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:

Hello, everybody. This is another one of our conversations with our PhD in Palliative Care Program. My name is Connie Dahlin, and I'm one of the faculty and I'm joined here by Dr. Lynn McPherson, who is really the mind behind this whole program and has gotten everybody started. We are joined today by Dr. Matthew Gonzalez, who is the chief medical officer at the Institute for Human Caring, although I know Matt from the Cambia Sojourns Scholars Leadership Group.

I think this is why it's really interesting for you as students to be sort of thinking about how people are entering into palliative care. Matt is a fellowship-trained, board-certified palliative medicine physician. As I said, he is a 2017 Cambia Health Foundation Sojourns Scholarship Leadership Program awardee, and he's part of the Catholic Health Association's Tomorrow's Leaders recipient. So that gives you a sense that we have somebody who's formed in a really interesting way for palliative care because his undergraduate degree was in human biology at Stanford.

He actually was a software engineer and helped develop public databases that helped clinicians tailor treatment for individuals with HIV. So that's what really predated his career in medicine, per se. He attended the Keck, University of Southern California School of Medicine and then completed his education at University of California at San Francisco. So welcome today. We're so excited to hear your view from technology because I think it's a lens that we don't think about as much in palliative care.

Let's have you kind of start off and give us more of an introduction, because I know I just offered a really small snippet of where you are.

Dr. Matthew Gonzalez:

Thanks, Connie. Honestly, it's so exciting to be here and to be talking with you and everybody else that's listening to this. I think exercises like this are so important to our future as a field to being able to reflect a little bit on where we've been, where we are now, and the future. All of that feels like a really important pause moment in our society. My past and a little bit about what I do now, I think, as you mentioned, I took a little bit of a winding road to get here is what I would say.

I think many people find that when they reflect back on their careers, there's a sense of serendipity and a sense of a bit of a wandering, that when you're younger it almost feels like, "I need to get things right." My sense is that life often works out. My initial story, Connie, really began when I was very young. I had an uncle who died of HIV/AIDS in the early '90s. That experience really made me realize that there was something within me that wanted to change his experience of illness and death.

Like many people in palliative care, there's a sort of fundamental early experience around somebody that they love. This is my favorite uncle that I can picture playing Monopoly with when I was young, that I can picture interacting with so much and to watch him go through a really painful, awful suffering and death inspired me to try to figure out how to change his experience. But I think unlike most people in palliative care, my first stab at trying to figure out how to change that was not necessarily through medicine.

I really took a focus on HIV itself and on computers and the use of computer technology to be able to guide treatment decisions in HIV. I went to undergrad in Silicon Valley in the late '90s, and it was pretty hard not to get a lot of computer science coming out of there back then. What I fell into was really deciding and looking at trying to fight HIV or fight his experience really by helping to craft a computer program to analyze the viral dynamics evolution and mutation patterns for HIV to then say, "Okay, this is the genetic changes that we see in an HIV genotype in your particular blood and that corresponds to interpreting how and what drug therapies you might likely respond to."

It was really fun and exciting. I felt like I was making a difference in terms of fighting his experience, but what I realized was that I wanted to have more impact. I could see the power of using computers in this space to be able to predict, for instance, what a patient would or wouldn't respond to, but I felt like I needed more training to really understand the clinical implications. So that's honestly when I went to med school. I thought, "I'm going to do infectious diseases." And then I went through this other space of trying to apply what I learned from viral dynamics to circulating cancer cells.

For a long time I thought I would do oncology. Honestly, by chance, when I was at UCSF doing my first year internship in internal medicine, I submitted a list of requests for my one-month elective. The one-month elective was it could be anything, but I put down the four choices of oncology electives because I'm like, "I want to be an oncologist." And then I put down this fifth thing of palliative care which, truthfully, was something I'd never heard about. That wasn't that long ago, but it was remarkable.

I had no idea what palliative care was. But I had to put in a fifth choice, so I put it in. Of course, that's what I got assigned to. I was pretty angry at the time. I remember the program person's name who did all the assignments. Her name was Joanie. I remember being like, "Joanie, how did you assign me to something I don't know?" But the truth is is that it was life-changing for me. I realized in the moments and the weeks that I spent with palliative care there and I spent some time with some really great clinicians, social workers, chaplains who'd been in for 40 years, teaching me some really amazing things, some amazing doctors that trained me, folks like BJ Miller and Wendy Anderson.

What they taught me really at this deeper level was that healing is possible even when cure isn't. For me, that resonated at a much deeper level with me than trying to create a computer program to be able to impact something that had happened to my uncle. When I really reflected back on that experience, it was this sense of not being able to attune to his basic needs, to be able to see him for who he was and talk with him about his hopes and fears and worries and have really good quality symptom management.

Those were the things that I found way more inspiring, and so I journeyed into this field of palliative care thinking, truthfully, at the time that I was going to have to abandon technology, thinking that tech was kind of outside here. I early on described them as two different parts of my brain, the technical part of my brain that likes coding and the more fuzzy side of my brain that really likes trying to dig into people's emotions and trying to understand what motivates them and what's important to them.

I would say the last six years though working at something called the Institute for Human Caring in this role as the chief medical information officer, I've found a way to really blend these parts of my brain. So it's sort of a palliative technology or palli-tech way of thinking about the world, recognizing that our lives are not becoming less technologic. The amount of technology that we all interface with on a daily basis is increasing exponentially over the last number of years.

You watch TV shows from the early 2000s and you see that no one was really carrying a cell phone. Now we all have computers in our pockets and on our wrists and everywhere. So I have really

tried to fundamentally frame the idea that palliative care needs to walk hand-in-hand with technology, and they're actually not different parts of my brain. They're trying to use different skillsets to really apply and to be able to advance the field, recognizing that in order for us to really achieve what we want to do to be able to get the best possible outcomes for patients and families, we have to figure out how to use technology well and responsibly in that. That's my day job and super fun.

Connie Dahlin:

Well, it's funny because, as you're talking, I'm sitting listening. You're trying to make this thing between clinical and tech, which is exactly what we've been trying to do about the mind/body, right?

Dr. Matthew Gonzalez:

Yes, very much.

Connie Dahlin:

So you're trying to do that, which is kind of interesting. I think the other part is that and I'm just going to jump in, of like saying we're at this really interesting venture right now. We're still in the pandemic, for all intents and purposes for whatever safety changes happen on a daily basis. I think for palliative care, this is a moment because I would venture to say, from what I hear, and I'm a practicing clinician still, it's been challenging for people to try to figure out this whole part of empathy and compassion when we've had to use telehealth.

I'd be kind of curious because, in my own perspective, I am of two thoughts of this. I think it's been a good learning experience for us because we've had to teach others. I think it's also been a good part for us because if you think about health equity and disparity, it kind of levels the field a bit. So I feel that we have to embrace this rather than push it away. So I'm kind of curious where you're at with that.

Dr. Matthew Gonzalez:

It's such a good question. I think we're struggling with it in our personal lives as well as our professional lives. I, this weekend, just got back from seeing my nephews for the very first time in 14 months. Oh my gosh, such overwhelming joy in a way that I don't get through FaceTime. A hug is so much more meaningful and powerful in that sense, I think partially because we've been built that way. But I agree with you that tele palliative care, tele palliation, telehealth in the palliative care space, whatever you want to brand it or call it, is here to stay.

I would say I have found it to be really powerful and impactful, particularly for those moments where folks have been kind of disconnected in the past. One of these classic palliative care vignettes is that you are working through and talking through goals of care with a patient or family and then the sister or the daughter from New York, because I live in California, it's always from New York, shows up and they haven't been there. They haven't been a part of any of the discussions.

They're like, "Wait, what's going on? We need to start all over from scratch." What I think we're learning is that we can really use technology to be able to bring those people and invite them into patient rooms or to invite them into the space to participate and get their questions answered early and engage in those conversations at a deeper level where two years ago we might have called you once and put you on the phone. But a picture is worth 1000 words. A video is probably worth 1000 pictures.

There's so much richness in seeing and interacting, that it's not perfect, but I'm hopeful that we learn to engage with this technology in a way that still inspires some empathy for people.

Connie Dahlin:

Well, I think it's an interesting part because I think you are talking about this internet part or intertwining. I think that the issue is that it's not a skillset we've learned well. So I'll say in my own practice, one of the things that I did last year with the ELNEC Project was to create these communication vignettes. When I created them, it was not only doing it, but was helping people think about it because it's such a new skill. I think there's a difference between different disciplines.

Physicians are at one level. Nurses are at another. This is when I think sometimes people get nervous about what they're saying if it's within the scope of practice. But all the rules went out the window. But I think it is this whole part. If it's here to stay, then how do we teach it? And then the flip side of how do we have people feel safe about learning it? Because, as you know, it's a very different ... We're talking with you right now. We're recording it.

We could have a family member or somebody record it and use it at will and distort. So there's a whole bunch of other things within that.

Dr. Matthew Gonzalez:

Yeah. I think the education piece you're landing on is really important. It's not a skillset that we have taught, and it probably should be something that we think about and teach. I imagine that it's going to get easier as time goes along. Our generation, I think, may struggle with it a little bit more. Young kids who are on FaceTime all the time now, they're probably going to find easier ways to communicate in this way. Or I think about using technologic solutions that may feel a little bit foreign to us.

For instance, I've always been fascinated with the idea that teenagers like to text more often. One wonders for grief support groups if in-person grief support is really the right way to engage, for instance, a teenager. Or maybe it's actually that they're more likely to engage with a text-based medium where they can interact with somebody in a way that feels very familiar to them. So I think it's a little bit about our conditioning and the way that we think about these things.

I would say also that you brought up the idea of recording family meetings. I've actually been thinking about that, not just in the Zoom sense, but in a creative sense of using some of these natural language tools, like Nuance in the Microsoft suite of projects, to actually think about having palliative care clinicians engage proactively in recording our own meetings for patients and families as a historical record. I think that we are a little bit worried about it because they could use that in some way.

I've seen some really interesting technological packages, for instance, that you can now record your visit with your doctor or your nurse or whoever it is, and it knows the difference between my voice and your voice. It's able to give you a line-by-line sentence of what was said, "You're coming in for your visit for cardiology today. We need to talk about your blood pressure," whatever it is. It also, in addition to that, is able to identify, for instance, things like "I want to get a chest X-ray for you," or, "I want to start you on albuterol."

It's able to identify those individual medical interventions and steps, which then provide patients and families links to high-quality information about what albuterol might be or what does a chest X-ray entail? Now, I'm not saying that those are the most valuable links in the palliative care setting, but it is technology that's being used in other types of doctor's visits or just healthcare visits in general. I wonder what that looks like for these highly important family meetings where sometimes you say one or two words and that's about all people remember and can engage with.

So I think about how we use technologies in these ways to record family meetings to really help patients to be able to hear these pieces back later or read the text description of them so that we're all

on the same page and that we can start working from the same sort of blueprint of how we move forward. It's something I haven't done yet, but I'm really fascinated in figuring out how we try.

Connie Dahlin:

Well, in my mind, it's taking one step forward of when we give handwritten things afterward. Lynn, I'll let you go in a second. But the other thing I was just going to say, when you were talking about a younger generation, I mean that is a paradox because when we're trying to teach, and this may be in nursing, not medicine, but when we have young adults right now who are in nursing school in their early 20s, communication skills, this face-to-face is not their skillset, exactly from what you're saying.

They're so used to Instagraming, texting. I'm trying to think of what the newest platform is, Snapchat, although that's going out of style. But they're so used to that, that they can't do the in-person. So it may be that it involves that way just because of that. So just interesting in that form. Lynn, you wanted to jump in?

Dr. Lynn McPherson:

Can technology be an impediment though? I mean I hear time and again from patients, "My provider is on the computer the whole time." I hear from hospice nurses, "I feel like I can't be upfront and personal with the patient because I've got to be typing on the computer the whole time or wait till I get home, and then I'm doing notes for four more hours." So can you do both? Can you be upfront and personal and be technological savvy?

Dr. Matthew Gonzalez:

I think so. To your point, Lynn, I don't think we've hit the right notes on this yet. I don't know exactly what the great comparison is, but I feel like we're in the evolution of technology in this space. For instance, VCRs were great, but they had a lot left to be desired. You had to set your timer and record the program, and now we just stream them. I think we're sort of in the VCR stage, I guess, of EHRs and the way that that works. It's a little better than watching it live, but we haven't realized the true power of it.

I think that part of that is is that what we in our field, I think, have tried to do is think about replicating what we did in a paper-based world in a digital world. That, to me, is the wrong solution. We shouldn't just take something analog and put it into a digital space. We've done it a lot with notes, the idea that, well, what I was writing down I now have to transcribe into my digital note and type out. The reality is is if we're storing these all in discreet data fields or we use, for instance, speech-to-text technology, that we could be able to make this a lot easier for clinicians.

I personally hate the two hours or three hours at the end of every day where you're just charting and typing things. I think that's going to go away within the next five to 10 years. That seems to be a long timeframe, but I can imagine that it'd be pretty easy for you guys to get a transcript of what was said here. I think and expect that EHRs will get to that solution. I think that medicine and palliative care and hospice, truthfully, has a much larger technical debt than other spaces.

That's something that we're going to have to pay into to be able to correct this so that we can move from this VCR stage or VHS stage up to current technologies where we're actually able to get information all the time. That's an expectation that our patients and families have, and we need to get there.

Connie Dahlin:

So two questions, one, for the students who are watching, the VHS and the VCR [inaudible 00:21:59] come in. You might not even know what they are. They're so gone. But if you're younger, they weren't around because you might have had DVDs. But I'm really intrigued by this part about you saying a technological debt. Tell us a little bit about what that is.

Dr. Matthew Gonzalez:

Yeah. I think my experience of this so far is that it's really en vogue in our field to complain about the electronic health record, the EMR. It's really easy to get anyone passionate at any one of our meetings by saying, "The EHR is broken." It's like a rallying cry for us. That's true. There are some things that are really broken by it, but I don't think we've spent the time thinking about how to make it work for us, which is a lot of what I spend my time trying to think about, trying to use everyday, practical tools that are in other spaces and apply them to our space.

I think that's partially because we spent a lot of time thinking about the highly relational nature of our field, the importance of teaching communication, the importance of good-quality symptom management, the importance of teaching people to even lean forward and use good body language. All of that is one part of people's brain, but I think it's we need to also start emphasizing that folks, as they're exploring their future career path in this way, is that they think about the ways to integrate technology into educational spaces, but also into the EHR.

I mean I think about the YouSA, for instance, in educational spaces around augmented reality or virtual reality in those spaces. But the EHR isn't the limit of our technical debt. We certainly need to focus on it because there's a lot that we can do. I'll just talk about one project that we've been doing within our group, which we actually drew inspiration from outside of healthcare, and that revolves around the concept of POLST Forms. There's these complicated forms that are really truthfully pretty ugly. They're black and white and they're all state-based.

They all kind of have similar fields. What's your first name? What's your last name? What's your medical record number? What is the CPR status of this individual? What are their desired other interventions that are on there? Do they want a feeding tube or not? It was tempting when we were trying to build a solution and take these POLST Forms into our electronic health record to just put in a static PDF and have people type all those things out. That, to me, would have been the wrong solution because it's an example of just taking something analog and making it digital.

So what we actually were inspired to do as we were looking at these forms is one of our analysts said, "This is really striking. These forms remind me of tax forms. They remind me of state-based tax forms." Everybody's got to put in their gross income. Everybody's got to put in the money that they paid. Everybody's got to put in their name. So we actually looked at TurboTax as an idea, as a model to be able to say, "Well, TurboTax is actually taking off as a product." They don't show you the actual forms.

They don't put your 1040 form in front of you. They ask you, "What's your name? What's your date of birth? Can I go and grab some information somewhere about what your income level is? Do you have any dependents?" So that's actually what we did with our POLST Forms because we have POLST in six different states because we're a large multi-state health system. So I now have this program that runs within our Epic build that we partnered with our IS colleagues to build, and it just asks you what it needs to know.

What's your CPR status? What is your other desired level of medical care wishes? For instance, Idaho has a question about antibiotics on there. No other state forms have antibiotics. So we don't ask you about antibiotics unless you're in Idaho because we don't need to know that information. So, at the end, we take in only the information we need, layer it onto a PDF, and then give you a copy to be able to

take home. To me, that's the type of design that we should be doing and thinking about instead of, for instance, doing things manually and accepting that and keeping track of things, quality metrics and the like, using Excel forms, which I would love to someday get rid of.

I think success in this space would be that in five to 10 years from now, I would be able to stand up at a national palliative meeting and be like, "The EHR is broken," and everyone's like, "Not really. What are you talking about? It works for us. It doesn't work against us."

Connie Dahlin:

Wow. I mean those are all such interesting things for us to think about because it is I think you're talking about the crossroads. I think it also is about comfort. Dictating was one skillset. Handwriting was another, trying to figure out Epic. I mean I think of my own self with technology is when we went to Epic, I don't find it user-friendly for me. One of the biggest things was our person said to me, "Connie, I'm going to give you a piece of advice. You will be competent at this, but you don't have the time and space to learn it. So you just have to accept that."

Now, being a palliative care person, I leapt up and gave her a big hug and said, "Thank you for giving me permission to be competent," because it wasn't going to be any other way. So I think what you're talking about is this whole movement for it, and I do like this part about not just recreating the analog into digital. But in that space, so what do you think are the biggest challenges in terms of what do you see for palliative care, particularly in technology? I mean you've mentioned some, but you must see others that you are excited about.

Dr. Matthew Gonzalez:

Yeah. Yeah. I think the EHR space, to take that component first and then moving on to other, more creative, interesting ones. So I think the EHRs are getting better. They recognize the need to be able to innovate in these levels and spaces at least for palliative care. The hospice components of the major EHR vendors still have a ways to go. I think one of the things that I would challenge people to do is to work with their local IS folks to be able to create, for instance, dynamic documentation. What I mean by that ... Hm?

Connie Dahlin:

Tell us what that means.

Dr. Matthew Gonzalez:

What I mean by that is that we have created pretty static documentation that pulls in, for instance, it pulls in a medication list or it pulls in your family history. But actually, because it's a computer system, it can evaluate rules that can make our lives easier. So, for instance, one of the things that I often think about in the inpatient setting is, has the patient had a bowel movement in the last two days? Well, I can, of course, in a non user-friendly way go to whatever it is, the flow sheet row and then scroll over a bunch of times to find the nursing documentation for is there a bowel movement.

But, truthfully, it's about 20 minutes of programming work for an analyst to be able to create a rule in documentation that goes and looks at that particular place on the chart. When I launch my note, it will either say one of two things. It'll say, "The patient has had a bowel movement in the last 48 hours." Or it will say, "There's no EHR documentation of a bowel movement within the last 48 hours. Does the patient report one? Yes or no?" To me, that's making the note work for you because now I'm just launching my note and it's evaluating a bunch of things.

Does this person have an advanced directive? Do they have a POLST Form? What are their preferences on that? It can give you prompts, depending on what you want it to or how you configure it, so that when you launch your note, it's already giving you a lot of guidance. It's not just our notes. I think about this in primary care notes. It should tell you when someone's last care planning conversation is and prompt you to do one if it hasn't been done in whatever amount of timeframe. That's all really easy and configurable.

I think that one of the things that we need to do better with in our field is interacting with the technical folks that can build those things. Because if you really build smart, dynamic documentation, you're not spending four hours at the end of the day charting because the computer's doing so much of that work for you. We just don't spend the time doing that. I think once that's done, Connie, then we can get to some really fun, creative things. It's not like the EA chart is broken or I don't know how to measure how many consults we're doing automatically or look at quality measures.

Those are all really important. But I think clinicians want to get creative in this space. I think we want to be able to explore what's out there. I think about, for instance, augmented reality, communication-based training and how we've seen these phones that do augmented reality now where you can actually have an avatar looking like they're standing in your room with you to be able to make it easier to interact with an AI-based simulation of communication-based training so that we can train our clinicians that work with us to be able to work through empathy more.

One of the things that keeps me up at night is there's not enough of us to do all these critical skills, and there's not enough of us to train every clinician. So leveraging technology to be able to create models that, for instance, can do an AR or VR, augmented or virtual reality training in this way is really powerful to being able to help ourselves know that we're changing the field and also not burning ourselves out because we tend to say yes to everything.

Dr. Lynn McPherson:

Can I ask one more thing?

Connie Dahlin:

Sure, go ahead.

Dr. Matthew Gonzalez:

Yeah.

Dr. Lynn McPherson:

One of the things I love to do and I'm very invested in is opiate-conversion calculations. I swear I have moved beyond my abacus. But it just seems to me these online calculators, people turn off their brain and their clinical judgment when some number pops up and they just run with it. So how can we build in or remind people, "Please don't disengage your brain just because technology's helping you here?"

Dr. Matthew Gonzalez:

That's a really good question. That is my experience as well, sadly. I will say your book has made massive strides in terms of changing that, I think. I've certainly bought and recommended copies to all of the hospitals at my local hospital for that reason. I think that there are ways to do this, for instance, in the prompting behavior. For instance, take the simple example that I gave, a bowel movement. I didn't, in

that moment, just insert something that says, "They do or don't have a bowel movement," because no one's ever going to read that.

It's like pulling in the medication list. No clinician actually goes and looks at that to make sure that it's right. I mean some do, but it's the rare person that actually goes line by line to think about and analyze that. I think the best way to engage people around this is to incentivize behaviors or to be able to prompt them to do something in response to something. So, i.e. there is no bowel movement charted, but we all know that not every bowel movement gets charted in Epic. It's just the reality of the world.

So being able to prompt the clinician to reengage their brain to say, "Hey, we don't have a record of this, but did you ask the patient and is there something different?" I wonder if there's tools like that in the opioid space where you can craft, someone like you could craft rules or parameters to be like, "Whoa, this seems like it might be a little bit outside the bounds," and then to prompt the clinician to really engage with those tools.

Dr. Lynn McPherson:

Good. That would be lovely.

Dr. Matthew Gonzalez:

It's a challenge to do well, but can be done.

Connie Dahlin:

Well, it's an interesting part, I think, of we don't want to be on autopilot because I think with palliative care, that's the whole relationship part and thinking about that. But I think you're right, of having people think about different things or where I thought, Lynn, you were going to go was, "Hey, these medications interact with each other. Have you thought about that?" Or you, as a palliative care clinician, you're about to add this. Are you thinking of doing an EKG because they have that?

I mean that would be something that I think would be helpful, that you're ... I think an interesting part of, again, what the technology part of this is and, as you said, to help us rather than just to switch it over. But I think, in my mind, it's funny. As you're talking, I think of the technology for charting. Obviously, I've been so scarred by it that I'm thinking about Epic to make sure I'm doing my billing right. The way the billing and coding is, there's no prompting because we're supposed to do it. You're just like, "Seriously, there's got to be a better way to say, 'What else is the rest of my team billing like?'"

We haven't had a quality assurance discussion with our biller in two years. I want to know, because I'm not there as often, what are we doing? So I think those are the things. But I think your part about education is also interesting because it could be that what you're saying is we could say, "Okay, we're going to do goals of care conversation." Well, wouldn't it also be cool that we become really aware because we don't say it, but it's really important. So when I'm teaching goals of care if I'm teaching to nurses, I need to know, are they registered nurses?

Are they nurse practitioners, CNSes? Two different languages that they're allowed to use. That is by scope of practice. So thinking about how does that happen? I think Lynn and I are working on this project where we're trying to think about common competencies, as we will, and one of the conversations that we've had, and I feel very strongly, this interdisciplinary team. I was told at some point, not in this group, but in a different work group, "Well, you can't have chaplains and social workers assess pain?" I'm like, "Absolutely, you can."

They might not treat the pain, but they might do better than some of our other colleagues. So what's the AI around some of that? So I mean when you're talking, there's a lot of exciting things that I imagine you must just have this whole list somewhere. I don't know. You might not do lists because that's an analog thing, but somewhere digitally about these-

Dr. Matthew Gonzalez:

Oh my gosh, no. I still carry pens around. There's something real about that. So many thoughts, so many thoughts. I guess one of the thoughts that I really have around this firstly is that I imagine technology, when used well, allowing us to connect more deeply. I agree that we haven't hit that yet. But I would like to offload people's brain and let the computer do the dumb things. There's a lot of stuff that we do that takes up time and effort and cognitive load that we could be using that time to be able to spend an extra few minutes connecting with patients and families.

That, I think, is really when we hit that right, we will make things a lot better. I don't know what apps people love that they're listening to, but they probably can think about one or two apps that makes their lives easier, whether it's a shopping app or I'm blanking on any ... Even navigating, Google Maps or anything like that that makes your life truly easier, if we can come up with the equivalent of that in our space, then I think it does allow us to be able to let go of that and focus on the patient and family in front of us. I hope that we can get there. For sure, it's going to take a little bit more time. I work-

Connie Dahlin:

Are there anything that keeps you up at-

Dr. Matthew Gonzalez:

Oh sorry.

Connie Dahlin:

Sorry.

Dr. Matthew Gonzalez:

Gosh. Two thoughts, one is just the last thought from my other piece, which is one of the things that we're doing around some of these trainings is we're actually pivoting because of COVID, but we planned this beforehand for a blended learning modules for our advanced communication training series, which is based on the CLRS Conversation Guide. Now that we're doing some online module training for this, we can branch people into different skill levels based on their discipline or based on their scope of practice.

So there's one piece where we get to talking about prognosis, where we split the class virtually into different modules. They each go through similar topics, but recognizing that there's different pieces of that that you can't do in a life training, that nurses versus NPs have different scopes and different abilities to engage with those pieces. So I'm really excited, truthfully, about our own efforts within those technology education pieces. What keeps me up at night is wanting more people that are cross-trained in technology and palliative care.

I think there's a real need, and I think that I've been talking about this with other folks in the field around trying to think about what does, for instance, another year of clinical training look like for people. I know doctor training well because that's where I came from, but another extra year of fellowship around clinical informatics for palliative care or an area of focus for training programs. As I mentioned, our lives are becoming increasingly reliant on technology.

Our fields can't stay in a bubble of saying, "Excel works for us. We're just going to stay there." We have to continue to innovate to stay ahead of the curve and to be able to use technology to our benefit.

Connie Dahlin:

And then what's going to have to happen is you have this younger generation that comes into it. And then we're going to have to train up mid-career people. So that's always kind of a challenge. You've said a lot of things that you think would make things better. Anything else that you want us to focus on in terms of these are students who you're giving them ideas of where to move into the future?

Dr. Matthew Gonzalez:

I think the most important thing is I think about it as being curious and dreaming big on some of these things, particularly in the technology space. There's a lot of tech out there, and some of it's good and some of it's bad, truthfully. But I think unless we engage young creative minds in this space, that it becomes really easy for us to continue plodding along doing the same things that we've always done the same ways that we've always done them. While I am not as technologically facile as some of the younger generations, I think it's fascinating to talk to them and learn from them.

So I invite folks to always brings those kind of wacky, crazy ideas that I might think are like, "Wow, we will never get there." But I think those big dreams helps us to be able to innovate and have something to aim for in this space for the future. It's really important for our growth, for our ability to continue to stay engaged and for us to be able to take the best care of patients and families.

Connie Dahlin:

Right. That's been amazing. Anything else that you want to say to our students about what they should be thinking about the future or them starting off?

Dr. Matthew Gonzalez:

Well, if you're still listening, congratulations. I'm excited. Certainly, it's been honestly just such a pleasure to be able to think about these things with you guys. It's really fun for me, and I very much look forward to your students' future because we need good leaders. We need good innovators in this space. It's deeply important.

Dr. Lynn McPherson:

Wow. Thank you.

Connie Dahlin:

Well, thank you, Matt. I mean I think it's so important to hear from you because I just think that you have been an innovator in this and so for our students to understand that if we'd had this conversation 10 years ago, we wouldn't have included Matt in it because technology hadn't really come of age to be as important in palliative care. So thank you so much for your time and for your thoughts. If you think of anything else, please let us know. But we are so appreciative for your time today.

Dr. Lynn McPherson:

Thank you, Dr. Gonzalez. 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

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