Dr. Lynn McPherson:

This is Dr. Lynn McPherson and 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. Hello everyone. This is Lynn McPherson, the program director of the master science graduate certificate and the super duper cool PhD in palliative care. And we're continuing our podcast series myself and Connie Dahlin. Who's one of the faculty members in this program, the PhD program and the master's program. And we are incontinent with excitement about our guest for this podcast, Dr. Diane Meier. Connie was going to introduce her but I said, "I can do it a lot quicker." She's the queen of palliative care. She was the founder and the CEO, and the leader of the ship of the Center to Advance Palliative Care. Recently retired, but I'm sure she's still getting an initiative. Dr. Meier, welcome. We're so pleased you're here.

Dr. Diane Meier:

Thank you. I'm very honored to be here. Thank you.

Dr. Lynn McPherson:

How would you like to expand on that introduction?

Dr. Diane Meier:

Well, I mean, I'm a doctor. That's my discipline, a geriatrician by training. And I chose to train in geriatrics because it seemed like the only part of medicine that was holistic. When I was in training everything else was partialit.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

The left ventricle of the heart or the bone marrow, or the kidney. It just didn't make any sense to me because I'm a lumper not a splitter. So in choosing geriatrics I was trying to find a field that paid attention not only to the human being as a whole, but the context, relationships, family, culture, wider community.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

Because that made more sense to me. So for a number of years I was a faculty member in the department of geriatrics at Mount Sinai, where I saw that basically the pressure of mainstream medicine and the culture of mainstream medicine was turning geriatrics into everybody else. So we were focused on our individual geriatric syndromes, for example, like falls or incontinence, or delirium. And we sort of, I think got deformed from our originating principles and goals. And I just saw a lot of suffering in the hospital, and a lot of things happening that didn't make any sense.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

That actually seemed to be harmful, not only not beneficial, but exempt harmful. And that was back in the '90s. And right at that time through coincidence really, some philanthropic funders decided that they also thought that addressing suffering was important, and that a lot of these philanthropists interested in this was precipitated by bad experiences with the healthcare system for their family first. And one thing I have learned to do in academic medicine is write grants. So it's probably the main useful skill [inaudible 00:04:08]. So I and several colleagues of mine, Jane Morris, a nurse, Judy Ann Heim, another geriatrician, Sean Morrison, another geriatrician. We worked together and came up with this idea to develop a palliative care service at Mount Sinai. And it was the four of us together who conceptualized it and wrote the proposals, and we were able to bring in some cash. What happens, at least in academic medicine is if you bring in the money they leave you alone. They let you do whatever crazy thing you want to do as long as you're not asking them for money.

And so, we actually have a lot of freedom and established a consultation service in our hospital. And I remember my biggest fear when we started that consultation service is that having had no training in opioid management, right? And get that in medical school or residency or fellowship, even though I'm a geriatrician. I was really worried that I wouldn't be able to do it, that I would be incompetent at it. And of course, the biggest reason that we were called or the most challenging reasons that we were called had to do with goals of care.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

And what are we doing here? And what is in the best interest of this patient and what does this patient want out of all this and their family in a big picture. And not that that was easier than pain management, but it was very different than anxieties that I had going into it. There was also the complexity of pain management. I had to teach myself since I hadn't received any training, literally, in my excellent medical school and residency, and fellowship. It's kind of shocking and kind of remarkable, and as you guys know all too well, still, all too often, the same level. The many and the most important things in healthcare are honored in the bridge, communication not taught, management not taught, supporting family caregivers in their role not taught, and these are so fundamental.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

And I sometimes think that it's an almost willful blindness to the important things, because if you focused on the important things, the cognitive dissonance between what we do in healthcare and what's important would be unbearable.

Dr. Lynn McPherson:

Mm-hmm (affirmative).

Dr. Diane Meier:

So we just don't let ourselves see it. There's a sort of willed blindness to reality. Anyway-

Dr. Lynn McPherson:

That's interesting you bring that up. I mean, Diane, there's a couple things, because I remember as you were starting and we were starting, and the interesting part was you were starting from inside, and I and Andy Billings were starting and we both had been in hospice. Right? So we kind of were doing that part. So I remember a lot of us were on parallel tracks, but I think the other part that you kind of bring up is this fairly interesting part about palliative care and hospice as it was starting too. We're sort of saying the status quo is not acceptable. We know that we can deliver care a better way. And yet, exactly what you're saying, we're in this really interesting part where... I know in palliative care we're trying to get it infused to be part of all good care.

And when we talk about that it scares people because it means they have to change, and people will say, "Well, this is the way we've done it and the whole way that we've incentivized care to this point is procedure based and in the hospital." And that is really threatening for people. So I wonder when you think about palliative care, a couple of things of one, have we arrived at the place where you felt like we should have arrived in this timing, and when will you feel we have succeeded?

Dr. Diane Meier:

Yeah. That's a great question. I will say that I think in addition to what you said, another reason that our colleagues may not be 100% enthusiastic about integrating palliative care principles and practices into their own work is because it makes a comment about what they've been doing their whole career. And I think it makes a comment that resonates with something they know deep inside already that has been suppressed, repressed. Because it's painful and that people don't know what to do about it. The sense that we're not helping people the way we thought we were going to when we went to nursing school or medical school, or pharmacy school, that we're a cog in a big machine. As someone wrote to me, a doctor the other day, he said, "I'm a dollar sign dressed up in a doctor costume. And I think that sense of disconnect between the originating impulses that drove people, all of us into healthcare and what we are actually doing all day is a pretty deep wound and is unconscious. And when we talk about asking people what's most important to them, asking people if they're in pain, addressing their symptoms, it says, "Oh, wait, this is possible."

I think it's again, unconsciously very threatening because of a preexisting awareness that this is what we were supposed to be doing all along, anyway. So then you asked when will we know that we've arrived? So we probably will never know that we've arrived, but there are two elements that I would like to see before I'm on my death bed. And one is accreditation requirements. So right now, even though 94% of large hospitals in the US have a palliative care team, there are no standards that are mandatory. There is no regulatory oversight at all. And right now many people may or may not know that in order to be paid by Medicare and by commercial insurers and Medicaid, you have to be accredited as a hospital. And accreditation used to be done entirely by the Joint Commission. We used to call them JCO. Now it's The Joint Commission. And about 10 years ago, the government in its wisdom decided there should be competition in the accreditation business because The Joint Commission had it all locked up.

They had a monopoly, and they deemed another organization called DNV, which actually is a Norwegian mega corporation that does quality in many industries, not just hospital care. And so both DNV and The Joint Commission were deemed as able to accredit hospitals, and that competition created tremendous hesitancy to change any [inaudible 00:12:12]. Because what has happened in the last 10 years is The Joint Commission has lost a fair amount of business with DNV. So although colleagues at The Joint Commission agree without argument that palliative care is an essential element of quality care in hospitals, and then it should be required. They won't do it because they're afraid they're going to lose business to their competitor and vice versa. So the competitor won't do it for fear that by adding another requirement, everyone will run in the opposite direction, back to the competitor. And so what they basically said to us is this won't happen without an act of Congress.

That a law would have to be passed, changing the accreditation requirements for hospitals. Okay. So we thought, all right, good, we'll get a law passed. And then we find out basically what everyone knows, but which I had denial about, which is the lobbyists control policy. And the hospital industry in many ways, good guys trying to keep the doors open to serve the community is dead set against any new requirements of any kind, no matter how obvious, necessary, or important they might be. And they are very powerful lobby. So I'm kind of up against the wall on that at the moment, and struggling to figure out whether either we can get Congress to do the right thing, despite opposing lobbying, or conversely we can get the hospital industry to cave.

Dr. Lynn McPherson:

Kind of a hard place.

Dr. Diane Meier:

Yeah, exactly. I think that it's been a lesson in how policy is made in this country. And it's better to know than not know-

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

because it's data, and you don't want to put energy into things that are wasting your precious time and energy. Like I said, I feel up against the wall on that. However, I think it's really important because until it is a required standard, it's the first thing to get cut, right?

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

It's optional. And a really great example of how this works is the Commission on Cancer which accredits or certifies cancer centers.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

Decided in its wisdom... And I guess they don't get lobbied, that cancer centers have to have palliative care programs in order to be certified or accredited. And overnight multiple cancer centers mostly in the south who didn't have them to begin with developed a palliative care program.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

It was a rapid rise. So that taught me something about the power of quality require means and quality standards, and that they make a difference, particularly when not everybody is doing things for the same reasons we are.

Dr. Lynn McPherson:

So in a question of that, I mean, two parts to that, Diane, one, if we think about chipping away and sort of saying, okay, so the hospitals are really powerful and maybe we focus a bit more on some of the community aspects, right? Because you and I both know that's a problem, because communities are all different and resources, but we don't even have a mandate on kind of some of the things for that, anything about rural. But then the second part of that would be to your point. Okay, so it happened in cancer centers. Would there be a strategy that kind of happens in transplant where we say palliative care is required for transplant? So we could go through and say for dialysis, palliative care is required before that. And so, maybe we can't do it in the bigger level, but we start making it kind of a health care requirement. And so we kind of circle a little bit for that so that we're pressuring in another way. I don't know.

Dr. Diane Meier:

I think that's a great idea. I mean, I think it's the incremental change strategy, which is of course the only way that change happens.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

So I think that's a really interesting strategy and we should talk more about it. Right now, I think for cardiac transplant or actually for VADs, ventricular assist devices-

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

the [inaudible 00:17:15] care team member has to be on the committee.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

Somebody wrote that into the ward and I still don't know who.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

But there is precedent for that.

Dr. Lynn McPherson:

Right. So Meier, I think you make me think of that. And I think the other part that you make me think of is that this whole policy part, and we've been talking about education and there's no requirement. And I know that we were all really hopeful in 2010 with the ACA. I think many of us thought it was our moment and we could make all this change, and here we are 10 years later and nothing's happened with PCHETA. And I keep wondering, okay, I know that a lot of people have done work with that, but I have to wonder. If we've been doing this for 10 years, do we need a new strategy? Do we need to kind of say, "Okay, we did that. And we tried and was a great effort and we pulled people together. But something about that and given our current political environment, doesn't feel it's going to open up anymore. So how do we help people kind of decide, okay, maybe we need to think about different strategies.

Dr. Diane Meier:

Well, I guess I would think of this in a both and kind of [inaudible 00:18:30] because I was quite frustrated and feeling, I don't know, not optimistic about PCHETA. PCHETA is the palliative care education and training act that basically creates some centers of excellence, provide some funding for training across disciplines, asks the NIH to do more investment in palliative care. So it's a very cheap piece of legislation and not the same thing as educational mandates. It's not an educational mandate, so you could still have most medical and nursing schools not teaching this [inaudible 00:19:13] PCHETA past. But what I was convinced by my colleagues at the American Cancer Society Cancer Action Network, which have been incredible leaders of this effort to get PCHETA across the finish line was that work of educating people, both in the Senate and the Congress on both sides of the aisle has been dramatically affected. The number of people in Congress. It was nearly, it was a unanimous congressional vote in favor of moving it forward. Both sides of the aisle that could not have happened 10 years ago. They know what palliative care is now. They see it as important and benign.

Dr. Lynn McPherson:

Yeah.

Dr. Diane Meier:

That of course, what happened in 2009 with all of the struggle around the affordable care act is the effort to label the affordable care act as rationally and unplugging grant. And that made palliative care untouchable by both parties.

Dr. Lynn McPherson:

Right. Right.

Dr. Diane Meier:

But that's over. And I think the reason that's over is because a tremendous amount of work was done by people from every state doing fly-ins, meeting with their elected representatives, bringing real patients and family members with them to talk about palliative care, what it is, and how it helped them. And so, even if that law never passes, and I guess I'm guardedly optimistic because it had all the votes it needed and got derailed at the end by something unrelated from the former president's health and human services, HHS, but not on the legislative side.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

It was an executive branch obstruction. We have educated an entire generation of elected representatives about what palliative care is. So I think it prepared the soil in a very important way.

Dr. Lynn McPherson:

Do you think, Diane, that with COVID and the role of palliative care that has helped the benefit or confused people? I mean, because I know and you've had a lot of webinars and things, and talking about how do we help people remember that it was our critical care of colleagues who were really the forefront. We were supporting them, we weren't making these decisions, and that we have to kind of help people get the pendulum back of palliative care upstream again at diagnosis and not just diagnoses where people are dying. So I wonder, how does that play into that with just all of the public hearing, all these different media stories about palliative care?

Dr. Diane Meier:

Yeah. Well, the truth is that a lot of the palliative care that was delivered during COVID was to people who did not die. But who had no one visiting them and no one paying attention to their relationships and their fears, and those stories need to come out. The profound social isolation and loss of identity that was therefore a consequence of being hospitalized with COVID, was something that palliative care teams recognized and responded to. And our colleagues in the ED and our colleagues in the ICU wanted to respond to that and literally did not.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

Literally did not have to call the family and bring the device into the patient, and find out about the patient and what they cared about. And did they coach little league, and were they a member of a faith community? How many kids did they have? No one had time for that. So our job was to help patients feel seen as fellow human beings and it's very powerful. And I think it was a gift to our colleagues who knew that needed to happen but couldn't do it themselves, but were able to by calling us or working with us to know that someone was treating this patient as a human being. So I think there's more basically good learning than bad learning for palliative care coming out of COVID because COVID was such an equal opportunities scorge. And everyone realized that in a moment, everything we took for granted could be taken away.

Dr. Lynn McPherson:

Okay.

Dr. Diane Meier:

And the fear of that and the recognition of how fragile we are, and how vulnerable and pretty widespread. So I think it's a positive, but it's not as good as an accreditation requirement.

Dr. Lynn McPherson:

Okay. Going to go back to that.

Dr. Diane Meier:

Yeah.

Dr. Lynn McPherson:

So you have had a seat at many tables and been involved in so much change. And so for our students to understand Dr. Meier actually was a recipient of a MacArthur award, which is very esteemed award for people who really have creative ideas and making change in many different areas, from medicine to art, to music, to technology. But you have this interesting perspective. So if you were to kind of think back, what do you feel have been the Seminole successes of hospice and palliative care?

Dr. Diane Meier:

Well, I'm going to start with hospice, and because it started first. And I think the fact that we have in a Medicare house expenditure in this country, we don't realize how lucky we are. So I've done a lot of traveling, and not every country has hospice. And if you are not able to get into a hospital, you die at home without help in many developed Western nations. And I was shocked to find that, I thought we were behind not ahead of the parent countries, the father lands. But we are very fortunate to have a Medicare benefit which is also a Medicaid benefit, and is also covered by most commercial insurance, that at least something is provided to help patients and families go through this universal human experience with hopefully people who are trained to help with common symptoms and to reassure, and to make the strange familiar, and to put the process of dying and caring for the dying into the human compass, as opposed to something that is incomprehensible terrifying, and occurs behind the walls, which is how it was for many years.

Dr. Lynn McPherson:

Mm-hmm (affirmative). Mm-hmm (affirmative).

Dr. Diane Meier:

So I think that's a huge accomplishment. And obviously, hospice has been through some ups and downs, not least the fact that two thirds of hospices are for profit, and it's hard to make a profit on people who are dying by delivering high quality care. So I think that's a concern. The issue of quality and regulation is a concern, which is true of hospitals, true of certified home health agencies, true of nursing homes. There's a bell curve of quality. Most are average, but chunk are above average, a chunk are below average. And the question is what can the federal government or the state government do that it can afford to ensure a better oversight of care quality? And it's pretty important, it's sort of like birth. Everyone remembers it forever. And so doing it badly has a very big price to pay in terms of social trust, social fabric, sense of being part of a safe committee.

So that's what I would say about hospice. What I would say about palliative care that I look back on as elements or contributors to the rapid growth in the field. One is that, as I said earlier in our conversation, I think it spoke to what people were unconsciously longing for in healthcare for a long time. So I think the fact that once the concept was named, so many people wanted to do it. It's not because they suddenly had a light bulb, it's because it spoke to discomforts, cognitive dissonance, feeling this isn't why I went to nursing school, this isn't why I went to medical school. Oh, that is why I went.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

And so, the field was populated with people who were prepared-

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

to make that jump. So that's one thing. The second thing I would say is that thanks to the Robert Wood Johnson Foundation, who was the original funder of the Center to Advance Palliative Care. And the program officer I had there, Rosemary Gibson, who had worked with many national entities that were trying to make social change. She realized I was just an ivory tower academic who knew how to write grants. I didn't know anything about driving social change, disseminating innovation. And fortunately, I knew I didn't know anything. So I listened to her really carefully. And what she said is, "Well, Diane, you need a financial consultant." And guess my reaction was, why would I need a financial consultant? This isn't about money. This is about taking good care of people. That's how naive I was, right? And then secondly, she said to me, "You need a social marketing consultant." And again, I reacted in the same like, "Unclean, why would I need marketing? I'm not trying to sell something to people, just trying to help people, right?" Again, totally naive. So basically these were two fundamental business principles that Rosemary forced me to understand and exploit. And the first was that there had to be a business case for delivering palliative care. No business case, no case, because the healthcare industry is not rolling in cash or some elements of that are rolling in cash, but not the elements that want to pay for palliative process.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

And so it was really important to do the research that showed the impact on hospital financing. And frankly, the impact on finances for patients and families because so much is out of pocket. So we did that, a number of people did that, and that research was a very powerful motivator for the C-suites of hospitals in America. And we actually developed, I don't know if you remember this, the case for hospital-based palliative care, which was a beautiful heavy paper stock, three colored, beautiful photos, lots of white space, lots of pictures, not too much text sent to every member of the C-suite in a hospital in the United States. And many people told me that is what caused them to decide to invest. So business data and marketing, and then the other piece... And that was Lynn Braggins by the way that we found when Rosemary said you have to have a finance consultant and once bargains remains the genius behind most of what CAPSI has done.

So the other person was a woman named Sharon Sutton who was a PhD in social marketing. And the essence of social marketing is recognizing that advertising or marketing can be used to make a profit and it can also be used to do good, that it's basically effective human education. And why is it effective human education? Because it pays attention to what the audience cares about and what the audience wants to know. That's why advertising works because of the tremendous amount of audience research that is done in the development of advertising. And so what we learned sitting at Sharon's feet is that a death doesn't sell. No one's in the market for a good death. Everyone's in the market for a good quality of life and as much of it as they can get. And that, to the extent that we either in palliative care or hospice talk about achieving a good death, we are driving people away, kicking and screaming.

And not because they're in denial or because they should be seeking a good death, but because they quite appropriately and rationally want to live, and want to live well. And it is disrespectful and narcissistic of us to say, "Oh, you should be thinking about a peaceful death." That's our priority, right? It's not their priority. And recognizing that it is respectful to find out what people care about and what they want before trying to pitch something really helped me get over my discomfort with the notion of marketing palliative care. And then, then the second thing we learned is that audiences are highly variable, right?

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

So what you might say about palliative care to the general public, quite different than what you might say to people living with a serious illness and their family members, quite different from what you would say to health professionals, right? What of health professionals want more than anything else? Time.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

Time is the thing that is most scarce for health professions. Talking about palliative care as a way to buy them time to do their work because we take care of the very complicated destruct families, because we manage the difficult to manage pain, dyspnea, constipation, fatigue, delirium. These are the things that make it very difficult for our colleagues to do their jobs. A, they have no training and B, it's very time consuming.

Dr. Lynn McPherson:

Right.

Dr. Diane Meier:

What's the message to payers? Completely different, right? If you meet people's needs in the community, at home, or in assisted living, or in a nursing home, they don't go back and forth to the hospital. So payers are best sprint and expanding access to palliative care because frankly it's in their financial best interest to do so. And then lastly, C-suites and hospitals and other organizations, you look at the pressures they're under.So people probably know that hospitals are paid through something called the diagnosis-related group, the DRG. And it's a lump sum payment for the whole hospital stay. So if you're admitted for pneumonia under Medicare and you get much better after a day and a half of IV antibiotics and are sent home on oral antibiotics, the hospital gets paid exactly the same amount as if you were in the hospital for three weeks with multiple complications. So what is the hospital's incentive? It's to get you into the hospital, yes.

To get that payment, but then to get you out as quickly and as safely as possible. And we were able to show that palliative care teams do that. The patients who receive palliative care are not in the hospital for three and a half weeks, they don't have multiple complications. They don't end up in conflict with their teams.They go home and they stay home because the discharge plan is safe and feasible, and doable by the family. Things that were not the case before palliative care was involved. And those were very powerful motivators for the C-suites. You see that we had to think about our audiences and we had to ask those audiences what was important to them, and that is respect, and that is good education. And that is social marketing. So I would say those are the kind of underground stream, under underground forces that allowed CAPSI to break through. And-

Dr. Lynn McPherson:

I could not agree more about the social marketing. I have found in trying to marketing the masters you can place ads, you can hire agencies, but you know what? It's Facebook, it's Twitter. That's where it's at. So can I wrap up with the question we're asking everybody? Dr. Meier, we look at our students in this PhD program and they're going to be the leaders of tomorrow in palliative care. What advice do you have for them?

Dr. Diane Meier:

Well, first of all, thank you for pursuing a PhD in palliative care. And thank you for stepping up to be a leader, because that is the number one highest priority that the field has.

Dr. Lynn McPherson:

Thank you.

Dr. Diane Meier:

As I travel around the country, the distinction between a well-run hospital and a poorly run hospital, a well-run palliative care team and a poorly run one is the caliber of leadership. And we don't teach this in medical school, or nursing school, or any other kind of school. Maybe some of it in business school. And yeah, it is the key characteristic that leads to the impact we're trying to. So thank you, that's the first thing. The second thing is courage that sometimes you have to say things out loud that are ordinarily not said out loud. So you have to have the courage of your convictions because when we say things that are ordinarily repressed or not talked about, everyone else can talk about them, too.

It liberates what everyone knows into conversation. And once you start talking about it, it's much easier to take action. If it's repressed and unconscious, it's very difficult to take action. We're seeing this with all the anti-racism work that's going on. So obviously speaking truth not in a manner that alienates or thanks, or insults, but in a manner that comes alongside and aligns, remembering that pretty much everybody working in healthcare, at least at some point chose the field because they wanted to help people and respecting that, assuming that of the people that we work with, and acknowledging the really serious challenges of work in healthcare means you're a partner and not an attacker. There you go. I think that's a really key leadership characteristic and the one that is consistently correlated with successful programs and successful builders.

Dr. Lynn McPherson:

Well, Dr. Meier, I think you are the quintessential example of somebody who weighs 92 pounds, speak softly, but carries a darn big steak girl. You are the bomb. Connie, any last comments or thoughts?

Connie Dahlin:

No. I mean, thank you. I think there's so much richness for our students to think about. And I think of hearing, again, you've given some of these textures for people to think about that are as you sort of said, they're not sometimes in front of us, but they really form what we're working with and the environments and the different audiences that we have to be aware of. And kind of this coordinated effort that we have to kind of think of going forward. And I just also think that you've offered just by discussing those, a range of possibilities for the students to sort of know it's not just the clinical, you mentioned social marketing, it's the business part, it's the administration, it's the policy. And that we have to be able to think about different times where we're going to concentrate on any given one. Sometimes it's hard too to kind of think about how you're going to plan that out. But I think this is such an opportunity for the students to be listening in real time perspectives about where we've come and where we're going to. So thank you.

Dr. Lynn McPherson:

Thank you so much. We appreciate it.

Dr. Diane Meier:

It was really fun. Thanks for inviting me you guys.

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 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.