

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

Connie Dahlin:

Welcome everyone. This is another of our podcasts for our PhD in Palliative Care Programs. My name is Connie Dahlin and I'm one of the faculty for the University of Maryland Palliative Care Program. Also I'm joined by Dr. Lynn McPherson, who is the Director of the Graduate Program in the Palliative Master's Program.

We are so thrilled today to have one of our esteemed colleagues, Dr. Judy Paice. Judy is the Director of the Cancer Pain Program in the Division of Hematology-Oncology and a Research Professor of Medicine at Northwestern University. She's also a member of the Comprehensive Cancer Working Group. The other part about Judy is Judy has had a lot of leadership positions, so she was president of the American Pain Society, and also had a leadership role in the International Association for the Study of Pain. She's been involved with a lot of the pain guidelines that we use, has really been teaching people for a long time how to use pain medicines and what are the right doses. She's been a part of this whole thought process that we started off in oncology with not having people address pain. Then came pain as the fifth vital sign. Then we moved into this opioid crisis and now we're trying to figure out the next steps. And so Judy is really one of the thought leaders in that.

And then finally, Judy has been part of the really established faculty for the End-of-Life Nursing Education Consortium, and has had an international impact because she's gone to pretty much every continent to be teaching cohorts of learners, whether they're nurses, physicians, social workers, community health workers about palliative care, but with a sensitivity of what is their environment like, what's their community like. And so it's been, I think this cultural broker in that what we have in the United States works here, but that may not work for some of the other countries. So, Judy we're just thrilled to have you today.

Dr. Judy Paice:

Thanks, Connie. And thanks Lynn. I am actually so excited to be here with two of my very favorite colleagues, from very different perspectives too. I've known Lynn from the pain world for a very long time, since we were infants. And Connie was actually very involved in ELNEC, is very involved in ELNEC and I had the opportunity to travel with you, Connie, to some of those continents. The only place we haven't been as you know is Antarctica. And so once penguins are ready to learn about palliative care, then we've got a place to go, but thank you all so very much for listening and for inviting me today.

Connie Dahlin:

So Judy, I think, I kind of mentioned a little bit about, you've had such an impressive career and I think as a nurse researcher and really having a leadership role in setting guidelines, but also in terms of helping us think about good clinical care, when you kind of think back about your involvement in getting into hospice and palliative care, what were some of the things that drew you to it and still draws you to it to this day?

Dr. Judy Paice:

That's a really interesting question and I hope you don't mind if I go back a little bit into a little historical perspective. I started out a very long time ago as a brand new staff nurse on an oncology unit in a VA hospital. And we were working with often very limited resources. And at the time people were only given opioids if they were essentially actively dying. And I just could see the amount of suffering that resulted because of those policies. And it wasn't specific to the VA, it was really endemic. We were fearful about opioids, we limited their use, and that just sparked in me a passion to try to find better ways to relieve suffering. Now at that time hospice was just getting started. I had really no idea about hospice at that point. And palliative care was just a dream in someone's heart and mind at that point.

So like many in the palliative care world, I came up from oncology, as Connie described, and focused on ways to improve pain management. So I certainly entered into palliative care after many other leaders had done all the hard work of establishing this field. I think that there is a lot of amazing groundwork that went on and that the field has evolved quite amazingly. And again, my context of pain is an interesting parallel because in the beginning palliative care was also only for those who were almost actively dying, right? And we are moving upstream, caring for people with serious illness that may live now for years and years. And we're also trying to sort out in the pain world, who are those people who might benefit from opioids and live years and years. So interesting parallels.

Dr. Lynn McPherson:

Connie you're muted.

Connie Dahlin:

The other issue for, I think our students to understand is I think Judy is really leading right now with not only deciding what is the best pain regimen for these people, but also thinking of this whole health equity issue, that we have people who may not be able to afford medications, this whole access that they live in pharmacy deserts. And I think the other part with all of the socio-political things that have been going on, some of this access to care for people who may have substance use disorder. And so I think, Judy you've been really a thought leader of, these are not easy answers, where do we use our best judgment? So I would love for you to kind of give some perspectives about some of the ways that you've had to, what you might've thought about guidelines before, what your opinions changed and any thoughts for where we are now.

Dr. Judy Paice:

Yeah, Connie. You've very eloquently stated the challenges that we all face. I think what has been a driver for me from the very beginning is that we need science, we need data. There is so much anecdote, and some of those are really valid. In the absence of data, it's our experience that can drive us. But what I have valued throughout my career is being a recipient of the large S, of the knowledge, of the wisdom, of people from many different fields. Just on this podcast right now, we've got a pharmacist and an advanced practice nurse and an advanced practice nurse. What a rich clinical experience the three of us bring? What I've always valued, why I was so active in the American Pain Society was that I loved, not only hearing from pharmacists, but from my basic science colleagues.

And frankly, I was a bit nervous about that because I didn't speak their language nor did they speak mine, but we were able to come together and really learn from one another and then develop policies or guidelines or other kinds of documents or studies that had the richness of the basic, the other kinds of health systems, kinds of science, and then the clinical experiences. So throughout my career,

what I have tried to do is to serve as that translator to pull in people from many different disciplines so that we do get the richness. And actually there's a parallel to palliative care. Isn't there? The palliative care is an interdisciplinary field. It's best when there are nurses and physicians and pharmacists and chaplains and social workers and all the others, anybody who can contribute to the team.

So that has been a driver for me. And I think for your students, I would so strongly encourage if there's trepidation about approaching others, overcome that as to the best that you can, because they will learn from you, you will certainly learn from them. And it is that richness that actually will build the field. If we stay in our silos, we will only know what we in our science, in our discipline know. I can't say it any more strongly.

Connie Dahlin:

No, I think you've made two good points. One is you were talking about wanting to be a translator of these different sciences. And in fact, I think palliative care, sometimes we're a translator, because people are hearing so many things and we're trying to break this down. I think this other part that you are speaking to is that as we think about the evolution of hospice and palliative care, first was just kind of getting the philosophy together and creating a consensus of what that is, to the extent that we can.

I think the second was sort of saying, okay, this is this clinical expertise, how do we define it by whatever? And now as we kind of move into the next stage of evolution, what you're speaking to, Judy, is that we do need to move outside of ourselves. We have to kind of think about, there are other people who've created new specialties, created new fields, and there's other work we can bring in. And that's the way that we're going to be able to move forward. Because it might be business concepts, it might be the technology, that's the way of the world. And if we stay insular, we're not going to grow. So I think that that's really important of what you kind of said with that of movement forward.

Dr. Judy Paice:

And...

Connie Dahlin:

Go ahead.

Dr. Judy Paice:

You mentioned business. For me, it was always the basic science. I'm not going to become a basic scientist, but I'm going to be critiquing that literature. You described the business perspective. I'm always going to be living within an institution that has business issues and philosophies and principles. And I need to at least at some level understand. So yes, you've highlighted it nicely, Connie.

Connie Dahlin:

And so then I think this interesting part about how do we learn and go forward. So I can think about, if you were to kind of frame it once since we had this crisis, because we weren't treating pain, then we had the AIDS crisis that we didn't know how to treat this new disease, then we got into trouble because we had chronic pain that we weren't treating. And now we're in an opioid crisis except for the fact that given some of the policies that happen, and you all can explicate it, and I hope you do. For our students to understand that as we developed this opioid strategy, there are less opioids being produced. And then when Puerto Rico got hit by the hurricane, they have never made it back. And so they have

factories that were, I guess, making opioids and other healthcare products and they've not come back online yet.

So we not only have this crisis, but then we have patients need to be treated, but we still have such a less production. So how would you kind of do, interpret simply for kind of like this part about where we've gone in this pain world? Because I think that would be really interesting from your perspective.

Dr. Judy Paice:

Sure. So, and again, this is the world according to me, so I see the world through a lens that everyone is going to have a slightly different lens. But again, back to the beginning, I saw pain poorly treated. I worked so hard to find ways, as I know you two did as well find ways to improve that management. And part of it was knowledge. So to try to improve education, but we know that pain being so subjective, it's more about attitudes as well. So working on both of those, it's not just enough to educate people to the equianalgesic dose of an opioid, as Lynn has done so nicely with all of her textbooks. And in your textbooks, you do with humor, ways to get over the stigma as well. So trying to help people understand.

There was an amazing program. And it's interesting, historically, everybody now is trying to look at who to point the fingers at. Some people have pointed fingers at the Joint Commission, others at the American Pain Society about the pain is the fifth vital sign. And I thought that was, and I still believe, that was an important program at the time. We were not documenting pain in the patient's medical record and it was not being acknowledged. So what a simple kind of strategy to add it to the vital signs so that it was normalized as an essential assessment parameter.

Now, nobody in any of those kind of strategies set and give them all the morphine they've ever wanted. It was, let's acknowledge that people have pain. Unfortunately, I've been called by reporters and many others who want to find out who in that American Pain Society pushed that program, because, that's the whole cause of the opioid epidemic. And thankfully I've had people who have taken the time to listen, to learn that that really is an awfully simplistic perspective. It was so much more complicated than that. And yes, now we've got all sorts of books and now documentaries about the role of pharma and how pharma was really pressing these medications, the role of the wholesalers, how they were delivering mega quantities of opioids to some little towns that were receiving orders of magnitude more opioid than the numbers of people in the population of those little towns.

So there were multiple variables that led to this problem of misuse. And some of it may have just been also the [inaudible 00:15:47] of our world. People looking for other ways to become inebriated, if you will. Substance use disorder, whether it's alcohol, tobacco, or opioids, benzodiazepines, these have been around for a very long period of time unfortunately. So the opioids that we were prescribing were entering the community, there is no doubt about it. We were not teaching people at that time about safe storage. It just wasn't on our radar screen.

So the pendulum went to the wrong direction. Many, many people who shouldn't have been getting these medicines did. And then after a while, people started to observe this and policies were put in place to help mitigate this. Some of them were a bit challenging to us, as Connie mentioned, things like the DEA who is responsible for not only the regulatory kinds of things that we know about with DEA, but they are also responsible for allocating the amount of powder, if you will, or free materials that go into the tablets that we then eventually order and dispense to our patients. And they diminished the amount of morphine for example, or opium type products that would be given to manufacturers by 10% per year. So it was incrementally being reduced. And then there were some other factors like hurricanes and things that interrupted supply.

And then we unfortunately saw that heroin and eventually fentanyl, illicit fentanyl became much cheaper than prescription opioids. And the prescription opioid misuse declined and we saw an extreme escalation in the illicit use of heroin and in fentanyl, and now we're seeing an extraordinary increase in methamphetamine as well. So unfortunately, there were also other byproducts, unintended consequences as I keep calling it. The insurance companies jumped on this as a way to limit their financial impact of having to pay for opioids. And so they've implemented something called a prior authorization. So for all of you that aren't stuck with those kinds of clinical responsibilities, I just came back to, after a three-day weekend and I had 10 different prescriptions I just had to write for folks who filled their pill boxes over the weekend. And I've already gotten three requests for prior authorizations from those 10 prescriptions.

What that means is I need to either go online or call the insurance companies from a draconian perspective. So much of this done by fax. Do you do anything by fax anymore? And I have to document the patient's medical diagnosis, which gosh, I hope the insurance company is aware of their diagnosis since they're paying for their chemotherapy and their other medications. So it's really quite a bit of jumping through hoops. And the sense quite frankly, is that it's just a way to limit access to these medications. And Connie, you also inferred that our patients with, people of color, people who live in neighborhoods that serve primarily people of color or people who have limited socio-economic status, those pharmacies tend to not want to carry these drugs. And so many of our patients have great difficulty accessing the medications. And as a result, many of my colleagues don't even want to prescribe these medicines anymore.

Dr. Lynn McPherson:

Judy, you mentioned unintended consequences, the CDC guidelines that came up in 2016, I believe it was, if you read them carefully, they're very well-intended and they make perfect sense to me, but they did kind of have a little bit of a boomerang effect. Can you speak to that?

Dr. Judy Paice:

So there were concerns, and here I sat on a different government panel at that time, and we were protesting the CDC guidelines when they were open for public comment. So there were a lot of concerns about the actual process and some of the consultants who were involved in the process. It was open for public comment for a very short period of time. Initially the document stated that it would exclude people in hospice. Well, we both know, everybody listening to this knows that it isn't just people in hospice who might need opioids. What about people in palliative care or people with active cancer treatment or many others? So we were able to modify some of those.

And Lynn, you're absolutely right. Most of it reads like mom and apple pie. It's a reasonable guideline, which by the way, it is being modified at this point and will be released very soon. But there were two components, two recommendations that really made many of us quite concerned. And for good reason, it turned out afterward. One was that even though the guideline was supposed to be for primary care docs and for people with chronic pain, they instilled two recommendations that were really related to acute pain. One was that patients shouldn't get any more than a three-day supply or in extreme circumstances, a seven days supply. And then the other was to limit the dosing to less than 60 milligrams. Never should be more than 90 milligrams of morphine equivalents.

And again, the insurance companies quickly picked up on those. And I had many, many patients who would bring the prescription that I would provide to their pharmacy and be told, oh, no, you can't get 100 pills, you can only get 20 pills because that's a three-day supply. Or no, you cannot get this amount of pain medicine, even though they have been receiving it. So it meant more communication

with the insurance companies and the pharmacies to override those recommendations. But now the insurance companies somewhat carry a bit of an imprimatur right. They had the adornment of the CDC guidelines that they could fall back on when they were limiting access.

Connie Dahlin:

Yes, it's really been a challenge. It really has. And one thing that, a couple of things strike me is as a prescriber, if you write for a long acting morphine and a short acting morphine as needed, the pharmacy has to count all possible doses, which could artificially throw the patient over that artificial limit, I would say, even if they never even used it as needed, short acting opioid. And my second observation is I've really been invested in this, because as you say, I'm very interested in opioid conversion calculations is how practitioners are widely disparate in their ability to do an opioid conversion calculation. And those online calculators are notoriously unreliable because there's no critical thinking that goes into it. So what are your thoughts on all that? Should we do away with the limits? What do you think?

Dr. Judy Paice:

I think they should just merely be guidance and not endorsed by the insurance companies either overtly or covertly. I agree with you about those online calculators. All it takes is one decimal point. If you do not understand what you believe to be the approximate equianalgesic conversion, if you don't have a sense of it and you just blindly follow those calculators, you can really cause serious harm.

Connie Dahlin:

Absolutely.

Dr. Judy Paice:

So I'm with you on that.

Connie Dahlin:

So do you think that the CDC guidance has had an impact on how we treat pain in hospice and palliative care patients?

Dr. Judy Paice:

I do not know about the hospice world as well. You would be able to respond to that, Lynn much better than me. I see it when I refer patients to hospice that because for example of the opioid epidemic, we do see the comfort kids are not being supplied like they used to be. Smaller amounts of medicines are being provided, which is not necessarily a bad thing if you live in an area where there's rapid access, but if you live in a rural area where it may take a while for your hospice team to get you additional medicines, then that's actually dangerous.

So from a hospice perspective, I think there are others who have greater expertise and awareness. From a palliative care perspective, I see my colleagues struggling with the same issues of prior authorizations. And in fact, some teams are having to use a significant portion of an FTE, and it's usually a nurse, who has to be the person on the phone with all of those insurance providers and pharmacies just trying to gain the access.

Dr. Lynn McPherson:

Yeah, well, I will say about the comfort kits or starter kits, comfort packs, whatever you call it. Part of the reason there is the drugs are so damn expensive. Where a comfort kit used to be \$10 or \$15, which was a very reasonable investment, now I'm seeing \$75, \$100. And so I think your point is so much medication is destroyed at the time of death, that I think more often our hospices are looking at what's the patient's clinical situation, because my other point is, most hospices now, large ones, have like a SWAT team for patients who you hope they live through the four hour admission visit and can sign the paperwork, because people are being referred so late in the game, they would not need a huge quantity of medication. And I do think hospices are sensitive to the patient not dying with a boatload of medications in the home, because now those medications belong to the patient, and by extension on their death to their family, and we can't make them destroy those medications. So it really is multifactorial.

Connie Dahlin:

And I would just say, I think my experience, and so, you both know that I started off in hospice and started an urban hospice. And so all the intricacies, Judy of what you're talking about of safety and what we're prescribing and how do people get medications and going to people's houses and, they were ripping off labels and stuff when they threw away bottles because they didn't want anybody to know what it was. To then do the palliative care team and now, I think the challenge that I have had, I would say for the last 20 years, is I never felt comfortable signing a comfort kit because I really wanted people to think through, what is the person's diagnosis? If we're going to think proactively, what are the symptoms based on their diagnosis that are going to happen?

So if we think they're going to get anxious, I'm happy to do, if you want, lorazepam or a diazepam. I'm not happy when you're telling me that you want me to write an ABHR suppository or something like that. I'm not happy when you're going to tell me that you're going to do ativan, rubbing it on your wrists. So like just the science of some of these. And people, particularly, I think this nurse to nurse part would say, Hey, you're a nurse. You're supposed to be sort of my practice. And I'm like, and I'm a prescriber. And so when people see what I'm prescribing, I want to be able to justify it. So I would be crossing off that list and doing whatever. So I can imagine sometimes I wasn't very popular.

But I think this part, what you're speaking to is thinking clinically what's in front of us and what is appropriate and what's not, I'm wondering, because I think the second part of what you said was so important for people to realize that in fact buying heroin and getting fentanyl is cheaper sometimes than people getting their prescriptions. And that if you have people who have to make a decision for better or worse, and if you think about the fact that we started off in hospice using heroin 60 years ago, it's not uncommon that people would be thinking about that, but we were doing this and then now we've just added, for a lot of people, when you're writing an opioid, you have to write Narcan. And the whole politics of that because that's another prescription, and I don't know what the cost is. I understand the reasoning and I just worry because, am I correct that at one point, the cost of that went up because people knew that there would be a demand for that and so the price for patients was more?

Dr. Judy Paice:

Yeah, in the Chicago area, it went from \$135, \$130 for it comes in two nasal applicators. And now it's running around \$150. Initially it was not paid for by insurance. Now it is, and I'll say most of the time, I would say about 90% of the time. But it takes a lot of time to help people understand what it's for, and with stigma already so profound about opioids, you really have to present this so carefully so that people aren't thinking that we're suggesting that they're going to misuse the drug or that we're accusing their children or grandchildren of potentially misusing the drug. I always try to present it as a safety

perspective and I kind of say it's kind of like a Murphy's law, if you've got it, you won't need it. But it's a challenge because now I'm trying to always remember, have I documented this, have I given the patient this, it expires in about a year. So for some of my patients who are living longer, I'm trying to remember to re-prescribe it. So it's another interesting wrinkle.

And Connie, you've kind of hit on the piece that I really want people to understand. There are the people who are the experts in pain. There are the people who are the experts in addiction. And now in palliative care, we are seeing both and it is to be expected that there's a certain level of substance use disorder within our society. Some are proposing that with COVID, maybe it's actually risen. And now they're presented with a serious illness. Is it unreasonable to expect that we're going to see folks who need that specialized kind of care? Initially, again, the pendulum just swings back and forth. Initially I would hear many of my palliative care colleagues say we shouldn't be taking care of those people because we don't have that expertise. And just from a perspective of who goes into palliative care, we're kind souls, and we're going to be manipulated seriously. I heard those kinds of arguments about why we shouldn't care for those people.

Now, am I saying that I have the expertise? I'm learning, I'm trying, and I hope everyone can. It is not an easy thing. We don't have enough palliative care staff and we don't have enough addiction staff. So here we have an absence of expertise in, especially on the addiction side. And so trying to, again, I'm trying to now build those kinds of bridges so that we can all speak the same language and learn from the science that each of us possess so we can provide better care for those patients with substance use disorder and those patients at risk for substance use disorder.

Connie Dahlin:

Well, I think, Judy, what you speak to also is this interesting part, because I'm thinking, academic medical hospitals you have addiction services. Or sometimes you do. But then the challenge is this, so thinking about a patient, I think where I learned was some of my attendings who came in later on had dual education in palliative care and pain, which was always amazing to bring to the team, but none of them had addiction. They hadn't done addictions and palliative care, so that hasn't come in that way. But it's an interesting part because I think of how do we get support to care for these patients? Because I think you do bring up this really important part because if we don't care for them who does, and if you're in a community and you have some providers who say, I'm not going to write for this, then the patients left without anything. And that we need to learn some skills, because I can remember saying, oh, in our hospice population, we only have 4% of people who may have a substance use disorder.

This was a long time ago. And I don't know where we even got that statistic, but I think it was during the pain part when we were saying, of course we should use pain medicines with chronic illness. And now I'm sure those numbers are higher, but I think where I get into just trying to make sure that I'm practicing well is that I don't practice in solo, that I'm working with my team and that we're talking through the addictions part so that we're coming up, even if they aren't seeing them on a regular basis, a plan of care that has been collaborative and we've consulted. And I worry sometimes that the piece that's missing for the palliative care providers has just been doing pry offs can be demanding. You need to take the time to think about when you're caring for these patients and you don't have that expertise, who are you kind of running these cases by? Do you know what I mean?

Lynn, I interrupted you, you were going to ask a question.

Dr. Lynn McPherson:

Well, I just think there's so much moral angst on the part of hospice and palliative care providers. When you're caring for someone who is actively abusing heroin or something else, and we desperately want to treat their pain and either somebody in the, we're paying for medications that are delivered to the home and hospice and maybe a family member is stealing their medication. Well, the nurses, but we still need to treat the pain. I know, I know we do. Or the patient says, I'm not going to stop my heroin or they'll take all of the methadone on day one, but we desperately want to treat their pain but there's a liability issue. I don't want to kill somebody. It's just a real conundrum, isn't it?

Dr. Judy Paice:

Mm-hmm (affirmative).

Dr. Lynn McPherson:

Oh my goodness. Judy, maybe you could speak just for a moment too. I know about two or three years ago, there was a big kerfluffle about, oh my gosh, look at this cancer survivors are using more opioids per capita than the general population. Well, duh. Even post-mastectomy or posts lymph node dissection survivors can have persistent pain forever. So what are your thoughts on that? I know you wrote report of a position paper on that.

Dr. Judy Paice:

Yeah. I was the lead author on the ASCO clinical practice guidelines for pain and cancer survivors. And that was published in 2016, around this time as the CDC guidelines. So I think it was a little overshadowed. And what I believe this document really contributes were twofold. One, we highlighted all of the pain syndromes, at least at that time. Now we could add to that list quite a bit because of the advent of immunotherapy, but there were quite a few syndromes that the average, I think oncology practitioner wasn't aware of the breadth and the intensity of some of these syndromes. And then we also talked a lot about risk mitigation. How do you assess who is at risk for misuse, and trying to then find that balance.

And you're absolutely right. There are some exquisitely painful syndromes that, and most of it is related to the treatments that we've provided. I've got a ton of stem cell transplant patients with horrible, a vascular necrosis, young people who can barely ambulate, but because their immune status is still somewhat tenuous, even years after transplant, the orthopods are not comfortable doing procedures, or they've had so many steroids that they're really worried about the integrity of the procedure, is there enough adequate bone to be able to put in those prostheses? That's just one example.

Unfortunately, when I do look at a lot of the studies of people with cancer who are survivors, we kind of slice and dice them, like when you mentioned post-mastectomy. Yeah, but after mastectomy, some women also then get radiation and many are getting aromatase inhibitors, which can cause severe arthralgia and myalgias. A bunch got chemotherapy and now they've got chemo induced peripheral neuropathy, but how do we treat those studies? The studies look at just the pain related to their axillary lymph node dissection, or their Sentinel lymph node biopsy. Anybody can really just become a small piece, it's the entire picture that we often miss. And the role of uncertainty for many, at least in the cancer world, and that's the group I can to the best, is that backache that I've got now, is that our recurrence of my cancer? Or is it because I played with the grandkids over the weekend?

Dr. Lynn McPherson:

Yeah. Can I ask Connie's favorite wrap-up question here. So you're a brilliant researcher and a clinician, Dr. Paice. So what advice would you have for the students in our PhD in palliative care program as they complete their degree and move forward in their career?

Dr. Judy Paice:

Follow the science. So stay as inquisitive as you can and learn and do branch out to those other disciplines, even if it's a little bit uncomfortable and you feel like, boy, I don't necessarily belong with that group, stick your toes in and learn. And I think the other thing I would strongly recommend beyond following the science and following your passion is be compassionate. It's a hard field. So take care of yourselves throughout this course and this program, but also throughout your career, because you need to be strong yourself and balanced yourself to be able to then share your wisdom and compassion with others.

Dr. Lynn McPherson:

Good advice.

Connie Dahlin:

I think, so Judy, you've kind of really spoken to so many things because I think, well, in this case of cancer care and pain, you've kind of shown for our students it's not just about the diagnosis, there's policy involved, there's clinical judgment, there's research, there's leadership moving that and then there's this whole academic part. And so, to me that also just speaks to why we all have these different perspectives and ways that we're going to lead forward. I also think it just shows to me, so for our students, Judy was also named in 2018 as one of the 30 visionaries in hospice and palliative care by the American Academy of Hospice and Palliative Medicine. And so you can see by her career and the work that she still continues to do that she's really still leading in really helping patients get the care that they need with a focus on pain management and also working with her team to kind of push this part about where are our boundaries.

And so, Judy, it's really always a delight to speak with you and hear what you've done and really appreciate your contributions to the field, but contributions to all of the students that you've taught so far and all of our learners who are going to be listening to this. So thank you so much for today.

Dr. Lynn McPherson:

You're the bomb girl.

Dr. Judy Paice:

Thank you both. This was so fun. Appreciate it.

Dr. Lynn McPherson:

Thank you so much.

Connie Dahlin:

Take good care.

Dr. Judy Paice:

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You too.

Dr. Lynn McPherson:

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