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 course work in the PhD in palliative care offered by the University of Maryland-Baltimore.

Connie Dahlin:

Good afternoon, everybody. Welcome to our University of Maryland PhD program podcast and I am Connie Dahlin, one of the faculty for the PhD program and I am joined by Lynn McPherson, who is, of course, the executive director of the Palliative Care Program at University of Maryland and we are thrilled today to have Betty Ferrell to talk to and many of you have heard Betty's name and seen a lot of her great work but I think we should just emphasize some of the things that Betty has done. Betty has been in nursing for a long time. She has expertise in clinical care. She is focused on pain management and so she's really helped with palliative care and oncology. She's looked at quality of life. She's looked at palliative care.

She currently is the Director of Nursing Research and Education and a professor at the City of Hope Medical Center in California. She's a fellow of the American Academy of Nursing and also the National Academy of Medicine, which is always very proud to see our nursing colleagues in leadership positions and she has been directing the End of Life Nursing Education Consortium or ELNEC for the last 20 years, amazing, with such an impact of over a million people who have been educated and that's not only nurses, that's a lot of different disciplines but she'll tell us more about that.

Betty's been very involved with the National Consensus for Quality Palliative Care Clinical Practice Guidelines, which you know as students, we will have you be looking at during this semester. She's edited the Oxford Textbook of Palliative Nursing and that's in its fifth edition and she's written a number of other important papers in terms of spirituality. So, we are so thrilled just to hear Betty's perspective from a lot of different angles, within nursing, from starting off from hospice to thinking about that. So Betty, I know I've only mentioned a little bit and scratched the surface, do you want to talk a little bit more about what you're proud of or introducing yourself so that the students even have more of a broad range of your expertise?

Betty Ferrell:

Sure. Well, first of all, I'm really glad to be a part of this interview and I have deep respect for both Connie and Lynn and am really, really excited about this PhD program and so the first thing I'd like to do is just congratulate anyone who's watching this because you're a part of this program. You truly will be pioneers in the United States. You're pioneering a new role, this notion of doctorate in palliative care is remarkable, amazing and so congratulations.

Just as a bit of background, I began my career 44 years ago this year and I started my career as a nurse, working on an oncology unit in a hospital I Oklahoma and just sort of as a part of history, an interesting thing is the week that I started, actually started working as a student, so a year before I really graduated from my bachelor's program in nursing but the day that I wandered up to the unit to see where I was going to be working was a momentous day because it was the first day that they were actually going to have an oncology unit.

Before that, cancer patients were just scattered throughout the hospital. If you had ovarian cancer, you probably were over on the OB/GYN unit, so you were dealing with ovarian cancer with a newborn baby in the room next to you and similarly, if you had breast cancer, you were over on the GYN floor also or wherever and so at that point in time, we didn't talk about death. We didn't talk about terminal illness and we didn't even say the word oncology.

And my first day, walking into the unit, I always share my career began because I stepped out on the floor to check out this unit and I saw this controversy, something was going on, people were very agitated and the controversy was that the hospital had decided to finally form an oncology unit and so they had sent ... And they had sent the engineers up to hang a sign on the wall that said oncology unit and as the engineers were trying to hang up this sign, there are all of these people very distressed, "You can't hang that on the wall. We can't say that. People won't ... They'll know they have cancer." Or "They won't want to come on this floor."

So, if you think about how far we've come from we wouldn't even say the word 'cancer' or 'oncology' to now we have this field of palliative care, it's pretty remarkable and so I consider myself incredibly fortunate to have lived this history.

So, I worked in oncology for the first three years after I graduated with my bachelor's degree in nursing and inpatient oncology and then the other big historic event was after three years working in the hospital, it was at a time where the hospital was the mecca, all healthcare happened in the hospital and if people were sick at home, we would say, "Well, come on in and stay." And so suddenly, what seemed like really overnight, this thing called DRGs came into being and so we all got this message saying you've got to get people out of the hospital and we thought, "What? We're going to send these terminally ill people home? How can that be?" And so that was really my first interest was to thinking how can these people leave the oncology unit and there was no such thing as hospice. There were a handful in the country and none in my state and so I was really intrigued with what's going to happen in people's homes.

So, that was my interest and that's really how I decided to go back and get my master's and then my doctorate is I thought, we have to understand what's happening to patients and families and then we need data, that was my point of going back for my doctorate is we have to change. We have to advocate for these patients and families and so how do I do that? Well, I need to be a researcher. I need data. And so that was my entry into the world of research and now, I've been at City of Hope for the last 32 years and as a researcher in this field. So, I feel like I am a part of the history and what a tremendous honor it's been to be a part of a field as the field has developed.

Dr. Lynn McPherson:

Dr. Ferrell, I have to tell you, one of my favorite books early in my career, I can picture it in my mind with purple and it was called Pain and the Elderly-

Betty Ferrell:

Yes.

Dr. Lynn McPherson:

[inaudible 00:07:26] that book and it was wonderful. It was from IASP. So thank you. Your career [inaudible 00:07:32] incredible.

Betty Ferrell:

As you mention pain, I was thinking about this just recently and honestly, the first few years of my career, there was no such thing as palliative care. There was no field. The word literally didn't exist and I started in pain management and now, later in my career, I look back and I think I was really fortunate to have that experience because I got to start with one thing, pain, and I learned methodology and I wrote and I learned around one problem and I think that was really helpful because then later in my career, when my net broadened to be all the palliative care and we were dealing with physical and psychological and spiritual and social and all aspects, I always feel like I cut my teeth on pain management and I'm really glad that I had that opportunity.

Connie Dahlin:

So, when you think about all of this and you think ... I'm going to just focus a little bit on nursing because I feel like sometimes we talk about hospice and palliative care now and we forget about how much nursing was at the forefront of this. Do you have some thoughts about that and maybe also not only where we are but in the sense of maybe where nursing needs to be?

Betty Ferrell:

Sure. Again, when I started the first hospice in my state in 1980 and our program, like many programs in the country, often began as purely a volunteer effort and so it was nurses who had other full-time jobs or physicians or a clergy person from the local church who they were starting these community hospice programs completely as volunteer efforts or perhaps there was a local VNA or home care agency that was going to try to develop a bit of a hospice program. But thinking of Florence Wald, who, of course, went from Yale New Haven, went over to the UK, observed the care at St. Christopher's and then came back to America.

I'll always remember the work of Jeanne Benoliel and her colleagues in California and that was one of the moments that really caught my attention and that is these were nurses, who, again, trying to just make the case that people who were dying were being really isolated and not cared for and they actually did a study where they timed how much time it took for nurses in the hospital to answer the call bell of a dying patient versus a patient expected to recover and the results showed that the dying patients were put in the last rooms in the hallway, far away from the nurse's station and it took the staff more time to get to them. There was total avoidance and I think so much how important that early work was to document what it was like when we still didn't even say the word 'death'.

I can remember I started my career in 1977. It was very close in time with Elisabeth Kubler-Ross' publication on death and dying and I remember just being just in awe of this notion of these chaplains working with Elisabeth Kubler-Ross to just make the case that there were terminally ill people. I think probably many people know the history that chaplains came to Elisabeth Kubler-Ross and said, "Help us," and so they went throughout this huge 1000-bed hospital in Chicago and they went unit by unit.

So, the chaplains thought, well, if the doctors asks, if this doctor helps us ... But they went unit by unit and they asked the question, which patients on the unit, on this unit, are not expected to recover or are dying and unit after unit after unit in this 1000-bed hospital, everybody said, "Oh no, no one's dying here." So, for me, to think back in the 1970s and even 1980s where we still didn't say the word, we didn't admit people were dying. We had no processes in place to care for them, that there was no such thing as a bereavement program. I mean there was such a void.

One of my personal relics is in 1980, when I started that first home-based hospice program, we put an advertisement, an ad, in the local newspaper to recruit for staff and it said, it was this home care agency and the ad basically said recruiting staff to work with a new hospice program. So, I placed the ad. A few days later, the newspaper office called me and they said, "We're getting all these phone calls from people who are saying, 'Well, what is that?' And also, how do you even pronounce it?" And so, they sent me back the ad and we had to revise the ad to explain what the word 'hospice' meant and how to say it.

And so I still have, in my archives, a copy of that ad that had hospice spelled out and how to pronounce it and defined it and that's amazing, right? To think that ... I mean I always say, when I started my career, there were no hospices in my state. There were a handful in the country. The word palliative care did not exist in our vocabulary and there was no such thing as a palliative care program and now, we look at the statistics, over 4000 hospices, 80% of hospitals that have a palliative care program, like that's amazing. It is amazing to see what decades of avoidance and silence have now resulted in remarkable change, such that people like you are getting a doctorate in a field that now exists. I mean that's so huge. It's so amazing.

Connie Dahlin:

Yeah, and I think that's the thing, Betty, that I am stunned by because I think even in palliative care, there are a lot of people who have no idea of the history. They have no idea of this connection of this volunteer movement, this Medicare benefit, which for better or for worse, defines hospice. Then there was this movement about palliative care because it was like hospice wasn't enough to then sort of now, a bit of a schism sometimes between hospice and palliative care. And so I think that's an interesting part because I think we want the students to be thinking, okay, there's always a context to things and things will change but like what is it that we need to keep, what is it that we not, how do we still stay together with this principle of care?

Betty Ferrell:

Right. And I would say, we are just barely at the jumping off point. It's not like we are late in history today, like this is 2021. We are barely touching the surface of the future of palliative care. We certainly, I think, in the last few years ... So, for example, with the release of the last addition of the national guidelines, just three years ago, we made that turn to say this can no longer be just about specialty palliative care. The important point here is how do we integrate palliative care in all systems of care for all people who are seriously ill and that is huge. It is remarkable.

But again, when I started my career and then when we first started hospice, I can remember clearly for the first several years, across the country, about 95% easily of all hospice patients were cancer patients. And it would be rare that you would ... In fact, if you heard that a pulmonary patient or heart failure patient was admitted, you'd be like, "What? How would that happen?" It was so rare. And of course, now, every day, I have a conversation with someone different about we really need this really increased palliative care in renal disease, in chronic pulmonary disease, in neurological diseases, in chronic serious pediatric illness.

So, we started, which was great, but we started with a really narrow vision and again, living through history, one of the things that, boy, really comes to my mind and is deep in my soul and will ever be there is living through the AIDS epidemic because I really remember that as a time where we still were hospice was very narrowly defined. There was no such thing as palliative care and it was completely cancer focused but suddenly, here was this population of people with this very serious disease that had just horrendous impact on symptoms and quality of life and so suddenly, hospices were there to say, we can provide care for people with AIDS.

Again, there was no palliative care. There was no effort to provide people with AIDS with the kind of care that they really needed from the time of diagnosis but at least there was that cushion of support that many people with AIDS were cared for by hospice programs. But I think that opened a door, in my mind, it opened a door in a way because suddenly, it wasn't just about cancer patients, it was about the kind of care and if hospice could also serve people with AIDS, maybe it could serve some other people. And I remember the earliest days when people in cardiology started saying, wait a minute, my patients are just as sick as your patients, why are they not getting this palliative care? And so it's been like an unfolding of one population at a time but we have so much to offer across so many settings. The opportunities are really just there waiting in so many ways. It's such an exciting time.

Connie Dahlin:

Well, I think also, what you mentioned, I remember caring for the AIDS patients too and just sort of trying to figure out would the hospice benefit and what was going to be covered and it was a younger group and as you said, it could be a really bad death and I think the other part, for me as a practitioner, it threw into a whole different light than what we had to deal from before was the whole ethical parts, right? Because to me, that was when this whole underground movement started that if we couldn't help them, they were creating all these other protocols and having to have discussions about hastening death because they knew what was going to happen with this dementia. They knew all of that, and so it sort of felt to me like it took us out of our naivety and also kind of moved us from teenagers to adults in having to have these conversations in a very different way.

And I think it's an interesting part when you think back of how much also I think because of the trajectory of cancer being more predictable at that time, I think it's so changed now with all of our therapies but AIDS being so much more unpredictable that it was sort of, in a certain sense, when you think about crises, in kind of a different version of what we've been going through with COVID, right? That palliative care got pushed to the front of COVID being present, not taking over from our critical care colleagues but really stepping with them.

And so what is that going to bring because, I think, we're at an interesting point and for the students, so that you know, Betty's daughter is a critical care physician, so she's been living this in a personal and a professional way too but how is are we going to kind of come through this so that we were there at this pandemic and helped when it really was end of life and we need to kind of help kind of space that out again and say we were here because you needed us but we're going to go back up stream? Do you have thoughts about that?

Betty Ferrell:

Yeah, it's so interesting. One of my memories and something I can think about is I had a graduate student when I first came to California, so this is 20, however many ... So this is like 1987, so what is that? Forty years ago? A long time ago, I guess 34 years ago. Anyway, she became a palliative care nurse and I remember her calling me when she then was getting her first job as an advanced practice nurse in a big hospital system and she was telling me that ... Which they were orienting her and she was starting her work, they said, palliative care is not allowed to walk onto the organ transplant unit. Do not walk past this door. Like they will call security. Palliative care cannot go here.

And they were very serious. They were very serious. So this is a large academic center and so there are all these patients awaiting lung transplants, heart transplants, et cetera and we all know what that really means and how many of those patients are ever going to get a transplant or those who do will survive the transplant, so we would all say that is a unit that needs palliative care and yet, at that point in time, which wasn't all that many years ago, it was we'll call security if palliative care tries to come here. I mean that's how crazy it was but then I loved the day that she called me back to say what happened is that it was one physician who had practiced in another state who moved, started working on that unit and that physician said, "Are you all crazy? I've always used palliative care for my transplant patients and I'm going to use them now and so there."

And so he started referring to the palliative care team, which then they could come onto the unit and of course, you all know the end of that story. It took a matter of a few months before the nurses were rioting on that unit to say this is unacceptable. Like we've seen how much they help these patients, why can they not help other patients? And of course, the nurse called me back to say, "Guess what? We have a meeting because they've now asked me to see every patient on the unit. So now I have a different problem. Like I can't see every patient on the organ transplant unit." So, I think it's the same sort of thing with COVID that we've made a lot of headway in the last 10-plus years with palliative care being accepted for people, a lot of older people and people with serious chronic illness.

Like there's not a lot of contention around going to see the heart failure patient or the severe COPD patient, end-stage renal disease but there ... Still, it's a very different thing when you have the 20-year-old with COVID in the ED and the person who was really healthy yesterday and now we are facing this pandemic where young people are ill as well as older people and people are declining rapidly. And so I think that COVID, I think we will look back and say COVID changed our field of palliative care and I see it in terms of the people who were really not yet converted to the importance of palliative care such as ICUs in many instances, EDs, that they began to see oh, that's what palliative care can do for us.

The other thing that I think really happened in the time as we're still living, COVID, is that having this pandemic that was affecting millions of people was the first time in my career that we, the healthcare providers, were also so threatened about getting this disease ourselves and dying ourselves. So personal threat was so enormous and grief. Just the profound grief of staff who were witnessing, in many settings, 10, 20 deaths a day. I mean we all saw the images of the trailers parked out in the parking lot to be the makeshift morgues because there were just too many bodies and so I think people also began to recognize the value of palliative care to be there to support the staff.

So there are such amazing examples around the country where the palliative care team was there to be in the unit and support that new graduate that was having the fourth death of her shift and to be there as some of our colleagues became ill. And so I think there's a whole different awareness, recognition, understanding of palliative care as a part of the healthcare system and I think we will look back at this time and recognize that much like the AIDS epidemic that this time of COVID also was a turning point for our field.

Connie Dahlin:

Yeah, I mean I think it's an interesting part to think of because as you said, I mean we're still in it. I'm not convinced we will be out of it for a little bit more time in spite of our safety changes by the CDC and I think here's the present time and how do we hold all of our palliative care providers knowing that many of them have experienced, I would say, PTSD and here we're so used to taking care of patients and families and then we've got to take care of ourselves and then I think also be prepared that we are going to lose, by choice, people who leave the profession and then I do think we are seeing some dark sides of people committing suicide that we just didn't hold them and so that, to me, also is a wake up call of how much palliative care, the psychosocial part, because it's in our language to actually talk about the challenge of the work. I don't know very many other specialties that they sort of are mandating that you talk about how hard this work is.

Betty Ferrell:

Right. I think that, for example, just the notion of bereavement and I think so many clinicians would say "Oh, bereavement, grief, bereavement, oh, that's somebody else takes care of that. I took care of the patient, the end. And so it's somebody else out there in the community maybe that I hope is offering some bereavement support." But I think that during this time of COVID, I think there's severe PTSD that we've only begun to even recognize that has not been fully experienced and I think that we are dealing with staff grief, we are dealing with the loss of our own colleagues, we're dealing with just too much loss.

And the fact that the personal threat, I think those first few months with the lack of protective equipment, the personal threat that clinicians felt was unlike anything I've known before. So, we are really ... I think there is a new awareness of moral distress, of staff stress and grief and bereavement and I'm really hoping that the palliative care community will have a lot to offer, particularly over the next year or two, because I think the palliative care teams have a lot they can do to support staff who are experiencing this extreme PTSD and also I hope that we use this opportunity to rethink how could we possibly not have support in place for staff? How can we possibly not have a plan for providing relief for staff?

I hope that we've learned. I can't imagine that anyone would think the last day we take off the last mask that we're returning to some pre-kind of normal times that the world is forever changed. We are forever changed. Healthcare is forever changed and certainly, palliative care is forever changed.

Connie Dahlin:

So, what are some of the other issues that you think our students should be thinking of now that they may not have been thinking about when they came in or they might not have experienced or that are just some things that people don't normally think about?

Betty Ferrell:

Right. I was talking to a university professor and she was talking about ... Talking to her incoming students, this has been a couple years ago, but she made the comment that most of the jobs that her new students would be going into are jobs that don't exist today. That when you're sitting there in your chair, if this is your first semester of your doctorate program, yes, you're here to prepare for a new life in your career for some new potential new career but the reality is that the world is changing so rapidly and that honestly, the opportunities for palliative care that you will walk into when you finish this degree are opportunities that I can't even tell you what they are because they don't exist.

And so what does that mean? I think what that means is that you are coming into this program to learn some theoretical knowledge and some history about the field and a lot of clinical skills and you're largely coming into this program to become researchers and leaders but the world that you will enter even a couple of years from now, completing your PhD, will be a world that has evolved while you were in this doctorate program, right? And so, I mean just ... There's one factor and if you took that one factor and disregarded everything else, it would make the case for palliative care and that is the aging population.

We have no plan. The number of people who will be living for decades with serious chronic illness, that in itself is the need for the entire field of palliative care but then add to that what we've now learned about the importance of palliative care in acute care. We haven't touched the potential for palliative care in mental health. We have not served the most underserved communities. The world of pediatrics exploding with opportunity for palliative care, exploding with opportunity. In our ELNEC project, I'm working this week actually with a taskforce that has been created within our ELNEC project to look at perinatal care. We started our pediatric palliative care and then after a few years, there was this huge demand for we need this in neonatal care and so we had to create palliative care for neonatal care.

Now, there's this big demand for we need palliative care to be integrated for perinatal care, for every parent, every family that is now with all of our genetic testing, et cetera, that we know that these are babies that are going to be born with life threatening or very serious illness. We need to upstream even further, upstream the upstream, right? And so the opportunities for palliative care in pediatrics, the opportunities in geriatrics, the opportunities to really revisit, in a very important way, care for people in nursing homes, all health systems.

We need models of care and we need data. We need research. We need rigorous science to create the evidence base. So, I think there's so many opportunities and many of the jobs that await someone with a PhD in palliative care maybe very different than sometimes we think oh, you get a PhD, you get a faculty role. There's going to be so many opportunities, so many places that knowledge in palliative care will just be such a valuable asset to make an impact in healthcare.

Dr. Lynn McPherson:

I don't think you're alone in that thinking, Dr. Ferrell. In the couple of weeks since I leaked word of this program hopefully being launched this fall, we have over 100 people on the list who say they're going to apply. So I think that you are not alone in that.

Betty Ferrell:

Mm-hmm (affirmative), absolutely.

Connie Dahlin:

I'm sorry. Go ahead, Lynn.

Dr. Lynn McPherson:

I was just going to say, the flip side of what you're saying is I think you've kind of made a good case for every healthcare provider should at least possess those basic primary palliative care skills, would you agree?

Betty Ferrell:

Absolutely. That's what primary palliative care means and that's what pick up the last issue of the National Palliative Care Guidelines and what it says is we need primary palliative care. Every clinician that cares for a seriously ill person needs to have, right? If I'm diagnosed with cancer and I go see my oncologist, you better believe that I hope that oncologist or the oncology nurse in that clinic or the social worker in that clinic, you better believe that I want them to know how to manage my pain, communicate well with me, help me make decisions, support my family, offer bereavement support, that should be an expectation. We should be shocked at the notion that you care for people with heart failure and you don't know palliative care, right?

So, primary palliative care is enormous. The one other thing I would add is this notion of interdisciplinary education and training because I represent still the generations of people taught in silos, right? Nurses were taught with nurses. Nurses were taught with the lens of nursing and then we all leave our silos and then move into health systems where we try to work together and we realize we do not speak the same language, right? So probably the biggest contribution that hospice made was this notion of wait a minute, when we say this is interdisciplinary care, we mean it, right?

And so over these last few decades, we've been learning about what that really looks like. What does interdisciplinary care mean and how do interdisciplinary teams work together? And so what you've created is a PhD program in palliative care but I would argue even more importantly than that, what you've created is an interdisciplinary doctoral program and that is the skillset that people need. And so the fact that you will graduate from this program with a PhD in this field of palliative care that is absolutely vital to the entire healthcare system of the future, and you've done that in an interdisciplinary program, again, you will have knowledge and skills beyond anything that we could imagine. It's amazing and so important.

Connie Dahlin:

And what I was just going to say though is taking it one further, like if we think about what COVID taught people is that beyond even primary palliative cadre, that all clinicians need a communication skillset. That all clinicians need some of these pieces. So maybe there's also a way for us to get palliative care principles, whether they're doing primary or specialty, kind of embedded more into the healthcare culture, right?

Betty Ferrell:

Right.

Connie Dahlin:

And so I think this other part about where I thought you might go or you mentioned a little bit was this whole part about health equity and we, in palliative care, still have some work to do with that. We can see by the hospice statistics and by the palliative care statistics that we are still meeting mostly a white population and we haven't kind of gone into the community. So I think also the opportunity to move into the communities and sort of not kind of focus everything on the hospital because where we know some of the patients who may be part of populations that have underserved or not served, they want to be in their community and so how are we going to pivot to meet the needs of the community and that offers a lot of opportunity as well.

Betty Ferrell:

Right, absolutely.

Connie Dahlin:

So are there any things, Betty, that worry you right now or that you feel like, hmm, we need to pay attention to this as we move forward so that we make sure that we're sailing in the right direction?

Betty Ferrell:

I think the demand for palliative care is the most worrisome thing because it is so enormous and one could argue that as we moved into the COVID pandemic that I think many people would say every person in the building needs palliative care, right? Because you're probably in the hospital because you have COVID or you are so sick, they couldn't keep you home despite the fact that we have this pandemic. People are isolated from their families and so there was such this apparent like wow, this ... How can we not provide palliative care to everybody kind of idea and so I think that's really the challenge when we say these words that we need to rethink what is the role of specialty palliative care and I think we need some new models of what specialty palliative care looks like and then I also think we need to ... We say these words, primary palliative care, but we need ... That will take new models. It will take operationalizing what does that really mean.

And I'll just sort of mention one project, we have an NCI training camp right now which is in its fifth year and it's R25-funded by NCI to take oncology advanced practice nurses and so you cannot be in palliative care, you can't have palliative care specialty training but oncology advanced practice nurses, so this is like the nurse that runs the breast clinic, the nurse giving chemotherapy, the oncology clinical specialist on the oncology unit teaching staff and doing staff development, we're bringing together these oncology advanced practice nurses and then we are training them through the ELNEC curriculum to give them the palliative care skillset and knowledge on top of their oncology knowledge and then we're sending them back home to implement and really integrate palliative care in their work, their daily work as an oncology nurse.

Part of that experience is they had to come with a letter of support from the palliative care team because we wanted to know that these nurses would have the support of palliative care and we are also requiring that they spend some time observing the palliative care team. We can teach them in the classroom, they need to witness palliative care happening. So that's an example of a model of really taking this notion of primary palliative care but then how do you make that happen? And so I think that will be a huge part of the future is how do we integrate this knowledge that we have about good communication skills and advanced care planning and psychosocial support and spiritual care, how do we take these elements and as the palliative care specialist, really guide their integration into the larger healthcare system?

So, the work we do will need to be re-imagined as palliative care specialists but then the role of the primary care clinician also needs to be re-imagined.

Connie Dahlin:

I mean it's fascinating to think about because I think we heard from the other part of just the changing technology of what we imagine now just even being in a technological world and so how will that all come together. Any other advice that you would give to our students as they go out and think about this and start in a leadership position just by taking ... By finishing a PhD program?

Betty Ferrell:

Yeah, I mean I think people who go to a doctorate program, the purpose of going to a doctorate program is really those two things. One is to develop research skills so that you can really contribute to the evidence base and the second thing is to learn how to be a leader and that's really where your energy should be. When it comes to the research component, I would say find the topic you love. Find your passion. Every one of you is going to sit in some course in this curriculum, I'm sure, that's the find your dissertation topic and dissertation seminar kinds of topics but ... And lots of people have ideas what you should do. So my advice to you is find what you're passionate about. Find what you wake up thinking about. Find what just gets you energized and that's where you should do your research.

Research done well should just look like passion, right? It should look like the finest form of patient advocacy that's ever existed. That's my advice about research. Find what's burning in your soul and by god, that's what your dissertation should be about. I think when it comes to leadership, I'm learning a lot about leadership, being a part of the Cambia Sojourns Scholar program and some other leadership, kind of mentorship experiences and you know what I would say there is I think the world of palliative care is also teaching some things about what leadership looks like. The leader of healthcare for the future is going to need a different set of skills than the leader of 10 years ago.

We are learning that yes, organizations need people with good, strong business sense and budget knowledge and strategic planning but organizations need leaders that are emotionally mature and that are great mentors and people who have vision and so I would just say as you're learning in the same way as you're learning to be a good researcher, follow your heart, I would say as you're learning to be a good leader, don't abandon the field of palliative care. Be a palliative care leader and so palliative care leaders bring a different skillset. Bring what you know about good communication and compassion and self-care and all of those things, all of those elements that make the field of palliative care what it is, those are the things to nurture. Those are the palliative care leaders that we need for the future.

Connie Dahlin:

Well, that, I think, is amazing advice and really good for our students to think about. Lynn, do you have any other comments or thoughts?

Dr. Lynn McPherson:

I think Dr. Ferrell hung the moon. That's all I have to say.

Connie Dahlin:

Well, thank you so much. We are so grateful and we know that the students who are listening to this will really have learned so much about just reflection and moving forward in the field.

Dr. Lynn McPherson:

Thank you, Dr. Ferrell.

Betty Ferrell:

Absolutely. It's a huge investment and I know to enter a doctorate program is a huge personal and professional commitment but I've always said I am grateful for everyday, and I am so grateful that I made the decision to get my doctoral degree because it just gives you just that strength you need to do the passionate work that we all want to do. So congratulations and I can't wait to see the wonderful things to come out of this program. It's amazing.

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.