Dr. Lynn McPher...: Hello, this is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science and Graduate Certificate Program at the University of Maryland. I am so excited about our three guests today. Boy, you have triple the fun! We have Dr. Balu Natarajan, Dr. Lyla Thomas and Dr. John Manfredonia, all really brilliant physicians with Seasons Hospice and Palliative Care. So I'm going to let them each tell you a little bit more about their story and what they do. Dr. Natarajan, let's start with you.

Dr. Balu Natara...: Hi there. How are you?

Dr. Lynn McPher...: Well. Very well, thank you. How about you?

Dr. Balu Natara...: I'm good, thanks. It's good to be here.

Dr. Lynn McPher...: Well thank you for joining us. So what's the backstory?

Dr. Balu Natara...: The backstory. How did I get to Seasons? I've been with Seasons Hospice and Palliative Care for over 20 years now and I'm the Chief Medical Officer for the past 10.

Dr. Lynn McPher...: That's wonderful. I've known you this whole 20 years as well.

Dr. Balu Natara...: It's true. It's been exciting. Quite the evolution.

Dr. Lynn McPher...: We're both still 29, right?

Dr. Balu Natara...: That's right. That's right, as far as you know.

Dr. Lynn McPher...: You were born on February 29th so you probably could claim even less than 29.

Dr. Balu Natara...: Yeah, my CEO was complaining the other day that he is going to get in trouble for child labor, so that's true.

Dr. Lynn McPher...: Absolutely. So, I understand that your background... Actually you've done a lot of Sports Medicine prior to coming into Hospice and Palliative Care, is that correct?

Dr. Balu Natara...: Yes, as a good internist, I was able to do all things related to adult medicine and after I finished my residency at Northwestern, I did a fellowship in Sports Medicine and I wound up taking a right hand turn for a minute. I took a hospitalist job for a year because I knew that my wife and I would be moving for her school an while I was a hospitalist, if you're a good hospitalist, doing good acute care medicine, you will be using hospice because there are plenty of people that use acute care who are in their final stages of life. And my hospitalist job was no exception. So I wound up referring a lot of people to hospice and the hospice nurse in that hospital asked me to cover team meeting

in late 2000 and I did with all of about five minutes of orientation and that went well enough that I was asked to do it again and the story has just blossomed from there.

Dr. Lynn McPher...: That's wonderful. I'm curious, does your Sports Medicine background, has that helped you at all in your career as a Hospice and Palliative Care physician?

Dr. Balu Natara...: It actually does. One of the things that's really important in Sports Medicine is the ability to do a head-to-toe assessment clinically quickly. So if you're ever watching a sporting event, and you see someone get injured, and you see those trainers running over to them, that's what they're doing. We always hear later that they went and got x-rays and whatever else, but we can see them doing that exam right there on the court or on the field. And it's pretty powerful. And quite frankly, that's what we have to do in hospice, right? We are responsible for figuring out what's going on without a lot of diagnostic tests. And in Palliative, sometimes we get those diagnostic tests, but even in those settings, often we don't. And so it's really the ability to do a history in the moment, do a solid physical exam and form an assessment of what's going on without a lot of bells and whistles. That forms the underpinning of Sports Medicine which is the same underpinning of Hospice and Palliative Medicine.

Dr. Lynn McPher...: That's wonderful. I think that would not have been as inherently obvious to people, so thanks for sharing that. And just so you all know, Dr. Natarajan teaches in our PALC 601 course, Principles and Practice of Hospice and Palliative Care, where he works with all of our learners to determine hospice eligibility and eligibility for re-certification, so people are always very engaged in that activity and that's worked out quite well.

So let's move to Dr. Lyla Thomas who I met a meeting years ago and said, "Hey, you should come work for Seasons." Do you remember that, Dr. Thomas?

Dr. Lyla Thomas: Yes, I do. So I actually started out in New York, which is where I'm originally from, and trained as a Hematologist/Oncologist. And when I came out of that, I felt that I needed to learn pain management. So I decided to go to Calvary Hospital which is a hospital, at the time in particular, taking care of advance cancer patients. So I went there with the expectation of just being there for a year, and 17 1/2 years later, I had taken care of their inpatients, their outpatients, their hospice, their home care, and their wound clinic. I then decided, well, let's see what else is going on besides cancer and went to Montefiore and was able to actually get the Project Death in America to actually fund the fellowship after I had written up the protocol and everything for that. But also realized along the way how much I hated ventilators and then went to Visiting Nurse Service of New York and worked there for seven and a half years and then eventually moved to Atlanta. Worked for Kindred for eight years and now it's Seasons for... Getting ready to do two years.

Dr. Lynn McPher...: Wow. So you've got quite an interesting background as well. I know when Dr. Thomas calls me, it's got to be one tough case because she's a smart cookie! And certainly get your fair share of pretty tough cases, don't you?

Dr. Lyla Thomas: Yes, I have. I have.

Dr. Lynn McPher...: She's who you call when you're in trouble. Well, thank you. And last, but not least by any means, we have Dr. John Manfredonia who obviously met... I met him while he was working for Seasons and he teaches in our very last course in the program, Advanced Team Based Palliative Care. So Dr. Manfredonia, welcome. What is your story, sir?

Dr. John Manfre...: Good morning. Yes, so I was in a Tucson, Arizona in a busy Family Practice with a lot of Obstetrics and it was in the late 90s when I got involved in hospice. I was taking a course actually up in Scottsdale for pain management and it was a three day course and was sitting next to a physician that was associated with hospice. And by the end of the course, he asked me to participate in one of their programs in Tucson, 35 Daily Senses Program and he said, "Just try it. I think you'd really be good there." And he said, "If you don't like it, just walk away." And I was really in a busy practice, a lot of obstetrics, but I tried it and actually I fell in love with it.

It was really a different approach than traditional medicine and I was that hospice for a couple of years and then they asked me to be an Area Medical Director and then a Regional Medical Director. And I enjoyed it so much that ultimately after actually by 2002, so after a few years, I elected to step away from Family Medicine; difficult decision, I really loved it. I'll just say from a humorist perspective, back in those days I received a certificate for delivering the most babies and signing the most death certificates in the same day.

Dr. Lynn McPher...: Well, that's a fair trade.

Dr. John Manfre...: Because the hospice used to bring over the death certificates that I used to fill out while I was waiting in Labor and Delivery.

Dr. Lynn McPher...: Well, that's a little creepy, actually, Dr. John.

Dr. John Manfre...: In any event, I was with essentially the same organization although it went through a number of acquisitions and was National Medical Director with Gentiva Kindred and then after departing them, shortly after departing, probably within a week, I received a call from Dr. Natarajan asking if I was interested in joining his organization. And here I am and currently really on a part time basis with Seasons as their National Medical Educator. I really love, predominately on the educational side, educating physicians and nurse practitioners. And just love Seasons and love continuing to be with Hospice and Palliative Medicine.

Dr. Lynn McPher...: I can certainly see how your robust experience in Family Practice has really paid off for you in Hospice and Palliative Care and I've witnessed that firsthand in our course. The students really appreciate how knowledgeable you are about such a wide range of topics. I remember one week you were talking about this COPD patient and you just blew me away because you just went on and on and on. Very valuable. So you each got such a different diverse background. I mean, Sports Medicine, Family Practice, Obstetrics, and Hem/Onc. What is it, on a visceral level, that drew each of you to Hospice and Palliative Care? Who would like to articulate that for our listeners?

Dr. Balu Natara...: Well, whoever wants. Lynn, you choose. Direct traffic.

Dr. Lynn McPher...: You go next. You go first since you're speaking.

Dr. Balu Natara...: Okay. It's interesting... When the summer of 1984, I wasn't even a teenager yet, I had gone to India. My grandfather was dying of prostate cancer and it was a very stressful time, he was in his 80's. One of the reasons it was stressful is my aunt, my mom only has one sister, and so my mom was here in the United States, my aunt was in India. She was taking care of their dad. And at the same time, this was in Bombay, her daughter was getting married. And so, here they were in this little flat, real estate is about as tough as Manhattan, here they are taking care of him in the hospital and planning for this wedding and hoping that he won't pass during the wedding or just before it. And so that was one of my first exposures to somebody who was sick and who was dying. And he was beyond curative treatment, right?

And everyone was just trying to take care of him and make sure that he wasn't suffering. And he passed away after the wedding, so we made it through all of that and we got him comfortable and there were all the family dynamics that were associated with two sisters; one who was living halfway around the world trying to figure out what to do, and the day after he died, I remember actually being at the funeral, we got a call from South India that my father's mom, another grandmother, was in a coma. And so we packed up and went south and then I got to see her with three of my uncles. My dad was not there; he was working here. He did not get to see her, but I got to see her a few hours before she died with three of my uncles.

And so that summer really opened my eyes to just the fact that every one of us is a mortal human being and that there is something like end of life and that there can be suffering at the end of life and that can have a domino effect on people all around one. And so that shaped my thinking. So even when I was applying to college and medical school, I wasn't afraid of death. It was something that happens. We are born and we die. And so it's not creepy to me, right? But John was managing both cradle and grave in the same setting because that's the circle of life. And we all know it in a vacuum, but that became very apparent to me at a very young age.

Dr. Lynn McPher...: Had you decided on Medical School prior to the summer you were 19?

Dr. Balu Natara...: Prior to that summer, in 1984 when I went, no. I was not quite teenager, but by later in high school it was very clear to me that I wanted to pursue medicine.

Dr. Lynn McPher...: I bet that summer had a big impact on your decision, didn't it?

Dr. Balu Natara...: Absolutely. Without a doubt.

Dr. Lynn McPher...: Wow. Dr. Lyla, how about you?

Dr. Lyla Thomas: So I have the experience of my father was a psychiatrist and he was the head of a large psychiatric hospital in New York. And as a medical student, I was able to actually go and work, because back then we didn't have all the certifications, et cetera, for recreation therapists, so I worked in the summer in the Terminal Chronic Schizophrenic Ward. And at that point, I saw patients who were dying and they were in excruciating pain and it annoyed me that these people were dying that way. And I also couldn't understand how people could live and be in such excruciating pain. And that really is what got me interested in the pain management aspect. One particular patient of course was totally nonverbal, but I'm one of those people I talk to everybody no matter what, and I would bring in books from the library about Poland because his family was originally from Poland, and I'd show him all these pictures and he hadn't spoken for years and he was a young man in his 40s.

And my last day there, his father and stepmother were there and I said to him, "Well, this is my last day and I'm leaving now, Walter." And he said, "Okay. Bye-bye." And everybody was stunned because here was this guy who had never spoken in years, spoke to me. And then the next day, he died. And after that, I always remembered the pain that he was in and part of my mission was to make sure my patients, when I decided on Hem/Onc, were never in pain. And certainly I can tell you that all of those patients I would get in Hem/Onc you're laughing about how I always give you the complicated patients, well, they always gave me all the complicated patients and the ones that... But it was a wonderful experience and it made me appreciate life so much at a relatively young age because I was now in my mid-20s.

Well, here it is, of course, you're young and you go out to clubs and everything else and you want your makeup perfect and I would see patients who would come in with terrible head and neck cancers and still be so very involved in life and appreciating life. It really taught me a lot about life and I think that that's really what led me to going to calvary and then ultimately staying there. Because it really satisfied that part of me that I needed to feel as though I was a physician and helping families completely.

Dr. Lynn McPher...: I have always thought that what we do in Hospice and Palliative Care is the reason why people go into the field of medicine. Because we want to help

people and that's 100% what we do. Dr. Thomas, let me ask you this, my mother, until the day she died, told me she disliked what I did for a living because it's just too darn depressing. So, isn't it kind of hard taking care of people who are very near the end? Wouldn't you rather deliver babies? What's the delio there?

Dr. Lyla Thomas: So I can tell you that I've told people at parties, for example, when they find out what I do and of course they give you that, "Oh my God, you're an angel" or "You're this" and I'm like, "Okay, well my halo is definitely held up by horns." As well as the fact that everybody is drawn to something that they can really do well. And for whatever reason, one of the things that I can do well is to get families who are distraught and patients who are in terrible discomfort, I can get them all in the same boat paddling down in the same direction for whatever reason. Now if you ask me to be a banker, I would be in jail because I can't even balance my own checkbook. That's just not my talent. And I just tell people that there are things that we all are able to do and we need to find what it is that we do well and, as I said, it has always opened my eyes to life and appreciating life.

Dr. Lynn McPher...: Absolutely. Dr. John, what do you think about that? This is hard work. What do you think?

Dr. John Manfre...: You know, you're always asked that question or when you talk to individuals or people they think, "Oh it's wonderful that you do that, but it's so hard. I don't know that I could." And actually, I find it easy. And I find it exceptionally rewarding. Dr. Natarajan mentioned the circle of life. I'm maybe a little bit of an emotional junkie that delivering babies is a very positive emotional experience at the time of delivery and leading up to delivery and of course afterwards that the family is just so in such an emotional excited state and it's really glorious. Well, I find that death, although the emotion is very the same, of course it's not as joyous necessarily, but very similar as far as the intensity, I guess, of the emotion is concerned. And in my early days of hospice, I realized that I was really not, even though I had taken care of individuals at the end of life, it was really not infrequently at the prompting or the assistance, I should say, of the nurses within hospice and so forth.

So in the early days when I got involved in hospice, I just thrived on increasing and improving my knowledge on end of life care and I just found it so rewarding. In traditional medicine, we almost had a mentality, I shouldn't say this, but of a BAND-AID mentality in that we would respond in reactive medicine. And in hospice, it was still, in the 90s, I think still in its relatively infancy or early adolescence. And there was such an opportunity, just like Dr. Thomas indicated, I always remember this one particular case.

This gentleman who had metastatic lung cancer, and relatively young in his probably late 40s and so forth, and I was visiting him at home almost on a weekly basis, interacting, he had three relatively young children at the home and so forth, and he was in the latter stages and he was in a bed that we

provided in the living room. And over the last... And because it was getting close, I visited relatively frequently. I established a bond or an attachment with the family and he hadn't spoken in probably four or five days and was in a relatively obtunded state.

And I remember the last day, just shortly before he passed, I spent some time with the family and the children and then I went over to him and I put my hand on his forehead and I said goodbye to him. And as I turned away, he sat up and said, "Goodbye, Dr. John." And then laid back down and closed his eyes and then passed within the next 30-45 minutes. And I was just always... And you have those experiences in hospice and it's such a rewarding field so I feel blessed that I was accidentally fell into the role of being a hospice physician.

Dr. Lynn McPher...: Yeah, I hear that time and again how people that end up in Hospice and Palliative Care almost as a happy accident, so that's pretty ironic. Dr. Natarajan, when I think about Seasons has as part of their mission statement, that everyone's entitled to a good death. And it sounds kind of a Pollyanna statement, but how do you reconcile that is even possible when this is a heavy lift? And then how do you handle that question at a party like Dr. Thomas said? That's a lot to pull together.

You're muted Dr. Natarajan.

Dr. Balu Natara...: Here we go. Part of the standard, part of the expectation, of good death, and we've actually said that there are times when the end of life experience can be perfect, that it's actually possible to be perfect. And there are a lot of people that are quite irritated by that notion and they're irritated by it because they've never experienced it, but it's not something we made up. We're quoting patients and families. We're quoting people where patients say, "This is what I want. This is how I would have it scripted." And we're quoting families who are saying, "Oh my God. I've never imagined that that was possible. That was perfect." And then the funeral is the celebration. But this notion of a good death actually came from my house. When my father-in-law had lung cancer in India, and I went to visit over there one day late in his illness, and it was clear that the family had minimized his lack of appetite, et cetera. So I called Todd Stern, our CEO, and I said, "I want to bring him home." And I said, "He doesn't have Medicare, he doesn't have anything." And he said, "Do what you have to do. Bring him home." And we brought him home and eventually he died comfortably in my living room and I did not have to take care of him.

The Seasons staff took care of him and he died and in the house were all of his kids and all of his grandkids. Everyone had come over. One set of family from DC, one family from India, and I was out for a walk and his wife was making a cup of tea and he died peacefully. And my wife looked at me, and I had been in hospice 11 years at this point, my wife looks at me because everything has been taken care of and my dad and I had gone to make funeral arrangements prior. And so things just happened. And they were able to basically spend time with

him and say goodbye. And she looked at me and said, "How do you do that? How do you answer the phone before it rings?" And it was so powerful that I felt that everyone should have that. And I knew it, but I hadn't lived it, and here we had lived it.

And interestingly, John talks about it being sad, right, when people die, which they do, but that nurse that recruited me to hospice in 2000, when she was dying 17 years later of lung cancer, she contacted me and said, "I want you to take care of me." And I went and made a home visit and she looks at me and she says, "Are you going to deliver my eulogy?" Which that's a strange question to be asked and so I didn't quite know what to do with that and I said, "Well, if you want me to." And she said, "I would imagine it would be quite humorous." So she basically set the tone for "I expect my funeral or memorial service to be light and fun and not somber." And at the time she had that conversation with me, she already had brain MEPs, so I really wasn't sure if she would ever share that conversation with anyone else.

She died six weeks later and her daughters called me and said, "Mom wanted you to do this, so we're building the memorial service around your schedule. You have to be there." And it was funny. The only thing freaking me out was the priest standing right behind me. Everyone else was laughing and I don't think he was laughing. But beyond that, I delivered what the nurse who recruited me, what Barb asked for, I was able to deliver on that promise and she wanted us to celebrate. She did not want us feeling somber. She did not want us feeling sorry for her or for ourselves. And there are a lot of people in a lot of families when we give permission to celebrate life and to have a legacy, they take it and they have an absolute blast with it.

Again, it goes back to the idea, right? Cradle to grave; everyone's going to be born, everyone's going to die. We can't escape it. We haven't found Ponce De Leon just yet, and so a lot of people say, "You know what? We might as well make the most of it." And have an absolute blast every possible breath we have on this earth.

Dr. Lynn McPher...: Well, you convinced me. If I was at the dinner party with you, I would certainly buy what you're selling. Absolutely. I look at the three of you with your collective experience which is amazing. So in your opinion, what has stood the test of time in Hospice and Palliative Care? What are we doing well? What's working? What do we do better than anybody else maybe? What do you think?

Dr. John Manfre...: I'll jump in. The team approach I think in hospice. I think we really transitioned from traditional medicine where it was the physician or the clinician who orchestrates and has oversight and direct interaction predominately with the patient but also the family to some extent usually in their environment rather than in the patient or family's environment. And I think in hospice, the team approach and the magnificent work that the entire... the RN Case Managers and the entire staff does in providing and interacting with the patient, the family,

and again, to reinforce it's not just the patient. It's about the patient, the family, the caregivers, the staff, it's an all very interrelated occurrence that occurs on a regular basis. And being able... I think also seeing them within their environment rather than our environment really makes a dramatic difference.

Dr. Lynn McPher...: Mm-hmm (affirmative). You know, I've been long a believer of transdisciplinary practice. I'm not happy unless everybody in my orbit is 10% pharmacist. And I swear on 10% social worker and 10% nurse. Dr. Thomas, do you agree? Do you think we are transdisciplinary in Hospice and Palliative Care to a degree?

Dr. Lyla Thomas: Oh absolutely. I know more about social work issues and trying to find placement and the regulations around homelessness or all of those other things that social workers usually do. I also know how to, I always tell everybody, I'm also a great nurse's aide. I actually know how to make the bed with the patient in it and get the chucks and the drawsheet in there and be able to get that patient rolled over onto a fresh new bed. So, yes, we are transdisciplinary, we do know all of those things. I think also jumping on John's what he had said, I think we also originated what we should have been doing all along which was patient and family centered care before it became the buzzword. That is what we have always done. Our care has always been focused on the patient and the family. And it is the team that brings that entire patient centered care home for that particular patient. And again, being in the home is the most important thing because that's where most patients and families want to go and to want to be at.

Dr. Lynn McPher...: You know, speaking to your point, I'm working on developing a proposal to extend our Master's in an online Ph.D. and we're going to have a course which historically has been called Patient Centered Research Outcomes, so when I ran this by the Advisory Committee, all the Social Workers said, "No, no, no. That should be Person Centered Research Outcomes." And even though we have a PCORI Institute which is patient, we are going to make it "Person Centered", so there. Dr. Balu, anything you want to add to what are we doing well in Hospice and Palliative Care? What has stood the test of time?

Dr. Balu Natara...: I think the notion of being interdisciplinary for sure. I think finding people who actually want to do this. We're still able to achieve that. There are still folks that are willing to run into the eye of the hurricane, so that part we're definitely doing well. And I think the other thing that we're doing well is thinking outside the box in terms of what else we can do. Music therapy now is becoming more and more a part of the interdisciplinary team. Adding pet therapy and art therapy, all of those sorts of things. So I think that the notion of getting to a bedside and bringing people together we're doing well. And quite frankly, even in the middle of a pandemic, we have figured out ways to preserve that and we've, in this setting, done that better than any acute care setting.

The acute care settings are still running around in gowns and masks and everything else, which is appropriate, but what they're not doing is making sure

that we can actually see one another and somehow connect with one another in a lot of settings. And so fear is driving that, whereas after some early bumps in the road in hospice in particular, we're doing our very, very best to tear down those walls. Masks on and gowns and gloves and hoods on as needed, but we are making sure that we at least have that contact with one another which there's still a lot of acute care settings which are not allowing that. And quite frankly, it's probably going to get worse here as the winter hits.

Dr. Lynn McPher...: Absolutely. I think Hospice and Palliative Care did put the person in Person Centered Care. I think another thing that we do differently than most of healthcare is we check our egos at the door. I mean, you look at people in our program, we all go by our first name. I don't care if you're an MD Ph.D., or whatever, I think we play well in the sandbox together. So when you look at healthcare in general, the whole field of healthcare, are we doing a good job? Are we playing well in the sandbox between Hospice and Palliative Medicine and the rest of the healthcare system? What are your thoughts on that? Are they using us appropriately? Should they use us more? What do you think?

Dr. Balu Natara...: I think there's still a lot of work to do. Do we check our egos at the door? I think the answer is yes. Do we still have a lot of work to do on that? I think the answer is yes. And I think the climate of the world, the attitude of the world, ebbs and flows. And I think everybody is having a bit of a rough time in a lot of parts of the world and the United States is no exception right now. And so at such times we tend to be more insular than open, so I think we have work to do when it comes to communicating openly and making it safe to have honest conversations with one another. I think it's better. I think that just the possibility of end of life care is front of mind in a way that it never used to be previously in various settings. We are able to get folks from C-Suites of hospitals and ACOs and Health Plans, et cetera to the table in a way that we never could before.

But, there's still a lot more conversation that needs to be had and I certainly wouldn't put that on just one group. There is sometimes a habit among those in Hospice and Palliative Medicine to not appreciate what charitive folks tend to do. But I would just ask that we remember all of our friends who were diagnosed with some sort of cancer who got cured. And that wouldn't happen were it not for our aggressive oncology colleagues. Or the cardiology interventionists who have added 10, 15, 20 years of life to one of our loved ones. Those folks have helped people in our spheres, some of whom are arm-in-arm with us taking care of the dying. So I think we would do well to be as fair as possible in acknowledging that and that may disarm just a little bit more and advance the conversation and make more conversation safe and possible.

Dr. Lynn McPher...: That makes sense. So, I think probably Dr. John and I are of a similar age now both being 29 for quite a few years now. But we witnessed, all of us to a degree, the evolution of Hospice and Palliative Care and when you look at how old Palliative Care is relative to the field of Internal Medicine, wow! I think it's crazy how quickly it's unfolded and been adopted and I agree with Dr. Balu, we still

have room to go. So let me end the whole conversation with this question. Let me pose this to you. What do you think the future holds for us? Who'd like to tackle that one? What's next on our dance card? What frontier should we take on? Don't be shy now! Come on, Dr. Thomas, what do you think?

Dr. Lyla Thomas: What does the frontier... So to me, the frontier still however is being able to get people to really, and I'm talking about physicians in particular, to see what it is that patients really want. And accepting that they need to be a true partner with that patient. That we need, as we said, need to check our egos at the door. For some of us, it's a lot easier to do that. For some of our other brethren, it is not so easy to do that. They still feel that they are the physician, they are the specialists, they know what's best and they will subvert some of the things that the patient really would like to do and has expressed because the patient again becomes so overwhelmed by their ego and what they think that they can do.

Dr. Lynn McPher...: I think we're the drippy faucet. I think that all of us who practice in Hospice and Palliative Care are good ambassadors for spreading that throughout the medical community and I will continue to beat that drum. Dr. John, what do you think about that? What does your Magic 8-Ball tell you?

Dr. John Manfre...: I alluded to earlier that we were either in our infancy or early adolescence, well maybe we're in our mid to late adolescence, but I really don't believe we're beyond that. I think as Lyla alluded to, we exist... There's such a rage for survival in this country, both on the patient side of the equation and family, I should include in that, but also on the physician side of the equation and I think we haven't learned where to distinguish where that transitional line is. That as Lyla said, our focus changes from we must do everything for survival, every intervention, especially as our technology progresses, and we lose sight of the heart of hospice and the heart of palliative care, of really making a determination of what's best as the patient/family determine, not as we determine what's best for them and allow them to travel that course. And I think we're getting there. I think probably hospice, within six months, may at some point, shorten a little bit. And palliative care will extend and integrate better with hospice and better with traditional medicine. But it's been a slow process.

Dr. Lynn McPher...: Mm-hmm (affirmative). I see this more as a continuum. I think we're the only country in the world that so clearly delineates between hospice and palliative care, but with the evolution of community based palliative care, I see this more as a continuum and I would like to see us move in that direction. Dr. Balu, I'm going to give you the closing word here. What's in your crystal ball?

Dr. Balu Natara...: I think that if we are wise, we will seize this notion of person over patient. And what that also means is that we can medicalize hopefully a little bit less and go back to a basic history and physical exam which is kind of how we started this conversation. I think that our push for fellowship training and boards and drips, et cetera, I think you have taught us that we can probably get as much done

with Methadone as we could with seven different drips going. And I think that the same holds true for if we would spend a little bit more time understanding where the patient is, where the family is, where their doctors are, we would probably get a lot further in advancing the true end of life conversation.

And we can probably manage a lot of symptoms with a few more minutes on a head-to-toe exam. I think that the future is as bright as we choose to make it by going back to our fundamentals, some of the basic things that got us here early in the infancy of this field. And so if John is saying that we are later in our adolescence, then we can probably take the idea of "everything we needed to know in hospice, we learned in Kindergarten" and then take it from there and I think that the future is very bright if we can remember that every now and then.

Dr. Lynn McPher...: What a great analogy. Thank you. Well, my acid test is when I look at a healthcare provider; a doctor, a nurse, I ask myself, "If I was sick, or someone I love was, would I trust this person to take care of me or my loved one?" And the answer for all three of you is, "Absolutely yes." So it's been a pleasure speaking with all of you. I'm proud to work with you, and thank you so much for doing this podcast. This has been so insightful. This is Dr. Lynn McPherson and this presentation is Copyright 2020, University of Maryland. For more information on our completely online Master of Science and Graduate Certificate Program in Palliative Care or for permission request regarding this podcast, please visit: graduate.umaryland.edu/palliative. Thank you.