Dr. Lynn McPherson:

This is Dr. Lynn McPherson. Welcome to Palliative Care Chat, the podcast series brought to you by the online master of science, PhD, and graduate certificate program in palliative care at the University of Maryland. I am delighted to welcome you to our podcast series titled Founders, Leaders and Futurists in Palliative Care, a series I have recorded with [Connie Dolan 00:00:25] to support coursework in the PhD in palliative care offered by the University of Maryland Baltimore. Hello all. This is Lynn McPherson. I'm the program director of the online master of science, graduate certificate, and PhD in palliative care, and I'm very excited to be here with Connie Dolan who is one of the faculty members in the first and the last course in the PhD, and she teaches in the master's program as well. We're recording a series of 8,000 people courtesy of Connie who are founders, leaders and futurists in palliative care.

I'm very excited with our guest in this particular episode Dr. Katherine Walker. Welcome Dr. Walker. How are you today?

Dr. Katherine Walker:

I'm doing great. Glad to be here.

Dr. Lynn McPherson:

Good. So I'm uniquely positioned to introduce Dr. Walker. If you go back about 17 years a colleague at School of Pharmacy asked me, "Hey, we want to interview a couple of candidates for our ambulatory care PGY2 residency. Would you be willing to interview the candidates?" I said, "Sure," because I'm a team player. So I interviewed the first two, they were fine. The third candidate walks in. It's this tall cool blonde. She sits down. We're talking about the ambulatory care residency. Within two minutes, I said to myself, "Self, no this is not going to work. I want her for my residency in palliative care." So after going through, I think I even said that. I said, "You know AM care is cool don't get me wrong. I've got a clinic. It's awesome. But you know what you really want to do is palliative care." She was like, "No, no, no, no, no. I really want AM care."

So we finished the interview, and I thought, "I don't know how I'm going to do it, but I'm going to get her for my residency." Well as things turned out, I had the opportunity to contact her and say, "Okay look, boy have I got a deal here for you. How about a residency that's mostly palliative care, but you also will get the AM care?" So she says, "I don't know. Let me call my parents." I said, "Okay," calls the parents who live in Maryland point for me, calls me back and says, "Okay I'm going to do it." I said, "Well fair warning. This is a new field. I'm not quite sure where it's going, but I'm jumping in. You want to come with?" She was like, "Okay, let's do it." Is that a fair assessment Dr. Walker?

Dr. Katherine Walker:

I think it's pretty fair. I remember the first thing I said to you when I walked in is I was like, "I love your yellow office." I think right then we knew, "Okay, we're going to get along just fine."

Dr. Lynn McPherson:

I do. It took me 10 years to get permission to paint that sucker yellow.

Dr. Katherine Walker:

I knew the rebel spirits were aligning at that moment, the bright yellow.

Dr. Lynn McPherson:

So fast forward now, Dr. Walker is a palliative care pharmacist of course, but she's also an assistant vice president of MedStar Health. She is in charge of all of palliative care for all nine or 10 MedStar hospitals. So but she still keeps her hand in clinically, and sees patients as well in practice. So Dr. Walker, did you make a good decision back 16, 17 years ago even though you were jumping into the unknown?

Dr. Katherine Walker:

I would say so. Well it's interesting because I remember during the interview just thinking of in TED Talk style when do failures serve you well, and that was a good example of thinking that my life's passion was primary care because I really love the patient centered aspect. For clinical, people that aren't familiar, clinical pharmacists, once you get your PharmD, you can work retail at a Target, Walmart giant pharmacy, and in a hospital staffing the pharmacy. But in order to be a clinical pharmacist, you have to do residency training. Although all the different fields, primary care was one that I had exposed to that could really connect with patients and really get to know them and build relationships, and have that continuity of care.

Little did I know, I mean that's palliative in spades. I just hadn't been exposed to it. So I remember being interviewed with you and then thinking, "She's trying to trick me because she's asking me if I really want to do her residency, but I'm interviewing for another one, so I can't say yes, but hers sounds really cool." I wasn't chosen for that residency position because someone else ahead of me had more experience. Although I was disappointed from that, then when you called I'm thinking, "Wow this field was such a much better alignment." So I tell a lot of people coming through school, I wish someone had told me to pay closer attention to how much your field aligns with your personality and your interests, because I think I would have poked out both my eyes had I been in primary care.

Palliative is just one of those fields where you can be creative. I feel like I love living on the edge of guidelines, and that's where palliative is where if it's cookbook and blood pressure management and [inaudible 00:05:01] I don't know 12 or whatever they're on, I'm just kidding, that if you're managing things that are 20 years down the line, that wasn't where I wanted to be. I really I guess I'm an immediate gratification person. I'm like, "I want to manage a symptom, know it's working, adjust it." It was much more exciting and creative where not all pharmacists can live on the edge like that, so.

Dr. Lynn McPherson:

True, that's true. Maybe you can share with our listeners the journey of your first job when I did tell you ahead of time there's a chance you are not going to get a job what you just trained in as a palliative care pharmacist. So you took a job as an oncology pharmacist. So how did you go from an oncology pharmacist to running the whole show?

Dr. Katherine Walker:

Yeah I think palliative care has come a long way since 2003 in this fact that I wanted to stay in the area because of my family who you mentioned before, but when the hospitals around at that point, no one was hiring for palliative care specifically, especially pharmacists. That was not on the radar for thinking hospitals, not that they all need it. They just didn't know they needed it. So this community hospital in our area that was a MedStar hospital at the time had an option for an opening for an oncology clinical pharmacist. Interestingly, and I think this is where those things stars just align, but that hospital also was the landing place, new landing place for a physician that trained with Dr. McPherson at the Harvard program, and you knew that. So there was a connection thinking he just trained in palliative care. He's probably going to be doing something in palliative care. They were honestly too small to really attract an oncology specialist pharmacist.

So it was a really good feat, but I think a lot of when creating a field or in a newly forming field is being able to really sell your skillset, and when I interviewed, I remember with the clinical coordinator there, I said, "Thanks so much for the interview itinerary, but can I add someone to my interview? Could I interview with this physician that you don't know yet because you just started?" I remember her saying, "I don't ever remember anyone asking to interview with more people, but I guess I can find him and put him on your list." Him and I when me met I was like, "If you're going to do something in palliative, then I want to come here and help you do that." Then to the pharmacist who was looking for an oncology pharmacist, I said, "Look, most of oncology is symptom management and supportive care for a pharmacy part of it. I can do that in my sleep."

"I trained under Lynn McPherson" She of course knew Lynn, but I was like, "I can do all the symptom management supportive care, the chemo stuff, med safety I'll learn that. I'll do whatever you need me to do to learn it, but you also are a specialty hospital, and you have a lot of unique pain needs with your specialty surgeries that I bet opioids are an issue that I could help you with as well." So it's really figuring out what the hospital was about and aligning, because palliative is front and center at any hospital, but really specifically making it pertinent to them. I think I just talked her into it because I was not qualified for that position that's for sure, so.

Dr. Lynn McPherson:

That position and I spent those two weeks at Harvard with Connie Dolan, so talk about small world.

Dr. Katherine Walker:

Small world. It is. I think that when I landed there, the hard thing was proving that it took years to prove to the hospital as many people and has been highlighted so nicely by [inaudible 00:08:27] many people in different health systems have done, I think then the challenge was doing the job that I was hired to do and then on top of that doing the job that I think I should be doing, which is palliative care. So it was very much a grassroots endeavor spreading the word by teaching the medical residents when you run out of options for a patient, you call us, and we'll help you, and just showing up. It meant a lot of long hours because I would do my regular job and then stay and see all the palliative patients. But I think that's its been fruitful, and it was at a time in my life that I could do that, so.

Dr. Lynn McPherson:

So talk to us about the leadership angle. So how did you go from creating your own personal space as a palliative care provider to ... I'm always amazed when we chat and you say, "Well I just talked to the hospital president, and I just got three positions approved for palliative care." I'm like, "How are you doing this?" So how do you pull that off?

Dr. Katherine Walker:

Well I don't know. I learned from the best. Which Peter's law is it where it's like if you [inaudible 00:09:35]-

Dr. Lynn McPherson:

I've heard that right?

Dr. Katherine Walker:

... you start one level higher? I mean I think it's just being able to I think the thing that I've learned for that piece of how its grown is that I've been at MedStar since 2003, so I think the having the relationships and just being very diligent about trying to craft a reputation that you can deliver on what one ask so then you can ask for more, and not being afraid to ask. I think sometimes that's where even from the beginning of asking to interview with someone, it's just like, "Well I mean they can always say no, and I'm not going to get my feelings hurt because I'm probably going to recraft my argument and come back again. I don't know maybe being the oldest child helped me prep for that. I don't know. I had a family of three girls, but I think just the persistence of being able to not take it personally when people say no the first time, and then just recrafting the argument.

Anytime I feel like someone says no to an ask that we have, I feel like it's a needs assessment. So if they say no, it's like, "Interesting. Why are you saying no? What's influencing that decision," because then that gives me all the information I need to go back and collect data and recraft it, and then bring back a stronger argument at the next fiscal quarter. So I always end every meeting with a no say, "Okay, I'll see you again soon. We'll be back."

Connie Dolan:

One of my persons that I worked with actually, there was a great quote that said, "No is the beginning of the conversation."

Dr. Katherine Walker:

So true. So true.

Connie Dolan:

So I think that that's the other part about leaderships that we don't back down, and we try to figure out some of those things. I also would say Kat that one of the things that I hear, I know that you and Lynn know each other very well, but I think there's always that part where we if we're a leader, we want a challenge. We don't want to do something we're really comfortable with because then we don't grow. That's the difference sometimes of when people can sense if they're ready for leadership. I think of some people who are like, "I don't see myself as a leader, but I want to do X, Y and Z." It's interesting of what their mirror is saying, if it's saying, "You're not a leader." I don't know what it is, but I'm like, "Everything you're talking about it's about leadership, and being ready to step in, having people around you who are going to help you succeed." Sometimes we don't have as many people, but just also knowing that sense of you are going to move something.

I think that that's something that we want our students to understand that A, in this field, there's a lot to step into because the field is so wide, and B, sometimes it's not what you expect, and that leadership opportunity presents itself with not a signpost that says, "Here's your leadership opportunity," but rather, "Oh this is an interesting thing." You start it, and then this whole other pathway gets opened up.

Dr. Katherine Walker:

Well I mean and think about back in 2003 when I started one there wasn't even well known from clinical pharmacists position on palliative care teams did not exist, much less the fact that a clinical pharmacist would be leading a health system palliative care team was unfathomable. I mean it just wouldn't even have crossed my mind that that was an option. So to your point, I think it's not always a perfectly planned out path. No one's going to ask you to do it because no one would have thought to ask a

pharmacist I think for some of these roles. I think one of my favorite things of our team's dynamic and also just being in the world of the business side of palliative over the years is when people say, "Wait, what's your background again?" I love that when the CFO asks because I can talk numbers with them. I'm like, "Well pharmacists work, we like numbers. We live in numbers." So it makes sense that we can handle financial information in a way that's very similar to dosing opioids or research studies or what not.

So I just think that that's what has been an important lesson similarly on our palliative care teams, we round, and our teams are so crosstrained and transdisciplinary that often after we round, the any learners that are with us are like, "Wait a second, what does everybody do again because the social worker was talking about [inaudible 00:13:56] settings, the pharmacist was talking about spiritual distress. I forget what everybody does again." That's success right is when we can learn all of these skills. I feel like it feels being in a leadership position has felt very comfortable because of being a clinician and cross training a lot of the disciplines. I feel like the same way we respect our other disciplines on our clinical teams, and we learn what a chaplain does, we learn what a social worker does, and that's been so valuable being a clinician in a leadership position. You got to know what the CFO struggles with.

You got to know what the COO struggles with, and learn a little bit about their world so that you can meet their needs, and then they'll say, "Yes" instead of "No." But that's been interesting to me is to say, and I think Dr. [inaudible 00:14:41] my partner [inaudible 00:14:42] was a good teacher in this realm as the all the people that we're meeting with are not big, scary people. I think early in my career I was very intimidated going into the boardrooms and the C Suites and pitching a lot of what we're doing and reviewing our plans. He's like, "Remember, the CFOs are in healthcare for a reason. His line was always, "They could be working at Bank of America or Bank of America, but they're not. They're all here with a mission similar to us." I found that to be thankfully I found that to be very true. So I think that not taking nos personally and then assuming that the best intentions of everyone you're working with, to get to know them has been really big.

Connie Dolan:

Kat you also talk about something that I think is so important just in how you spoken just talks about the evolution of the field, right, that you are talking about growing a team, and understand the business aspects, right? If you think about it, there were many people who said, "Oh I'm going to do this, and because I love to do it it'll be fine, and everybody will be drawn to it, and they'll support me forever." But we know that you have to have some sort of business plan, and you need to know some of the language, not that you're going to get your MBA, but you have to be able to relate to them. So you figured out the language and some of the principles that you needed to be able to work in that space, knowing that they were the business experts, but you had to work alongside them, and then the same way translate for your team, "Here's the clinical part, but you need to understand this business part that I'm working with."

Because with all programs now, if you don't know who's supporting you, you're going to be on the chopping block. If you don't understand the concepts, then you can't explain it, then that's even another issue. But I also think in terms of the sophistication, Lynn and I have talked to people who were doing hospice when it was volunteer. They did it after their regular job which just astounds me. But then I think, "Okay well they didn't have the regulations right because they were doing it volunteer. You do something volunteer, you can do it however you want." But I think the issue that it has to be built on passion, but it cannot any longer, no program can ever be passion alone. It has to have the clinical. It has to have the administration. It has to have the IT. Has to have the quality. You've illustrated that just in your career of learning into that.

So I just think that that's really powerful for our students to hear the sophistication and the different ways that they'll have to translate and know who you're working with to be able to understand what language you're speaking at any one time.

Dr. Lynn McPherson:

Yeah Walker teaches in our master's program too in the leadership pathway by the way. So I guess I would ask if you look at our students in our PhD program, one of our [inaudible 00:17:39] performance objectives is they be leaders. Now they may or may not end up like you and be leaders on a system level, but what advice do you have for our students as they move forward either to assume an actual leadership position such as you have, or minimally standing in their own power as a leader? What advice do you have?

Dr. Katherine Walker:

That's a good question. I mean I think many people I think the biggest thing that I feel like I'm not taking any credit for myself because I've stolen all of it from other people that have mentored me, but one big thing is that it felt like my primary I would say mentor so you, Dr. McPherson, and Dr. [inaudible 00:18:22] my physician mentor I would say have very much illustrated the importance of staying in clinical practice. So I would say a lot people, and I hear this around our system is you're buying down your clinical time so that you can do non clinical things and leadership opportunities, and research and all of that. But I would say just to be careful because I think you always want to keep the patients within your realm, because that really anchors you in everything you're doing. It also makes you very relevant in the boardroom. I think a lot of the conversations we have that we do cross coverage on our health system across seven hospitals.

To be able to say to the vice president [inaudible 00:19:05] Hospital, "Oh the patient I saw at your hospital two weeks ago was dealing with this," just really makes, it's just more real, and it keeps you in touch with some of the struggles that are going on and changes. So I would say staying within don't lose all of your clinical practice no matter how much leadership you pursue is one piece of it. Then I think that other big principle that I feel like I'm always keeping myself in check about is just that transdisciplinary nature of where you came from as a clinician, and what holes am I missing, what gaps am I missing? I feel like my customer has changed a little bit because of caring for patients, I mean I do care for patients on a population level now I think. We have almost 8,000 patients that we'll be serving this year at MedStar which is awesome considering our first year we saw 50.

So I feel like I'm responsible for patients on maybe a more global level, but I feel like really my customer day to day is really our teams. I think as a leader really having that servant mentality where you're not there to lead people but to serve them and help them be their best and remove barriers for them, and be able to use system level resources and influence to really clear the path for all the good ideas that are coming from the teams. So that's been one thing that I think our vice president of medicine at MedStar told me, when we first started working at the system level, we were like, "What do you need from us?" He's like, "No, no, no, that's backwards. I'm the leader. I'm here to serve you. You tell me what you need, and my job is to clear the path for you." That really helped me set my course I think as a reminder to say people aren't looking at me to lead but help coordinate and remove barriers for them.

My job is to serve our teams really, so. It feels very similar to being a clinician a lot of times I think when you're showing up and serving the patients, so.

Dr. Lynn McPherson:

Yeah, so what about individuals though? How can individuals stand in their own power and serve as a leader?

Dr. Katherine Walker:

Well I mean I think that everybody, I think the biggest thing, and this is one thing I'm always stuck by in our teams is I think that it's a shame if you have a good idea and you don't share it. I think that everybody brings such a unique perspective, and you can lead by influence in so many creative ways. I bet that you have ideas that nobody else has thought of. I think championing good ideas is awesome, and you need to speak up about them, but then taking steps of responsibility along the way for those ideas, and not just putting those ideas on someone else, but actually saying, "Well what's something that I can do to further the idea, or to support it, or help develop it," and just start putting on projects, or taking on some things that can help develop skills. Then you meet people on forum collaborations that grow and grow and grow over time. So I would say it all starts with I think sharing good ideas and speaking up.

I mean there's one person within our group I'm thinking of recently who I would have never thought to ask to do anything more because she's contributed so much especially this last yeah through COVID. I would never think to ask more of her. She came and she said, "Because I've done so much this year, I think I'm ready to do more." She's like, "I actually would like to do some research. Do you think I could publish an article?" I'm like, "Yes." I would have never thought that would have been something on her radar, but the fact, it's like, "Thanks for asking, because there's a lot of articles that we need written and are prime for writing. Go for it." I think some of it is just saying your interest and good ideas, and letting people know. There's so much influence that people can bring, and that's leadership.

Dr. Lynn McPherson:

Absolutely. I think the three of us all share the belief that people have a personal responsibility for continuing professional development. What are your thoughts on that?

Dr. Katherine Walker:

100%. I mean I think similarly to how our fields grown, I mean no one's going to beg you to be at the table, right? I just think that that's not how things work. No one's going to have the perfectly formed job. You're not going to be a leader until someone gives you a job title or something. I think that it's important to just grow, because you're learning for everything. Every project you learn something from. Even if it doesn't work out, then you probably learn the most from those. But I do. I think that that initiative is so critical. [inaudible 00:23:44].

Dr. Lynn McPherson:

I'm sorry. Connie what other questions do you have for Kat?

Connie Dolan:

Well I mean I think you were just talking about this interesting part about our role as leaders and you may have seen something that [inaudible 00:23:59] wrote in our interdisciplinary team about as a palliative care team, we want all of our other team members to be able to rise up as well in that leadership, right? So what is it that excites them? Is it writing an article? Is it serving on a committee? Is it being a liaison? Is it doing policy work? Is it writing a database? It's not only about us right, and so that leadership gets distributed I think is so important. Then I think the other part is that there is so much

interest for me as I think about, and I'd be curious what you have to say about this Kat. There's been a lot of discussion about what may have been what leadership felt like for people who were more pioneers in the field, and trying to get this established, and then where we are now, and then mixed that with this multigenerational work force, and what does that look like?

I think that that's been a challenge because as I mentioning before, I have found that for some of my younger colleagues, if they've just grown up on technology, their whole learning has been so different, and that interpersonal part for them, that's their learning curve. I mean for them to even talk to patients is terrifying right? I think of my own daughter sometimes where like, "Oh mom, if I talk to her, I'm going to die." I'm like, "No, no you won't die. I know that people don't die from communication. That's true. I know that to be true." But that's really a learning point for them. So then working with a team, but then the next part is when they're stepping into leadership, it's a very interesting part because I think maybe with the pandemic too, its made us think about work styles, right? But there's still a lot of communication that has to happen.

What does it happen? What does it look like when its on Zoom, and how do we all feel about that versus the amount that we need to be in person? You're balancing not only the evolution of the field, these different generations and then these different needs. So when you think about your role in leading and helping other people to be leaders, what about that rings true for you?

Dr. Katherine Walker:

Well it's funny that you say that because it was going through your mind when you said that was it's interesting now when people come onto our team now. We have about 90 FTEs in our health system for palliative.

Connie Dolan:

Wow.

Dr. Katherine Walker:

So much larger team we started off with well zero because we weren't even officially hired. When we started our department, there were four of us. The nurse practitioner was our first hire, nurse practitioner, physician, pharmacist, social worker. So from four to 90, the group that joined initially, and we still have many of them still on our teams, there's a grassroots efforts. Palliative conquering our health system mentality is much different than the people that come on now that see now we have corporate structure. We've got an orientation planned. So the people that didn't have that are like, "I figured out myself. You can figure if out." But then it's like, "But we're so big. We should be organized about this at the price of having a little bit more bureaucracy." It's interesting because we started to much, and much like the field of palliative right we started with I think back to the earlier AAHPM conferences, and I even came in midstream because there was a whole generation before I was involved.

Went from a much grassroots type of feeling to now being like these big corporate events. There is a little bit of a different feel for that, but then you wonder is this the sign of success that we are now corporatised? So for our teams I wonder about that too. We struggle with how much of it gets standardized, and there's consistency, and people have to do things the same way versus adjusting to generationally differences and peoples' place on our teams, different, all the preferences that passionate palliative people have to get aligned and move as a force together. There's a lot of strength in that. We also want to make sure that we're respecting a lot of different perspectives. There's a lot of

value there in having everybody wrestle with our differences, and bring different things to the table. So I don't know. I was thinking about that as you said that as just the transition from a grassroots effort to more of like a big machine.

Connie Dolan:

Well but it's also quality, right? That's why we started writing NCP guidelines so that we were saying, "When I say palliative, you say palliative, we have some structure." I think the other part is it also speaks to you have to think about at different times what's your leadership, and all of us have to think about our leadership styles. We'll want the students to be thinking about what their leadership style is. But the third part I'll just say as a clinician, I went and made a transition from an academic medical center which I started the program, and I went to a community hospital with some fellows that I train. Now I'm an expert in palliative care. I walked on, but I had no orientation. I have to tell you, I can do the work, but coming into a new culture, trying to even just know what's the phone number of the pharmacist? What's the best pharmacist for me to call when I'm trying to talk through all of this, what's the phone numbers of the units? What's the translator? I mean it took me three months of following the team to take notes.

I made an orientation for myself, and I would say, "How would you think I would know that?" "Oh well we figured you'd figure it out." It was not an effective way for me to join that team, right? I love them dearly, and we joke about it because they were like, "Oh we just figured you were being detailed oriented." I was thinking, "Well if anybody comes along after me, I want them to be able to have more of a strength." So it's an interesting part about is that a part of pull up your bootstraps. We all had it hard and you're going to have to do it," or do we think about it saying, "Let's make sure that we're using everybody's time effectively. If we can give everybody the tools that they need up front and start that way, that's great."

Then they might be able to give us feedback that what works and what doesn't work, right? I mean because you also spoke about orientation. I think that's a really important thing about leadership of understanding the culture of your team. I can say that one of my early teams really great team, but everybody was really pretty high achieving. I would say it was probably hard for us to have some learners sometimes because we were in this fast mode all the time that we weren't able to go back to that learner's mentality a bit. But I also think that when you do, you also spoke really well about really giving people the possibility of practicing to the scope of practice with that transdisciplinary model. I love that because I think when we put our disciplines in their boxes of what they can and cannot do, it really limits the team.

I think I've had some social workers who do better pain assessments than some of our clinicians for the like. So I think you've talked about looking at your team as people, and what's their potential, and understanding that different people at different times may be able to take on or want to take on more, and then there might be people who are just happy to be part of the team, and where they're at in life or just emotionally or whatever. That's what they'll contribute.

Dr. Katherine Walker:

Yeah, absolutely.

Dr. Lynn McPherson:

I've heard Kat say a thousand times, "I want to make sure all my people are practicing at the top of their license."

Dr. Katherine Walker:

Well I've changed that recently. So now one of my colleagues corrected me, and so now I've learned my lesson. This was maybe a couple months ago. They said, "We don't say that anymore." I go, "Oh gosh." We're always learning new language preferences. I was like, "Oh gosh, what's the new trend?" I said, "No, now it's top of experience." So they said just because you're at the top of your license might say you can do this, but your experience would say you shouldn't do that." So now it's practicing to the top. So now I catch myself because I'll go top of experience. So I was like, "Oh I like that. That's probably true." He says a lot of people have a lot of experience. You can do a lot more than if you don't. I'm like, "Okay, I guess I'll buy that." Really it's top of their license, but.

Dr. Lynn McPherson:

We don't want anybody going to jail, but we want to bring their A game, right?

Dr. Katherine Walker:

That's right. That's right. That's right.

Connie Dolan:

No interesting I think. We do have to keep on top of the language because I was going to say that in May because of nurses week the National Academy of Medicine put out the future of nursing, charting a pathway to health equity. They very much have to think about licensure, what's the different levels of nurses and licensure. That's also because of the audience. I think we also have to know which disciplines sometimes are under more scrutiny than others.

Dr. Katherine Walker:

Yeah what I would say for a pharmacist for in our field, we're at a really interesting time because I feel like we have become a more popular commodity, but I would say we are still considered really a nice to have and not a need to have. I think that there's a lot of advocacy that can and should and will be done to really help demonstrate value, much like other non billable team members, but I think that there's a lot of work to be done there. In our health system, I think we've been able to do it, but it's not easy. There's no magic formula. I wish there was. Our society for pain and palliative care pharmacists are always like, "What are the metrics that we need to measure?" I'm like, "In my experience, at 10 different hospitals, and there's 10 different arguments that are made each time. They all have different pain points." But I think our field's very similar because there's, I remember talking to [inaudible 00:34:31] saying, "What do pharmacists need to do to be at the table?" She's like, "Define yourselves."

"We don't even know what a palliative care pharmacist when we see one. Do you all need to do residency training?" There's no board certification. A hospice pharmacist might have different requirements than an in patient palliative care pharmacist. So I think for our field, we have a lot of work to do there. So hopefully all your PhD students can help us figure that out. Go get some good data around this.

Connie Dolan:

I think though, and I don't mean both of you would be the people that I would ask now, but I mean when I started off in hospice, and I had my pharmacist that I used every day, I mean I would call them up them up to say, "I'm trying to think through this. What do we have available? What's going to be that?" I mean I wouldn't have made recommendations really without talking to them, right? Then when I went

to and so that was in hospice and then home health, and I started palliative care program out of a home health program at one point. Then I think what happened when I was at Mass General is we had a pharmacist who self selected to be our liaison. She was excellent in sending us all these articles.

So I mean I also she would say, "Here when I'm on, you can do this," and would tell me who I should talk to because I think one of my challenge with pharmacy at some point is if I'd call, and it wasn't somebody who was well versed in palliative care, they would cite me literature that was very different, and then I would have to be like, "Okay, what are the buzzwords that I need to use right now that I can learn and think of what the pharmacists who are working with would tell me to say right now so I could break through some of that resistance?" So I think that if anybody's experienced having a pharmacist that works alongside them, it is such a gift right of even Lynn has talked about this, the online pain calculators, I was chuckling because I never used them. I would rather do my own calculation and then call up a pharmacist or somebody else and say, "Hey, I'm doing this dosing. It's really serious. It's methadone or fentanyl or whatever. Talk me through, and let's see where we come from." I want that personal connection.

Dr. Katherine Walker:

Yeah did you forget to include a variable that would impact nursing? Absolutely.

Connie Dolan:

What's their dose reduction, or what are they thinking? What do we even have on formulary right? Am I making up something that they're going to call me in two hours and say, "Connie we're out of this. You're going to have to do this," right? So I just don't think a lot of people have had that experience of that expertise.

Dr. Katherine Walker:

Agreed.

Connie Dolan:

I think Diane's right of how are you as a field a pharmacy showing your value and your identity of how do we foster good outcomes, right? It's not you know this. I mean it's not going to be about the monetary part, or what are the outcomes, the bad outcomes that are avoided because of that? I know also both of you are in the [inaudible 00:37:38] prescribing, so I know that's a whole other part. But I think that's all of our disciplines are having to do that. Even though we're saying we're transdisciplinary, we need all the disciplines, I think people forget, which is why we have these primary palliative care programs that maybe only have one or two disciplines. They're a great start, and we need them. I think how do we push forward.

So you raised some really neat points.

Dr. Katherine Walker:

Yeah I mean I think there's a spectrum for the viewpoints on this, and I think this is where there's it's a challenge to get aligned because there's purists. I would say I'm probably more in the purist camp I guess in saying that you wouldn't throw an untrained pharmacist in the ICU and expect them to round on their patients and know what your drip rates are. Palliative care pharmacists can do more harm than good without good training. So we're talking about the most complex patients in our health system with the most high risk meds. We're having people weigh in on things with organ systems failing, lab values

all over the place, drug interactions. It's not, this is not easy. I think sometimes people think, "Oh palliative care, hold their hand. Give a little morphine." No, so you're always talking about that.

Then there's other people that are like, "Oh well any old pharmacist is better than no pharmacist." I think there could be harm done there. So it would be interesting to see where our field goes. I don't know stay tuned, but it is hard. There's not enough of us yet, but we're hoping to fix that yet right Dr. McPherson?

Dr. Lynn McPherson:

Absolutely.

Dr. Katherine Walker:

Churn them out as fast we can.

Connie Dolan:

Well I think the one last thing I would say though, it is going to be interesting to think what happens in pharmacy in particular as we try to recognize quality, and we're looking at program certification and discipline certification, whether it's by exam or by competencies. It will be interesting for me to watch what pharmacy does because I think there's going to be some sort of philosophical part that you're going to have to think about of people saying, "So how do you show the public that you've had this specialty training," that they will quickly be able to recognize? I mean we're going to have to do that in palliative care overall, but I just think when you look at the disciplines and moving toward certification, if programs can't afford program certification which is a big investment, but they're going to show insurance companies percentage of who is certified on the team, that's just some place to be thinking about.

Dr. Lynn McPherson:

Absolutely. Well thank you so much Dr. Walker. Any last comments as we wrap up? Any last thoughts?

Dr. Katherine Walker:

No. I mean I think that I'm so jealous of all of your students learning from the best of the best. So I can't wait to see all the other podcasts that are done, and hopefully this one was helpful and gave some good pearls.

Dr. Lynn McPherson:

Absolutely. Last words from you before we wrap up?

Connie Dolan:

I think thank you for your wide range of thoughts and your really role modeling leadership as its occurring, and thinking of all the current issues, and for all that you've done, I mean I think that that's showing our students what you can do with time and thinking of the possibilities. I think that you are really showing that. I look forward to seeing more of what you're doing in the future.

Dr. Lynn McPherson:

Thank you so much. I'd like to thank our guest today and Connie Dolan 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.