

Palliative Care Chat – Episode 25

Clinical Practice Guidelines for Quality Palliative Care An Interview with Drs. Ferrell and Twaddle

Dr. McPherson: 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 beyond excited to introduce my guests today, Dr. Betty Ferrell and Dr. Martha Twaddle.

Dr. Twaddle is a physician who currently serves as Medical Director for Palliative Medicine and Supportive Care at Northwestern Medicine, Lake Forest Hospital. Her academic work includes developing curriculum, guidelines and models of care for health care professionals to provide care for the seriously ill in all settings.

Dr. Betty Ferrell is an RN, PhD and 57 other things behind her name. She's been in nursing for quite a while. She's the Director of the Division of Nursing, Research and Education, and a professor at City of Hope National Medical Center in California, and she's very well known as serving as a principal investigator for the End-of-Life Nursing Education Consortium. She completed a master's in theology, ethics and culture and her PhD is in nursing, so ladies, welcome. I'm very excited to be with you today.

Dr. Ferrell: Thank you.

Dr. Twaddle: Great to be with you, Lynn.

Dr. McPherson: Thank you. Doctors Ferrell and Twaddle served as co-chairs of the National Consensus Project steering committee that resulted in publication of the Clinical Practice Guidelines for Quality Palliative Care, the 4th edition. This was published by the National Consensus Project for Quality Palliative Care and the National Coalition for Hospice & Palliative care. A herculean effort to be sure, ladies. A lot of people were involved in this. I just want you to know that I did curricular mapping for our Online Master of Science degree using these guidelines, so obviously I'm a big fan.

Let's start at the top, so Dr. Twaddle, maybe you could take this one. Why clinical practice guidelines for palliative care? Can't we all just agree to get along and do good things for patients and families?

Dr. Twaddle: I think we do agree, and so by having that agreement around it, we want to create a framework, something that is durable, that helps inform clinical practice, best practice, that helps just like you did, create a framework around what should the educational curricula be for caring for seriously ill people. Guidelines go further to help support quality measures, the development of quality measures. They help in the policy and procedure at a local level for maybe a program, but they also help with policy at a large level, like at CMS.

They end up informing program development and even payment, so having a framework like this really helps move the field forward, and it helps create consistency. What Betty and I get really excited about as well is it helps create accountability, ways of measuring accountability that people are doing the right thing for seriously ill people and their families.

Dr. McPherson: That's so important. You know, I noticed you said seriously ill people, so Dr. Ferrell, why did Dr. Twaddle just use that phrase, and in the Guidelines you all chose to say, "Patients and families living with serious illness," not advanced illness or life-limiting illness. What's the scoop with that, and how do you define serious illness?

Dr. Ferrell: Yes, I'm so glad you raised that issue, because it is one of the most important new dimensions of the 4th edition of the Guidelines. I think all of us in this field have lived historically with this issue that really overshadows our practice, and that is both the good news and the bad news is that this field started with hospice care, and hospice is and remains a model of caring for people at the end of life.

What we all know has happened since then, because that was our origin, people still think that palliative care is also focused only at the end of life. We see this every day in our practice, as there's hesitancy to refer people to palliative care until they're imminently dying. We've tried all kinds of things over the last 20 years. We've tried explaining, defining, encouraging, lots of models to say, "No, palliative care needs to start at the point of diagnosis, earlier, upstream." These are words that we've used.

In this edition we decided to take a different approach, building on certainly the work of many other scholars. Amy Kelley, her colleagues at Mount Sinai, have published work where they've used this term "serious illness," and the idea being let's refocus on the patient, and the patient that we want to reach is really anyone living with a serious illness.

When we're looking at a patient with end-stage heart disease, rather than arguing, you know, where are they in their trajectory, how close are they to dying, if we just step back and say, "Is end-stage heart disease a serious illness? Absolutely," then there should be no hesitancy to get that patient in palliative care. I think it's more than just a new term. It really reframes how we think about the opportunities for palliative area.

Dr. McPherson: That's great.

Dr. Twaddle: To jump in, Lynn, if it's okay, Amy's definition is serious illness is a health condition that carries a high risk of mortality, and either negatively impacts that person's ability to function on a day-to-day basis or their quality of life, or excessively strains their caregiver. This is a defined term. It is broad. It speaks to quality of life, and what we also love is it speaks to the impact that that person

with serious illness, that they're not in isolation of those who love and care for them.

Dr. McPherson: I think the definition is so important. We continue to struggle with practitioners knowing when it's time for hospice, let alone what are the triggers for palliative care, so I really appreciate that. You ladies were involved in the 4th edition, so how did this whole ball of wax get started? When did the Guidelines first come to be? Who wrote them? Were they reviewed? Do you have people review these for you? What's the scoop? Maybe, Dr. Twaddle, you could take that.

Dr. Twaddle: Well, I'll start, Lynn, and have my wonderful colleague chime in, because Betty and I have had opportunities, particularly Betty, to be involved in all four editions. I was part of the initial creation of the Guidelines back in I think around 2000, 2001, and those initial Guidelines were the gestation of an elephant. They took over three years to create and to get to publication. Betty was involved in every edition of the Guidelines as they have grown and become more robust.

This edition, we were asked to initially, interestingly, look at community-based guidelines, and what we realized after our summit ... we had a wonderful summit in Chicago in June of 2017, where we convened stakeholders to speak to what the Guidelines had been for them thus far, as we thought about where we needed to take them. What we realized is that this isn't about a setting of care. This is about the person receiving the care and those who love and care for them. This is about the seriously ill person, regardless of the setting of care, and creating continuity across all sites of care. Betty, do you want to add anything to that?

Dr. Ferrell: Yes. I think I had the privilege of being the co-chair for each of the four editions, and I'll tell you that when I was first contacted back about the year 2000 to say, "Would you co-chair this new thing, that's going to be called the National Consensus Project to create national guidelines," my first question was, "What? Why do we need that?" Through the help of my colleagues, I quickly realized of course we need this, because we really do need to define the field and we really do need to set the bar, so that the [inaudible 00:08:21]. The patients again, it always goes back to what do our patients need, and our patients across this country need reliably good care.

Every edition of the Guidelines ... and of course, you know, we are a rapidly-evolving field. Martha and I both are a testament to the fact that ... we started our careers at a time where people still couldn't pronounce the word "hospice," and there were, you know, none in many states and literally a handful across the country, and the word "palliative care" did not exist in our vocabulary. There was no such thing. When we say defining the field, we mean defining the field, and so there's a lot of wonderful things.

One of the things I most appreciated, that from the time of the very first edition, our guidelines are interdisciplinary. We have always had at the table the many

professions who serve patients and families, and yes, this is ... over now these 19 years, we've had four editions of the Guidelines because we've needed to keep up, right?

Again, even when palliative care first started, many of us can recall that, whether it was hospice or palliative care, easily 90% of the patients we were serving had cancer. Then, you know, many of us were around during the time of the height of the AIDS crisis, and so then suddenly it was like, "Oh, wait a minute. Instead of 90% cancer, our programs can really meet this social need and serve the AIDS community as well," and I think that opened the door to start us thinking, "There are a lot of serious illnesses that could benefit from palliative care." I can remember when the idea of serving someone with end-stage heart disease was a very unusual thing, and of course now we see that, end-stage heart failure, serious pulmonary disease.

You know, we are beginning. We are just beginning to see the opportunities for palliative care. Of course, while we've all been, you know, working away the last 20 years on these Guidelines, our world has changed. The aging of our population, now all the diseases people used to die from at age 65 to 70, people are living with until age, you know, 90 and above, and so it's been important to revise the Guidelines to keep pace with what's happening in society, what's happening throughout our world.

Dr. McPherson: Since you have that historical perspective, Dr. Ferrell, what specifically prompted the 4th edition? Anything in particular, or just the continued evolution?

Dr. Ferrell: There's a huge factor, and that is we are, in the field of palliative care, the victims of our success. By that I mean, you know, many of us spent the first several years saying, "Please come, please refer, please, please." You know, there were lots of palliative care people and not enough patients coming to us. That is a distant memory, because now what exists is that there is an abundance of patients who desperately need palliative care, and honestly, even if we tripled tomorrow the number of specialist palliative care providers, if we could raise a magic wand ... and we can't ... but if we could double or triple the number of board-certified palliative medicine physicians, certified nurses, others, social workers, chaplains, that still is not going to begin to care for the seriously ill.

The real impetus behind this 4th edition was to say, as Martha alluded to, "We need to continue to define the specialty practice of palliative care," but this edition made a huge leap forward by saying, "and we also must now develop generalist palliative care," meaning if we believe that people with cancer and heart failure and COPD have serious illness impacting quality of life for patients and families, then we also believe that all of those providers who are caring for them ... cardiologists, oncologists, pulmonologists, family practice, PAs, all

providers, nurse practitioners ... that all of those people also need palliative care skills.

When we started this edition, at that first summit that Martha mentioned we actually asked the question, "Should there be two sets of guidelines? Should there still be a continuing specialist version of the guidelines and then separately a generalist version," the group said, "Absolutely not. That would be very confusing for the field, and honestly, it's the same patient."

It's the patient diagnosed by their family practitioner that now may come to an urban medical center and be seen through diagnosis and maybe initial treatment, but the patient's going back into her community. It's the veteran being seen in their rural VA clinic, a patient being seen back in their primary care by a nurse practitioner. It's a PA seeing this patient in an underserved community, and so it's one set of guidelines, but this set of guidelines now addresses both the specialty practice of palliative care but also the generalist application of palliative care.

Dr. McPherson: Well, I'm happy to do my part. We can run them all through my master's program, and then everybody'll know how to do this correctly. That would be wonderful.

Dr. Ferrell: Exactly. Equip them.

Dr. McPherson: There you go. I see in some of your literature that I are off your web page, you do have a little section in each domain talking about the essential palliative care skills needed by all clinicians. Is that what you meant by referring to like a primary palliative care person?

Dr. Ferrell: Martha, do you want to describe the practice example?

Dr. Twaddle: Absolutely, yeah. I think what's unique in palliative, very unique, is this emphasis inherent in our definition that we are a team, that this is an integration of a team-like structure into the care model, so embracing the health care professionals that are already involved in the care of that person and their family, but then enhancing it through adding different disciplines who can further address the needs of that person and family. Palliative care is so unique in that aspect of a team sport.

What I often liken it to is I think of medicine as typically multidisciplinary, and that's different than interdisciplinary. Multidisciplinary care is we're in our swim lane. In our role, we perform the care within our scope. We document. We may not really communicate, but we've got it in the chart, right, and so a lot of swim lanes. Palliative care is more of synchronized swimming, in the sense that the person and family are in the middle.

It's kind of Esther Williams, for those who remember that generation, and we're coordinating the care through communication and coordination and collaboration. It's all those wonderful "C" words, and that requires the integration of folks who may not have a specialty title, but they're inherently important to the care of that patient to optimize the outcomes, to help with facilitating the best possible care for the seriously ill person and family.

I think the other thing I'd really want to stress is that guidelines help drive quality measures and a way for people to set standards and say, "Are you doing this for your patient? Are you assessing the caregivers for strain and stress? Are you providing a psychological assessment? Are you looking for the social determinants of care, so that we can create accountabilities for those who care for this oftentimes vulnerable population?"

Dr. McPherson: Uh-huh. I love your analogy of the swim lane versus the synchronized swimming. That's such a graphic. I like that.

Dr. Twaddle: Do you see a swim cap with little flowers on it?

Dr. McPherson: I do.

Dr. Twaddle: That's what immediately comes to mind, yep.

Dr. McPherson: You and I are 29 and we remember Esther, right? Isn't it funny? Yeah. Let's dive into the guts of the Guidelines. I understand there are eight domains. Would either of you like to elaborate on what these domains are?

Dr. Twaddle: Betty, you are so good at articulating. I think you recite this in your sleep. Why don't you lead off, and throw whatever you want to me.

Dr. Ferrell: Sure. I think the way that I always think about the Guidelines is we begin with the first domain, which is structures and process of care, and that is such an important domain because what we are saying very much is that, unless we have structures and processes of care, unless we have the processes in place for how this care should happen, then it's just all good ideas, right?

For example, we can say, "Oh, we value, it's important to us, that we respond to physical and psychological symptoms," but unless we really build that into our system, how do we routinely assess? How do we communicate with each other what we have learned about the patient's symptoms? How do we document those symptoms? How do we follow up to make sure that those symptoms ... that our interventions have worked? Unless we have those processes in place, we won't be successful.

We start with that domain, which is so important, and I really encourage people to spend time thinking about that. Then we move into the other domains, which are really what I call kind of the clinical domains, the real nuts and bolts of what

defines our specialty. We then start in with the physical aspects of care, and again, everyone with any sort of background in hospice or palliative care knows that a hallmark of our field really is taking care of patients' symptoms. It's the distressing part, a very distressing part of their illness.

Then again, because we are palliative care, then the defining part of us is that we care for more than just the physical symptoms, that we care for the whole person, and so we then move into the domain of the psychological and psychiatric aspects of care. There's some wonderful, wonderful content in this edition, and I would strongly encourage any social worker or everyone who works with a social worker to spend a lot of time looking at this domain, because Domain Three in the 4th edition and throughout, we've added a lot more detail about the critical role of social workers ...

Dr. Twaddle: Yes.

Dr. Ferrell: ... in our field with assessing mental health needs and emotional needs, and really being at the forefront of those issues.

Dr. Twaddle: [Crosstalk 00:20:33] that we really, I think increasingly in health care, appreciate the social determinants of health, that where a person lives and who is helping them receive care will affect the outcome. By having these different domains as well, it also reinforces that one person can't do all this. Again, if you're going to address the holistic needs of a person and family who are seriously ill and you're going to address all these domains, it's going to take a team to do that.

Dr. Ferrell: Absolutely, and leads directly into the fourth domain, which is social aspects of care, and the social aspect links the things Martha was just alluding to and also focuses a lot on the family. As Martha said earlier in the call, part of the definition of serious illness is not only the patient who being impacted by a disease, but serious illness is also defined as instances where the family is very stressed by the illness, so it fits well. The fourth domain is social aspects, a lot of emphasis on family.

The fifth domain is spiritual, religious and existential aspects of care, and this is one of the domains that I have been most committed to and I feel we have such an opportunity through these Guidelines, because again it all goes back to our roots in hospice. The first days of hospice, you know, Dame Cicely Saunders and all of the early leaders in our field said, "People are spiritual beings, and some of our patients happen to be religious, but everyone is a spiritual being, and so if we truly provide whole-person care, then we will also pay attention to the spiritual, religious and existential aspects."

Domain five, in this version of the Guidelines we also emphasize very much that the chaplain is not the only person who should be concerned about spiritual care. Every member, right? This is the synchronized swimming that Martha just talked about, right? Don't stay in your lane and say, "I'm the nurse, and the

chaplain will take care of that." This is the synchronized swimming of palliative care, that how can we all ... you know, so often, I could give you a thousand examples, where the patient that's new to the service has just said, "Absolutely not. Don't call the chaplain," for the hundreds of reasons that we know, and we're going to respect that.

We are not going to call in the chaplain today. We're going to take the opportunities to continue to let the patient know about the role of our chaplain, but what this means is that the social worker is going to see the patient tomorrow, and because that social worker knows that this is a patient that has declined chaplaincy, then the social worker has the great opportunity to explore with the patient what is the meaning of their life, what are they most proud of, what is their legacy. Every member of the palliative care team serves this domain.

The sixth domain is cultural aspects, and again we should all be committed to providing care to the most diverse communities. One of the other things this reminds me of is that in each version of the Guidelines, people often ask us, "Are these sort of minimal recommendations or are these reach," and we've always proudly said, "These guidelines are reach guidelines, right? We don't expect any program in the country to be able to pick up these guidelines and say, 'We're perfect, we already do all of this.'"

Dr. Twaddle: Yeah. Yeah, sure.

Dr. McPherson: Right, yeah.

Dr. Ferrell: Right, we expect every program to pick up these guidelines. In this domain, what I would expect is for people to say, "You know, we actually do a pretty good job when we're caring for English-speaking, highly-educated patients who have big, supportive families and lots of resources," right, but maybe we aren't providing that same level of care to a family that looks a little different than us, to the new immigrant, the person for whom English is not the primary language, to lesbian, gay, transgendered, bisexual patients and families.

Diversity means diversity. It means in all realms of diversity, and so how can we challenge ourselves to provide superb palliative care even in the most diverse communities? The seventh domain, Martha, do you want to comment on [crosstalk 00:25:40] end of life? I know this is your passion.

Dr. Twaddle: Sure, yes. Well, it's where I started. Like Betty said, most of us started our careers in end-of-life, in hospice, and many of us like myself started our careers as volunteers, not really understanding at the time that this could be our career. It's so exciting to see people who are blazing through their professional training with a commitment from day one that this is where they want to be and this is who they want to serve.

The last I checked, 100% of people die, you know? The mortality for people is 100%, so every one of our patients is going to come to the end of life. Again looping back to what Betty said, these guidelines aren't for just specialists. God forbid that only specialists could care for those who are dying if 100% of people are going to die, right? We have to create a way for people to understand, embrace and feel qualified and confident in caring for people as they near the end of life.

Now, hospice in our country has grown and developed tremendously, and now 42% of Americans who die use hospice care, which is amazing, considering that when I started in the field in the early '90s, I think it was hovering around 10%, so watching this amazing growth. Yet, not everyone, unfortunately, will, for many reasons, be able to access that best model of care. We want people to think about it and introduce it and integrate it as early as possible when that person is eligible for that type of insurance support.

However, again, some people can't, whether they don't have the insurance or they don't have ... most hospices provide quality charity care and it doesn't matter if they can't pay, but some people just don't have opportunity to access that type of support. We all have to be qualified to care for a person nearing the end of life and through the end of life.

Looking at the ethical and legal, who are the decision makers for this patient? Is the person able to make decisions on their own? Do they have capacity for decisions? Who's the surrogate decision maker? Understanding, documenting, making sure that those aspects of care are very much addressed.

What Betty has really highlighted as we've gone through these domains is that the idea of the interdisciplinary team is that every person on the team, regardless of their background or their level of expertise or their role, has the ability to screen for unmet needs outside of their specialty. That's what an interdisciplinary team is.

Myself as a physician can screen for unmet social needs and unmet spiritual needs, and then grab the folks that have the expertise to go deeper into assessment and a care plan. Likewise, social work, pharmacists, could screen for physical issues that aren't well addressed, and we can work together to get a holistic care plan to improve symptom management.

Dr. McPherson: Don't you wish all of medicine would work this way?

Dr. Twaddle: Well, you know, it's really good that you said that, Lynn, because in truth, that's why palliative care came into being. When we became a medical specialty ... and I had the blessing of being part of that early, disruptive change group ... the idea of becoming a specialty wasn't because, "Oh, gee, I want to wear a certain nametag, I want to pay for another exam." It was because we believed that

medicine was hungry to return to its deepest roots, which is caring for a person body, mind and spirit.

If you read the writings of Plato and those early philosophers of medicine ... and there are probably some women who just didn't get good PR ... they spoke to holism as the very essence of what good care is all about, body, mind and spirit. Our thought, our belief, was that if we became a specialty, then every student begins to ... they have to spend time with us. Our questions and competencies infiltrate into training, nursing training, social work training, medical training, and we can begin to restore medicine to what it really was intended to be.

Dr. McPherson: Uh-huh. That's great. Well, that's certainly very comprehensive. I have seen from your literature that each domain you talk about the Six C's, which are comprehensive assessment, care coordination, care transitions, caregiver needs, cultural inclusion and communication, so that's really comprehensive.

Dr. Twaddle: That's a lot of C's.

Dr. Ferrell: It's a lot. If we could go back for just a second, the last domain, Domain Eight, we kind of got carried away, obviously our passion about care of the patient nearing the end of life, but the eighth domain is ethical and legal aspects of care, just to be clear on that, which is of course so important. In this 4th edition of the Guidelines, we've tried to also acknowledge that these are evolving too. I mean, many of us were around when ... you know, the Nancy Cruzan case and other pivotal cases that then created a focus on issues such as withdrawal of food or fluids, withdrawal of life support.

Again, now, state by state, many of our colleagues are addressing the issues of medically-assisted death. You know, we're struggling even with some daily issues around medicalization and availability of cannabis, and so what are our obligations of continued safe care. You know, competency issues become more important as our population ages, so the eighth domain has always been ethical and legal aspects, and it remains a very important aspect of the Guidelines, and yet we have to constantly be in tune of what are the most prominent ethical issues that clinicians face daily.

Dr. McPherson: Yeah. Just looking at these different domains and the Six C's and so forth, it strikes me this would be a good elective course ... but not elective, a mandated course ... that every student should take in every school, medicine, nursing, pharmacy, social work and more. I mean, we ... people ask me, my pharmacy colleagues, "How can you stand to be so specialized," and I say, "Well, I am, but I'm not," because as Dr. Twaddle pointed out, we're all going to die, so I think this is really important.

Here's the big question for me. Do your Guidelines go beyond "shoulding" on people ... you should do this, you should do that ... and give them specific clinical and organizational strategies for implementation?

Dr. Twaddle: In every guideline. Yes, in every guideline. The way they are formatted, it speaks to those operational strategies, what will happen when you implement or look to implement. The other piece that came out in this guideline that I'm super excited about is we also gave clinical practice examples. These are real programs doing this work, and how they did this.

Remember that guidelines are not standards, so those words are non-interchangeable. People create standards based on guidelines, so programs would look at this and say, like Betty was talking about, "This is aspirational," and we want people to always look at these and say, "You know, I could ... our group, our team, we could do even more, and so how would we know that we got there?"

Let's set some standards around a certain project, let's measure where we are now, let's implement a strategy to improve the care of seriously ill people and their families, and let's see how we change our care plan moving forward. It isn't about just "shoulding." It's about, yes, you need to, and there is a very methodical way through process improvement that one can continue to move the bar forward and improve the care models.

Dr. McPherson: You include real-life examples and suggestions for exactly how to do that?

Dr. Twaddle: Real-life examples, yes.

Dr. McPherson: Outstanding. Now that everybody's on the edge of their seat wanting to know, "How can I get this," how can we get the Guidelines? Do you have to pay for them, or free for the asking? What's the scoop?

Dr. Twaddle: Well, if you want the ring binder and to have that big tome on your desk, then you need to pay for that, because obviously there's a printing cost. I think Betty and I would both say that the online version of the Guidelines, which I have hyperlinked on my taskbar, is likely the best way to use the Guidelines. Betty, which format do you like to use the most?

Dr. Ferrell: You know, I personally think that it's nice to have different formats. For example, I do have the bound copy sitting right above my chair at my desk, because there are times I just personally find it helpful to reach up and grab it and sort of flip to the page, and check myself or check something. When you go to the website, nationalcoalitionhpc.org/ncp, you will see the complete Guidelines there, free, no cost. You will see a PDF version, an ePub version. You will see, if you do want to purchase, how to do that. Everything is there. It's so accessible and very easy to then forward, share with your colleagues, point them to the site.

Also there's a lot of other things on that site, so even if you did purchase your version of the Guidelines, go to the website, because click on the section that says Resources and you'll find a lot of information there. Obviously, once the

version is print it's a little harder to update, but Gwynne Sullivan and, you know, everyone involved with the NCP are constantly updating the website, sharing news and Coalition activities, so I definitely encourage people to go to the nationalcoalitionhpc.org website.

Dr. Twaddle: The one I really enjoy too is the online version, because it's searchable, so you can put in certain terms and find in what domain that aspect of care is spoken to. One of the things that we did in this guideline project that was unique and Betty and I are super excited about is a systematic review. Really, our field has gotten to a place with its literature, with its research, where there was an opportunity to do a systematic review of what we have thus far. That article, the systematic review of systematic reviews, is accessible for free via our website, and it shows that there are gaps. It's a call to action as well. The Guidelines are a call to action. There is always an opportunity to improve, and here's a framework and a map to help you on that journey.

Dr. McPherson: That's outstanding. Well, this is required reading for all the students in our program, and I know that must make you happy.

Dr. Twaddle: It does.

Dr. McPherson: I'm sure that we're not the only ones. This has been just tremendous. Is there any last stone we have left unturned, ladies, that you would like to share?

Dr. Twaddle: Super grateful to you, Lynn, for making this recording, this opportunity, come together and talk about the Guidelines, because Betty and I obviously put a lot of work into this, and worked with some amazing people. When the Guidelines were published on October 31st, 2018, they were endorsed very quickly. What was it, 82 organizations, Betty, that have endorsed the Guidelines?

Dr. Ferrell: Right, uh-huh. Yeah, we had 80 endorsements before they were published, and so that's ... again, this says these are not just guidelines for those of us in the specialty, that many, many national organizations have endorsed these guidelines, and emphasized both adult and pediatric. These guidelines are as relevant for pediatric palliative care as they are for adult palliative care. It was a wonderful village, and when you look at the Guidelines you'll see the long list, all the people that served on the writing group, the steering committee, the organizations. It's a great community that we're a part of.

Dr. Twaddle: Yeah.

Dr. McPherson: That's wonderful. Well, you've had five or six months off for good behavior, so have you started the Fifth Edition yet, is what I want to know?

Dr. Twaddle: Not yet. Let's get some roadwork with this one. Let's move forward with this one for a while.

Dr. McPherson:

Well, that's fantastic. Ladies, thank you so, so, so much. This was so informative and so helpful, and I know our listeners will really enjoy this. Thank you again, Dr. Betty Ferrell, Dr. Martha Twaddle, and thank you all for listening to the Palliative Care Chat podcast.

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