greedy. I see these people working in academia, I see them being as the leader of a large palliative care center and an academic medical institution, maybe working for a research center, perhaps working for a granting foundation.

So, what Connie is trying to say is, for these people who will be the leaders of hospice and palliative care for the next 20, 30, 40 years, what advice do you have for them?

Loring Conant:

Well, the most generic advice is, make sure that there's always a human connection with the ultimate goal of their energy, which is the patient. And to always keep in their fore brain, maybe that they can each develop a reference point, oh yeah, my grandmother or my grandfather keep that as a template for how they would like for an optimum outcome for a patient to be cared for. This is not a criticism but this is just a logical result of an academic process, we get so excited about some of the details of the economics or the organization that we lose the human context of what we're ultimately working with.

Dr. Lynn McPherson:

When we spoke with Dr. [Coralis 00:40:06], she made the point that we see the mounting death toll from COVID and we've almost become immune because the number is so large that we have to remember that every one of those people was somebody's family member that people love them and they love people. And it's so easy to lose sight on when you're looking at 600,000, for example. Huge.

Connie Dahlin:

I think for our students to remember, we come into this role with a "professional" role, be it a clinician, be it an administrator, be it a policy person, but we also will be patients too. I think one of the things that I stretched myself to do is, when I'm having health encounters to see what that experience is like as a patient. So for instance, I'll be asked to participate in a study and I will do that. And I'll be like, okay, this is interesting for me to notice from a patient perspective, what did I like and what did I not like. How do people greet me? I'm not one of those people who likes to be called honey and dearie right upon that. I find that little condescending until they've checked it out with me or I'm recently having to have an annual screening mammogram and man, I had the best tech. She said, "This is what's going to happen, I'm going to do this. Here's the positions, let me know." That was so professional and excellent.

I walked out of it saying, that was a great experience because even though I knew a lot being a clinician and I wrote my master's thesis on decision-making in breast cancer, knowing a lot about this, I thought, okay, I can see patients to being good with that, but you walk into some places and from... I try to get people to think about the experience of people trying to make an appointment when they get, I have to call five or six times, or now you have to press zero to talk to somebody. I mean, okay, then we are entering into the space, be it a clinic, be it somebody who's going to come to their home, be in a long-term care setting, who's greets them, how do they get told where to go? What happens when we walk into the room as clinician to tell patients who we are, what we're going to do?

Lynn's heard me say this, I've been working in the hospital and I recently had two older patients who not only had dementia but spoke another language and so we couldn't use an interpreter. They couldn't use the online because they couldn't even connect in their language. The interpreter is saying, "I have no idea." So now we've taken this person out of whatever environment that they were comfortable with, to the extent they could be because it wasn't their home anymore. Brought them to a new one. We can't communicate them. We're doing all these things to them and plus they're being interrupted all the time. I thought, oh my goodness, this is just horrible.

And then their families couldn't come in and visit, that just did not feel good. So, thinking about if it were me, my loved one, how would I be wanting to make a change? But then when people are discharged and Loring, you might've experienced this where we're looking at a discharge and we're thinking this is set up to fail. And we as a palliative care person step in, and then the team, oh my goodness, they are so angry with us because how dare you, we had this set. And like, "You may have had this set." But I'm trying to look at, let's do the discharge once and have it succeed to the extent that it can and get the right fit. And then the people get home and we haven't told them how to get scripts.

We haven't told them that if they need opioids, CVS, or Walgreens, or Target only stock on Tuesdays and Thursdays, and this is a Wednesday and they're already out, so they don't get their meds until Sunday. I mean, Lynn knows much more about this. I mean, so it's just this part about how do we think about that experience and then think about it from what if it were us, would we find it acceptable or if it was for loved one, would we think it's okay. So I think you've stepped to that human experience on very many different levels.

Loring Conant:

Yeah. I think the tension that obviously exists with the students who will be pursuing their career in these various realms is the tension between trying to work out a system that will work. But how do you craft it for the individual? I mean, the diversity of individuals and contexts are such that we cannot lose sight of that ever. You mentioned interpreters, I hope that the PhD program might incorporate dealing with through a major hospital where they have a formal interpreter service, just have some time to talk with them and what their perception is of dealing with people from different cultures. Because I think that will open up some portals of understanding that it will help you craft a more, well, I guess the word is sensitive or appropriate system to meet their needs.

Connie Dahlin:

Well, Dr. Corner, that today has been lovely. You've really brought a new dimension to our podcasts of really thinking about this patient as an individual honoring who they are and just bringing this wealth. So, I just want to thank you for all that you've done for patients and students and colleagues myself included are so grateful to have had you as a guide and a mentor. So thank you for providing your wisdom to our students today.

Dr. Lynn McPherson:

Thank you so much.

Loring Conant:

Thank you for asking me.

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 also like to thank you for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson, and this part 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.