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Dr. Lynn McPherson:

This is Dr. Lynn McPherson, and welcome to Palliative Care Chat. The podcast series is 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. To our podcast that is, What Comes Next? The Future of Palliative Care. And I am so excited today that we have one of our social work colleagues who has really been a pioneer in palliative social work and in the field, and that is Shirley Otis-Green. Shirley has really spent her whole career being dedicated to enhancing the delivery of contextualized care to address the symptoms and the stress of serious illness. Her education in research and consultation focuses on quality of life, and palliative care, and transformational leadership. She was a principal investigator on many studies with over $3.5 million in external's funding. And her work has been disseminated through more than 100 publications and 500 professional presentations. Her resume must be really long.

Shirley is a member of the National Association of Social Workers as a pioneer, and she's been recognized with fellowships by the Association of Oncology Social Work, the California Healthcare Foundation, and the National Academies of Practice. And she was among the first to receive an Interprofessional Master of Arts in Health Research in Palliative Care from Lancaster University in Great Britain. And one of her also crowning achievements, because those of us who have been editors know, she is the co-editor of Oxford Textbook of Palliative Social Work, and the second edition is do out. So, welcome Shirley.

Shirley Otis-Green:

Thank you.

Connie Dahlin:

So, what we have done and what we are doing for our PhD students and for the world is really thinking about where we've come from, and they have had that, and now we're looking at where we're going to. And so, we're really wanting you to tell us about yourself. And you have to include one fact entertaining or otherwise that most people don't know about you.

Shirley Otis-Green:

Well, for those who have followed all of Lynn's amazing podcasts to date, they will know about me that I am an equine enthusiast. And I think there are so much we can learn from being outdoors, and especially outdoors around horses. So, that's my favorite thing. And in terms of who I am, again, thank you for those kind words, but I'm an Oncology and Palliative Care social worker with a background clinically in doing program planning, and then that morphed into doing research, and of course that morphs into education. And so, I'm fortunate now to be in a role of a consultant and able to pull all those threads together and share my passion and enthusiasm for all things palliative care with anybody who will sit still enough to listen.

Connie Dahlin:

Well, I'm thinking about the image for me about being a social worker to the horse, so if I guess that you can be a horse-whisperer, you could probably be a person whisperer.

Shirley Otis-Green:

Exactly.

Connie Dahlin:

So, tell us more about what you're doing now and what do you love because we can already see your passion in your face.

Shirley Otis-Green:

I have that right across my forehead. I think what I love best about palliative care is its collaborative team approach. And so, as a social worker, we're dipped in that secret sauce of systems thinking and contextualizing the individual or the circumstances or the situation. And so, trying to understand, again... As you could imagine when I started a thousand years ago, you hear things like, go see the delivery room 206. You're just from an early age to realize that there was more than just delivery room 206, and it was important to see the whole person, and more than that, to see the family that surrounded that person, and more than that, to see the community that surrounds the family of that whole person.

So I think what I like best about palliative care is it always sees the whole person. It sees that person in context or in the environment. And that opens up doors for social determinants of health. It opens up doors for looking at quality of life issues. We have been [inaudible 00:04:45] the same friends, Connie. And so, thinking in terms of nurses, or social workers, or pharmacists, or our chaplain buddies, or of course our doctors and our therapists of all kind. If we can put all of these different heads together, we have a much better chance of being able to address the multidimensional aspects of suffering, and so [crosstalk 00:05:06]-

Dr. Lynn McPherson:

If I can jump in.

Shirley Otis-Green:

[inaudible 00:05:08]. No, no. Yes, please.

Dr. Lynn McPherson:

I just wanted to point out that Shirley is the reason our course is titled, Person-Centered Care instead of Patient-Centered Care, building on your dialogue there. So, I'm sorry. Go back to where you were.

Connie Dahlin:

I will say that what's also important is just yesterday, the Future of Nursing 2020 to 2030 report, which was a Pathway to Health Equity was released. But Shirley, you made me think about... It's funny what you remember from a presentation. The most important statement yesterday for me amongst the rough four was the new thing that they are promoting, which is just awesome to me, is its patient-centered, family-centered, and community-centered. We haven't pulled them in before like that. And so, their focus is on obviously moving out of the hospital and to the community, but I thought, well, the social workers are going to love that because it is about the circles of care.

Shirley Otis-Green:

That's right. Absolutely. And again, like you say that palliative care I think has led the way in that. We've been able to look at actions more holistically. And again, thank you, Lynn, for noting that difference in terms of semantics because again, words matter so much, right? So, being able to say person verus patient, recognizing that a person is so much more than just their interface with the medical system, and being able to have that broader lens I think is so important. So, those are the things that, again, any opportunity that I have to play with healthcare systems that are looking at how to improve communication, or look at how to integrate advanced care planning, or how to help the social workers to be more effective advocates for the patients that they see, or helping the other healthcare professionals to be a little bit more of that broader lens. Those are the things that I am excited to be doing at this point.

Connie Dahlin:

I think most of also the people who are watching this should know that you had a big role at California Healthcare Foundation in doing some of their work. And so, what we want our students to understand, it's actually like a test case because you have a state that's mandated palliative care that has money into it, and so you guys can trial these models, and you have the California Healthcare Foundation supporting that. And so, that's been really amazing because people can learn from what you're doing. They may not be able to do the same thing because they don't have the same mandates or the money behind it, but I think that work that you've been doing is also really important. Do you want to talk a little bit about that?

Shirley Otis-Green:

I think... Again, it is absolutely a blessing to look back on a career and be able to see how the circles of influence have gotten broader. Again, when you start or when I stared at least, I was so delighted if I could make a difference to the person in room 206, if there was some resource I could connect them with or some moment of presence that could be a bomb. That was gratifying. But pretty early on, there was the desire, if I could, to be more influential for more folks because you see the need and you see how desperate we need to change healthcare, which is why I applaud all of you or the students listening to this because we need to transform this. So, being able to think about how do we do program planning in an institution, how do we create systems that are going to have less people falling through the gaps because when I hear the word equity that you were mentioning earlier for the nursing conference and the goals of moving forward, we are so clear that we have not done equity in healthcare. It's so broken.

So then you'd think, okay, well, how can we expand beyond just the institution? What can we do in a broader way? And as you say, the CHCF, the California Healthcare Foundation is looking at how can we, within a state, make a difference. And that state then can become a model for how can the country make a difference. As you know that I've been blessed to be able to travel some internationally and to be able to be involved with people that are looking at how is a country can we make difference. I think that that's what's so exciting, is that we have these different pilots or different models that are out there and if we can build on those. So SB 1004 is the bill that was passed in California that says if you were going to provide Medi-Cal, you have to be able to provide palliative care. How cool is that? Our Medi-Cal is other people's Medicaid, but for all the folks that would otherwise not have access to that kind of team approach to care, suddenly that door opens.

And it really is an exciting time to be able to look at how can we influence policy in a way that, again, might be able to make a difference in the lives of a certain population of folks, but they have that even... Perhaps, be a model that others can learn and tweak because again, it's not perfect it turns out.

It's not perfect, but there are things that others can do that will help to make it better in whatever next state does whatever. And I think that of all the good things that came Massachusets and from your state's pilot work, that becomes the affordable care act, which becomes, again, a policy that has worldwide implications at this point. Other countries and other places see something that works can grab that and can model it for themselves. So, it is an exciting time to be alive.

Connie Dahlin:

Shirley, remind me how old that bill is in California?

Shirley Otis-Green:

I thought you were going to how old are you?

Connie Dahlin:

No, no. [crosstalk 00:10:59]. That's never polite to ask. How old is the bill? Is it [crosstalk 00:11:03] years old?

Shirley Otis-Green:

What a good question. I have lost all track of time. COVID, I'm going to use as my example or my reasoning, but I didn't know time before. But relatively recent, maybe 2016, does that sound right? No. Probably later than that.

Connie Dahlin:

Okay. But I was just asking because I was thinking about what's happened in four years since, so you've been able to do these models and going forward. So, when you think about the neat work that you all have been able to do and to be sort of this incubator, what do you think are some of our challenges that we're facing in the future? And what keeps you up at night?

Shirley Otis-Green:

That's keep me up at night, for sure. We've got to get that drip fixed on the [inaudible 00:11:52]. But in terms of challenges, they are many. And I'm going to go back to we need to transform healthcare. I think our system have... How many hours did you say this was? Our system of healthcare is so very broken, that it's tied into a person's employment for example, that it's not a human right. Again, you're talking to a social worker, so I believe healthcare is a human right. Just by definition of birth, you have hopefully the right to access a quality healthcare and to have kiddies that will jump in front of you when you're being interviewed. It's important I think for people to have that healthcare not be based on whether your parents have a good job that has benefits, or whether, again, a certain color of your skin or amount of melatonin that you might have, whether you speak English, whether you are of a certain age. Those kinds of disparities are unfortunately a big part of what keeps me up. And so, being able to think of how could we make healthcare more...

I really believe that I try [inaudible 00:13:01] fragments. The Institute for Healthcare Improvement has a wonderful goal that they talk about, called the Triple Aim, and that's to do better care for [inaudible 00:13:10], to do a better care for more people and do all of that at less cost. Other folks have wisely said that that's not enough. I mean, they have the [inaudible 00:13:22], and that puts the joy back into the provision of care. And I think that is our goal, right? To be able to provide better care for more people more equitably and to be able to do that in a way that lowers world stress and helps people to feel good about the care that they provide. And I think that until we are able literally prioritize healthcare as a right, and that quality of life matters, and that we need to be able to not have an assembly line of care. Again, another of the things that bothers me is that when we treat delivery room in 206, we say, okay, that person has breast cancer. This is how we treat breast cancer, and boom, you're on a conveyor belt. And you get what you get because that's how we do breast cancer.

I love the idea of having standards of care, so that's a good thing. But when we standardize care to the degree that we lose sight of the person who happens to have the breast cancer, then I think we had not done a service. So, being able to customize service, to be able to have [inaudible 00:14:39] that is more... Gosh. That is more... It's hard to not be distracted. To have care that is more customized and nuanced and individualized, that is person-centered, family-focused, culturally congruent, to have shared goals of care, to have conversations that really look at what matters to this person from a cultural and spiritual and existential place as part of their values and beliefs and preferences. If we aren't able [inaudible 00:15:12] all of the resources of the United States to provide that kind of care across the board for everyone, again, regardless of their insurance status or any of those other factors.

It is very sad because we have this enormous amount of money that's going into a system that is not providing us with the kind of quality outcomes that I'm sure you guys are learning about. We have currently this enormous amount of spending. Compared to other places, we don't have the quality of life, and we don't have the quantity of life that you would expect for that kind of a per person expenditure. So again, I think we just need to rethink the whole little system. We need different ways of doing reimbursement. We need different policies. We need a whole different mechanism for how do we look at what should be the minimal standards of practice and what should be the expectations that we get for the amount of money that we spend. I think we need to just rethink all of that.

Connie Dahlin:

Well, it's an interesting thing you say because you may be aware. Certainly, the World Health Organization says that palliative care is a human right and comes out of healthcare. And so, when you look at what they're trying to do of implementing palliative care in pediatrics, in primary care, and you're looking at their methods and just talking about developed countries and developing countries, it is an interesting model to think about because I think you've said a couple things that I think in the future, we are all talking about. I've just been writing about time to define social determinants of health, and there are six or seven definitions. That's great. I think the challenge is that... It was funny because somebody corrected me and said, "You're wrong." I'm like, well no, it depends on what your lens is, right?

And so, how do we help in palliative care people decide what lens? And then I think where social work comes in, you all have a skill and it's so innate. But when you talk about standardization, one of the things that we do need to do is that we need to help other team members be able to assess for social determinants of health. And we have no tools that are systematically evidence-based. So, that's a challenge for the future of saying, we keep talking about this, and how do we do this, and you can also imagine of just what you said about reimbursement. As palliative care, we pride ourselves on having the time to do things that other people don't have, right? So you can imagine that, okay, they don't want to spend the time, so we get these patients. And so, we are going to have to do some of that work of the social determinants. And we still haven't figured out a model where people understand the complexity of what we do if you look at wRVU value or if you're looking at some of that.

And so, we're going to be even more complex, and yet I know from my own practice when I write a consult note, people aren't necessarily always looking at my recommendations. They're looking at what I've found out in my cultural and social history that is affecting the decisions that are being made, right? Lynn will disagree with this, but I think there's something to be said. There's a lot of us that can do pain and symptom management. And I could send you to several websites and say, here's how you do this. I'll walk you through it. Hopefully, we're going to have a science vow. But this other part when we get to the personal part, becomes more qualitative and stand besides standardization of a quality metric. Do you know what I mean? Does that make sense?

Shirley Otis-Green:

It does. And to your point and to all the good people that are putting all of their heads together to figure out how do we have quality standards, what should that look like, how do we measure X and Y. I think that [Therine 00:19:20] is one of the reasons that social work or chaplaincy, and to some degree, I think nursing as well, why we are often incorporated into the bed rate because we don't know what to do with those good folks. On some level, we know we need them, and we know that something magical and mystical happens when we have them and something doesn't happen always when we don't, and yet exactly what is the secret sauce? I think of the [Tamel 00:19:48] study, and I think of your good work as being part of that, but being able to discern what was in the syringe as they like to say. What was it that made palliative care so effective? What was the alchemy of bringing this group of people together that had this enormously influential outcomes?

And I think Therine is part of the rob, right? How do we measure presence? How do we measure that kind of compassionate listening, that ability to hear the question behind the question that's underneath the question? To be able to peel off all those layers, to be able to create a trusting environment where the person can say to you, hey, the reason that mama didn't come back was because she overheard people saying things that made her feel unsafe in your environment. How do we measure that? How do we understand those kinds of things? It is tricky for sure the campaigns to measure what matters or have moved forward [inaudible 00:21:01] lots of experts by [HKIM 00:21:03] and other organizations to look at what were the... Each organizational area or discipline [inaudible 00:21:14] the five things that we should do to try and... Can you remember what that was called? But there have been lots of different ways that people can try to take a bite out of said elephant. And I don't think that our current system is set up to help us to do that very well.

Again, back to the transformation. I think that part of what we have to do is rethink how we measure those kinds of things. Too often, they become processed measures and not outcome measures. And if they are going to be outcome measures, whose outcome? Are we going to be able to really have person-centered, person reported outcomes? How do we collect those in real time? These are big issues. How do we figure that all out? But I don't think we've always been asking the right questions. Not to get too off course here [inaudible 00:22:09], but one of the challenges is our electronic health record when you just say that you write something and you know the part that they read. When most social workers write something, we know they don't read any part. And [inaudible 00:22:21]. We really do want folks to read what we write. We want the sharing of communication back and forth, and that doesn't happen currently. The healthcare medical record is designed for billing purposes. It's designed to maximize that, and then it's morphed into this other thing.

But again, it wasn't designed to be this communication tool the way that it currently is being used. So, that is another part of what needs to have an overhaul. We need to rethink and start afresh. If one of our amigas from Mars were to land on our lovely planet and walk around and try and understand how we do it and why we do it and what we do in healthcare in the United States, they would have a perplexing consternated look upon their little amiga faces because there is no rational way that this makes any sense at all. When you try to figure it out and you see how piecemeal it is, and I'm so excited that you're going to have people expose to the different historical backgrounds of palliative care from the different disciplines, but you'll see how we morph this from hospice. And we took this from over here, and we took that from over there, and we piece it together, and it works for some people some of the time if you have enough resources. But it clearly is a very cumbersome system, and again, not the one that provides care in a way that, again, our patients and families deserve nor in the way that, again, would get past the best quality of life, and our quality of life matters.

So back to the medical record, we tend to have our conversations if you were the patient and I was the doctor and [inaudible 00:24:10]. That is the opposite of what is going to produce a sense of relationship, and a sense of a trust, and a sense of rapport with the provider. The provider is literally following the prompts, and the cues, and the shortcuts, and the required metrics from the dashboard of the medical record, and not again being able to be nuanced to the needs of that person that's in front of them, or in this case [inaudible 00:24:45]. So, we need to do that differently. It's another of the aspects of moral distress that leads us to having way too many of our brother and sister that are burned out, that have that enormous risk for suicide, homicide, divorce, anxiety, depression, moral distress, again, on every level. We talk to people in COVID. Oh my gosh. We saw the rates of that, just enormously high. Again clearly, we need to do better.

Dr. Lynn McPherson:

Can I ask? If the system is broken, is it irrevocable? And if were not really providing equity in healthcare, and we're really not doing a good job of person-centered care, if it was the universe according to Shirley, what would be one or two corrective steps you would recommend immediately?

Shirley Otis-Green:

Thank you for asking. No one ever does ask what I think we should [inaudible 00:25:44] world. I think palliative care would become synonymous with healthcare. That's one of the steps that I would take. So, you couldn't be a healthcare provider of any discipline if you didn't know those core principles and apply them and integrate them into your practice. So for example, you might be asking, what would that look like? So, I couldn't be a doctor of any variant, of any kind, if I wasn't able to communicate compassionately and competently with patients and families that looked and acted and sounded differently than I did. If I couldn't meet that bar, and again, how would I measure that? Devil is in the details, but nonetheless, if I couldn't meet that bar, I couldn't be a doctor. If I wasn't committed to be an advocate, I couldn't in healthcare. One of the things that's so interesting to me is when we look historically, and I know [inaudible 00:26:45] looking forward, but when we look historically because it influences our forward, and the people that were against social security and Medicare, and even the hospice benefit was the AMA. Interestingly enough, right?

How is it that we have been able to dissect and fragment healthcare the way that we have? This interesting separation of mind, and body, and spirit when... Again, we kind of are a package. Back to my social work lens, I see the world as systemically intertwined, so I would not allow us in fact, I would be an autocrat, but I would not allow us to be able to do that kind of segregation. So, I wouldn't be able to opt out of paying attention to the spiritual and existential and social concerns of the people that we serve. I think that that ability to be... Oh, I don't do that. I don't want any social worker that I ever interact with to be, oh, pain management, I don't do that. It's like, no. Yes, I don't change the medications, I don't titrate the drugs, I don't you know, but I sure as hell better be able to do a pain assessment. I sure as hell I would be able to know when I should call 911 for the doc and nurse on duty and say, hello, I think we have a concern here. I sure as hell I would be able to know how to help the person to access the medications that they need and where their friendly pharmacist who carries the right drug is going to be.

Palliative care has a beautiful synergy that I would want incorporated into all of the professions. I think that would go a really long way. Again, I think the world is better when we integrate versus segregate, so you can probably tell my political means. But given that, I'd want my Denis to do palliative care, not because I think he's going to drill so deep that I'm at end of life, but because I'd want him to be paying attention to my fears and anxieties and my desire to have good quality of life. And that means we'll be able to chew, and eat, and to swallow, and have all the parts work as well as they can, right? Improve quality of life and improve function are two things that palliative care cares about, but doesn't every discipline care about those two things? Or shouldn't every discipline care about those two things? So again, if I were king or queen, I would definitely want all of the folks to go through Lynn's program. I would want [inaudible 00:29:27]... She smiles at that. I would want everyone to have those core clinical skills, the primary principles of palliative care incorporated into their practice so that they saw that they couldn't do this in a vacuum, that again, the fragmentation of healthcare is I think where the double lies. We need to be able to see how this is all interconnected.

We've been caring for my mother-in-law with dementia for a zillion years at this point, more so it feels, and in that process, we can see... So again, both for my professional world but also for my personal place as a care provider, it is so clear how, again, we fragment the family and how we talk to or about the patient separately from the impact of what's going on for everyone else that's in that household and the people that are, again, important but are just outside that household. So all of my, both personal and then my professional experiences, just underscore how incredibly useful palliative care is and how incredibly valuable it would be if we adapted those principles, and again, outside of even healthcare. I think that'd be the solution to the problems in the Middle East and what's going on in the Senate and a whole lot of other places if we could see how we need to be on the same side. In theory, what are those unifying goals that we have? And if we could all be person-centered, we all have that true [inaudible 00:31:04]. If we all had that perspective where we could be welling together, I think we could solve and off a lot of the world's problems, but we can't-

Connie Dahlin:

I'm going to ask a question a little bit about... So one of the things that I see a challenge is, is you said a couple things. One, this part about non-physicians being part of the bed rate. I know you said that. When you said it, it hit me as a gut because there's something about that that means that we are invisible. We're part of a bed rate. I think the second part is thinking a little bit for social work, but I think for all, for pharmacy, and nursing, and all that, is like this whole issue of scope of practice because from state to state, it differs, and people are kept out. Where I work right now, one of the things that... I will not say tragedy but does break my heart when I see very talented social workers who are diminished to the role... I shouldn't say it that way. Who are not used to their full scope of practice to look at a bigger situation but are really, truly about discharge planning, getting the patient out, not even the coordination, just getting the patient out. And that just feels... [inaudible 00:32:25] like just a gap, right? What are we going to do for the future so that that doesn't happen? Because I think, hospital say, oh, we're going to save money. We're going to slot these people into that, whether that's part of the bed rate or not.

And then, what happens is that, like you've said, we focus on just getting the patient out rather than thinking about what is this patient and family about. Is this going to be a good discharge? Is it a discharge where they're coping even though we all know it might not work? We have to let them do it, which I find sometimes it will get very paternalistic and maternalistic and say, they can't do that? I'm like, yeah they can, and they're going to have to do this and fail, and then next time, they'll be able to listen to us. Or what happens is I look at this plan and I'm like, what are we doing? And I question it and then everybody is like, kill the messenger, me. Oh palliative care, you're so bad. You stopped us from discharging that. And I'm like, well, I'm trying to stop them from being readmitted. Our goals are totally [inaudible 00:33:32]. So, just think about a little bit of that when you think about when we're looking to the future, and we're thinking about social work, and we're thinking about this integration, what does that bring up for you?

Shirley Otis-Green:

A couple of things. One is back to what's broken and how can we fix it. What's broken is we have not only disincentivize the things that we say we wanted, but we have misaligned our incentives so dramatically and so [inaudible 00:34:01], I don't know if that's a word, that we've resulted in the outcomes that we currently have. So, resistance that is in some measure of equilibrium is there because things supported being there, right? So, the system is getting the results. It was designed to get... And that's the part that breaks my heart, back to why am I staying late at night because our system is designed to keep repeating the same mistakes. There's going to be another shooting of another police officer involved shooting of another person who's an unarmed person of color within moments of watching this video because that's what the system... And how do we know that? We look at the results and we can say those results [inaudible 00:34:46]. If they keep repeating, then we have to say that there's a systemic thing going on.

So our system, our healthcare system is getting the results it's denying to get, and that's why I keep saying we need to do this differently. So, we need to change the incentives. The current reimbursement system does not pay for the kinds of quality of care or the collaboration of care that we're talking about. And so for instance, like a durable discharge comes into play and [inaudible 00:35:17] a lot of the transactional language, a lot of that comes [inaudible 00:35:23] per service that's very much of a system that's designed to bring in, that healthcare can be a for profit enterprise in a way that it had developed until fairly recently without any other alternative payment models. And that's why they call it alternative because everything was in this system and people have been able to tweak the system in such a way that they could maximize dollars in and cross out. Capitalism has lots of good factors, but maybe isn't the best way to do healthcare in this way if what we want is, again, something where the people who go in to healthcare have a desire to make a difference in people's lives and if patients and families and communities are able to have voice in how this is going to be done.

So, the challenges that yeah, if we're going to not pay differently, if it's part of the bed rate, then it means there is no differentiation between whether there was a good social worker involved, or whether a chaplain was there, or whether a nurse did a drive by, or whether the therapist did whatever, a physical therapist or occupational therapist, whoever in those guys could talk and bill. But that idea that a lot of this stuff is the same payment whether or not it happens makes all of those with people optional. And therefore, why would you do it? If you only care about... And that's back to the incentives not being aligned that the person who cares about quality, and the person who bills over here, and the person who does a cost avoidance over there, and the person who pays the salary over here, those things aren't seen as part of the package, right? It's still beyond me. I can only say it's just beyond me. I don't understand how I've never met a physician, and I met a lot, who was happy with the current system of turnaround time for a clinic visit, the expectation that you will have a 12-minute visit so that you, in theory, have a 3-minute documentation and go right to the next one. So, every 15 minutes that you've got somebody that you're seeing.

When your schedule is like that, there is this dissatisfaction, it seems to me. And so, I don't understand from a social work lens, given what seems to be the power and influence of physicians, how we all don't hold our hands and say, hell no, we will not go, right? How is it that we, as a healthcare field, don't literally just draw a line that says, that's not how you do it. That's not what I signed up for. That's not what I trained for. That's not what I... If we're going to talk about evidence informed practice, [inaudible 00:38:30] evidence-based, but evidence informed practice, we wouldn't do it this way. And again, it's not a rational way to do this. So, it is interesting to me that we have abdicated our responsibility as healthcare professionals to allow someone else to decree how often and how much time we should have with whatever person. As a social worker, I give our field all kinds of grief whenever I can that we have accommodated to those kinds of expectations. We need to hold [inaudible 00:39:10] and say, that's not how we do this. If my role is only to get you out of the bed, I didn't get a Master in Social Work to get you out of the bed.

That means I'm ignoring the code of ethics that I presumably swore allegiance to. It means I'm not following best practices as set by any of the professional organizations I might be involved with. It means I have sold my soul. And again, selling one's soul is never a good plan in my opinion because again, it's related back to the moral distress and the feelings of enormous grief that go with that. Souls are really [inaudible 00:40:02]. So, I think that there is a... And back to one of the requirements that I would have in my reformed healthcare is that idea of advocacy and that we would advocate with one another, right? And so, if I'm part of an organization that is slashing the numbers of social workers because they're too expensive, and we don't bring in revenue, and so we are not... We are a negative service in some of the language that you'll hear.

When we'd like think that the rest of our colleagues would lock arms with us and would say no, we're not going to practice in a place that does that. It's not okay that there's one lone little chaplain for a hospital bed, hospital with 427 beds, and we're going to say, no, spiritual care is an important aspect to quality of life. And we have to do this differently. If we all, again, saw ourselves as part of a team, it would seem to me that we would be able to have more influence, but we tend to fragment amongst ourselves and [crosstalk 00:41:15]-

Dr. Lynn McPherson:

It's interesting to see a autocratic leader campaigning for revolution. I like how you rolled, Shirley.

Shirley Otis-Green:

Yeah, there you go. Nothing but contradiction.

Connie Dahlin:

So, if you think about that though, I mean, I think of... So, we have students who were wanting them to think broadly for the future. What advice are you giving somebody starting in the field? What are they need to be thinking about to help change the future? You've said some things about, kind of theoretically, but can you think of some specific things that they should be doing?

Shirley Otis-Green:

I think by getting a doctor in any discipline, in any specialized field. What you've done is put your stake in the sand and you've said, I care about... Hopefully, you've said, I care about this so passionately that I'm going to devote zillions of hours of effort, and I'm going to slog through all of the requirements, but I'm doing that because... So hopefully, my good advice, is that you're really clear about your personal and your professional motivation because getting [inaudible 00:42:30] hard. And so, you're going to need something that buck you up. So I recommend doing a little deep breathing mantra, and spending some time in personal reflection, and thinking about a patient story, a professional moment of some sort where you knew if things were different, you would have had an outcome that would have been so much better. And you can hold that story in your heart so when things get tough, you're able to remind yourself of why I'm doing this. And in the same way, because it is important as that is, I think we need to have a personal motivation as well.

And so again, the same thing [inaudible 00:43:17]. Deep breath. That moment of real reflection. And you'd say, why am I doing this? How can I make a difference? The only reason you're doing a doctorate is because you're going to make a difference in the world, and God bless you for [inaudible 00:43:30]. So, you're going to make a difference in the world and you need to have some motivation for why, that you're going to get up in the next day and slog through another, whatever it is. So for myself, it's real clear to me. I have several patients that are right there for me, but one of those patients who's a person in pain. And I was a good little social worker and I believed in my good little team, and they said, we were giving her the maximum amount of opioids and we had a saline, and she had reached it, and oh well, it's too bad that that still hurt. We all felt terrible about it, but I trusted our doc and our team, and we did the best we could and [inaudible 00:44:08] are. And later, I moved into a different place, and I had the opportunity to be invited to learn beyond my previously narrow scope and realized that there is no automatic saline and opioid use, and that indeed there were other things that we could do. And her cry still hunt me to this day.

So, one of the reasons that I've done work in pain and symptom management is because I feel guilty and sadness and a death to the patients that I didn't provide the best care for and knew that [inaudible 00:44:45] but didn't know what to do and didn't know that that could be part of my scope. And when I learn more, hopefully then I can do better. But I hold those patients as part of my motivation. And in the same, I have drunk the kool-aid that tells me that everyone is mortal. And if that's true, then that means my dear son is mortal, and he's the best [inaudible 00:45:09] best, and I want him to get the best care. And until I can believe that he is going to get the very best care no matter where his care is going to be delivered and no matter, again, hopefully, knock on the wood, it's zillions years from now, but at some point when he's on a serious illness, when he has a need to have medical care, I want that medical care to be better than I am confidently would be at this point. So all of that was to say, my advice is to identify why you do what you do. Identify why it matters, and then move forward with that.

I think the best and most useful thing that we can do, I've studied this actually a lot, I think resilience is a really important attribute. And I think we build resilience by doing things that are tough and by having a sense of purpose. We have to have a sense of meaning in our work. And that's the good news about palliative care, again, and to all of life's problems because it is a meaningful work, so you get a chance to literally make a difference in people's lives. So, in whatever way you can help make the world a better place, you are not only making the world a better place that's nice, that's going to make a difference in patient lives and other people's lives, even makes a difference in your life. You're going to feel better at the end of the day when you know that what you did was good, what you did was meaningful, what you did could be impactful, what you did had purpose, what you did help move that rock up the mountain just a little bit further. It's a big mountain and it's a heavy rock, and so we need to have all of our friends come in. And that's the other good thing about getting a doctorate in palliative care, is you're going to meet the finest people on the planet: the faculty, your colleagues, your teammates, your co-students, your [inaudible 00:47:14] of students.

You're going to meet, by definition, the finest people who walk the earth. And you're going to have friends from different countries, and different timezones, and different geographic areas, and different disciplines, and different genders, and different races, and different ethnicities. And all of those different things are going to help you to have some comfort at night when you do go back to bed exhausted from that hard day, but satisfied that you're part of a team that's on the right side of the world. If there's a problem, whether you can fix it or not, it's another whole story, but it's so much better to be on the side that's trying to fix it versus the side that's given up or having forbid the side that is making it worse. So yeah, I think my best advice is to celebrate the opportunities that the program offers, to take advantage of those opportunities, to learn from others, to think outside [inaudible 00:48:27]. Again, that's why you could do that education, right? To broaden that lens, to think outside of your scope, and to be able to develop the skills so that you can feel better about the work that you do.

Dr. Lynn McPherson:

Oh, that sounds like a wrap. What do you think, Connie?

Connie Dahlin:

I do think so. Shirley, that was awesome. Thank you so much.

Shirley Otis-Green:

Well, you are most welcome. Thank you for the opportunity to think these thoughts with you.

Dr. Lynn McPherson:

I'd like to think our guest today and Connie Dahlin for the continuing journey in our podcast series title, 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 cut 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 request regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.